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Replies to initial written questions raised by Legislative Council Members in examining the Estimates of Expenditure 2025-26

Director of Bureau : Secretary for Health

Session No. : 20

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HHB314	3419	CHAN Hoi-yan	37	(1) Statutory Functions (2) Disease Prevention
HHB315	3420	CHAN Hoi-yan	37	(2) Disease Prevention
HHB316	3422	CHAN Hoi-yan	37	(3) Health Promotion
HHB317	3423	CHAN Hoi-yan	37	(1) Statutory Functions
HHB318	3424	CHAN Hoi-yan	37	(2) Disease Prevention
HHB319	3895	CHAN Hoi-yan	37	(4) Curative Care
HHB320	3481	LEUNG Hei, Edward	37	(2) Disease Prevention
HHB321	3506	LEUNG Hei, Edward	37	(4) Curative Care
HHB322	4001	MA Fung-kwok	37	(3) Health Promotion
HHB323	4023	MA Fung-kwok	37	(2) Disease Prevention
HHB324	3934	SHANG Hailong	37	(4) Curative Care
HHB325	3645	TIK Chi-yuen	37	(2) Disease Prevention (3) Health Promotion
HHB326	3646	TIK Chi-yuen	37	(2) Disease Prevention (3) Health Promotion
HHB327	3647	TIK Chi-yuen	37	(2) Disease Prevention (3) Health Promotion
HHB328	3648	TIK Chi-yuen	37	(2) Disease Prevention (3) Health Promotion
HHB329	3649	TIK Chi-yuen	37	(2) Disease Prevention (3) Health Promotion
HHB330	3650	TIK Chi-yuen	37	(2) Disease Prevention (3) Health Promotion
HHB331	3651	TIK Chi-yuen	37	(2) Disease Prevention (3) Health Promotion
HHB332	3652	TIK Chi-yuen	37	(2) Disease Prevention (3) Health Promotion
HHB333	3666	TIK Chi-yuen	37	(5) Rehabilitation
HHB334	3675	TIK Chi-yuen	37	(4) Curative Care
HHB335	4009	TSE Wai-chun, Paul	37	(2) Disease Prevention

CONTROLLING OFFICER'S REPLY

HHB001

(Question Serial No. 3115)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in Matters Requiring Special Attention in 2025-26 that the Government will continue to take forward and implement policy initiatives to promote the development of primary healthcare having regard to the Primary Healthcare Blueprint (the Blueprint). Please inform this Committee of:

1. the respective annual expenditure allocated to various initiatives in the Blueprint since its release in 2022; and
2. the estimated expenditure involved in taking forward and implementing the various policy initiatives in the Blueprint in 2025-26. How will the estimated expenditure be allocated among different initiatives, such as enhancing the Chronic Disease Co-care Pilot Scheme, expanding the Elderly Health Care Voucher Greater Bay Area Pilot Scheme, developing a community drug formulary and a community pharmacy programme, and strengthening preventive care services at the General Outpatient Clinics?

Asked by: Hon CHAN Chun-ying (LegCo internal reference no.: 1)

Reply:

(1) and (2)

The Government released the Primary Healthcare Blueprint (the Blueprint) in December 2022, setting out the development direction and strategies for coping with the challenges brought about by an ageing population and the increasing prevalence of chronic diseases. The Government is progressively taking forward various recommendations of the Blueprint over the short, medium and long term.

Following the announcement of the Blueprint, the Government is committed to advocate the concept of “Family Doctor for All” to tie in with the development of primary healthcare services. In this regard, with effect from 6 October 2023, only doctors enlisted in the Primary Care Directory (PCD) are allowed to take part in various government-subsidised

primary healthcare programmes, including District Health Centre (DHC) services, the Elderly Health Care Voucher (EHCV) Scheme, the Vaccination Subsidy Scheme, the Residential Care Home Vaccination Programme, the Colorectal Cancer Screening Programme and the Hospital Authority (HA) General Out-patient Clinic Public-Private Partnership Programme, with a view to standardising the arrangements across various subsidised programmes. With effect from 1 March 2025, such arrangement also applies to dentists who participate in the EHCV Scheme.

The expenditures since the announcement of the Blueprint and the 2025-26 estimates of the various Government-subsidised primary healthcare programmes are tabulated as follows:

Primary Healthcare Programme ^{Note 1,2,3}	2022-23 Expenditure (\$ million)	2023-24 Expenditure (\$ million)	2024-25 Revised Estimates (\$ million)	2025-26 Estimates (\$ million)
DHC Service	364	491	483	- ^{Note 4}
DHC Express (DHCE) Service	116	155	155	
Elderly Health Care Voucher Scheme	2,785.9	3,333.1	3,446.9	4,151.0 ^{Note 5}
Vaccination Subsidy Scheme	195.6	258.0	259.2	258.1
Residential Care Home Vaccination Programme	9.2	9.7	10.7	10.7
Colorectal Cancer Screening Programme	151.6	175.6	222.7	287.8
HA General Outpatient Clinic Public-Private Partnership Programme	101.8	127.2	127.7	124.9
HA Family Medicine Clinic (including General Out-patient Clinic and Family Medicine Specialist) ^{Note 6,7}	3,898	4,908	4,811	5,122

Note:

1. At the primary healthcare level, apart from the primary healthcare programmes under the Blueprint listed above, the Department of Health (DH) currently delivers free or subsidised services using a life course approach through various areas of work with emphasis on preventive care (including Family Health Service, Student Health Service, Elderly Health Service, etc.). The expenditure and specific outcome on supporting the measures to improve primary healthcare cannot be separately quantified by DH.
2. The above expenditure is mainly used to subsidise the relevant healthcare services provided to the participants.
3. The community drug formulary and the community pharmacy programme are at the planning and preparatory stage, and hence the actual expenditure for 2025-26 is not yet available.
4. Upon the upgrading of the 3 DHCEs (Central and Western District, Eastern District and Yau Tsim Mong District) to DHCs this year, the 11 existing DHCEs will gradually

reduce to 8, while the number of DHCs will increase to 10. As the Health Bureau (HHB) is now handling some of the contractual matters relating to the DHCs and DHCEs, the estimated expenditure for 2025-26 is not yet available for the time being.

5. The expenditure of the EHCV Greater Bay Area Pilot Scheme is absorbed by the overall provision for the EHCV Scheme, and hence there is no separate breakdown of the estimated expenditure.
6. The costs of General Out-patient Clinic and Family Medicine Specialist services include direct staff costs (e.g. medical officers and nurses) for providing services to patients; expenditure on various clinical support services (e.g. pharmacy, diagnostic radiology and pathology tests) and other operating expenses (e.g. expenditure on utility services and maintenance of medical equipment).
7. In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA has adjusted its services to cope with the outbreak. With the subsiding of local COVID-19 epidemic situation and cessation of anti-epidemic measures in early 2023, the HA has been gradually resuming provision of all of its public healthcare services to tie in with the Government's normalcy measures. This should be taken into consideration when comparing the service capacity of the HA in previous years.

Furthermore, the Government launched the three-year Chronic Disease Co-Care Pilot Scheme (CDCC Pilot Scheme) on 13 November 2023, which is the first major initiative after the announcement of the Blueprint at the end of 2022. The Government aims to establish a family doctor regime and position DHCs and DHCEs as hubs through the CDCC Pilot Scheme to foster expansion of the community healthcare network, so as to properly manage chronic diseases in the community through a multi-disciplinary approach. The requirement for family doctors to be enlisted in the PCD is also applicable to the CDCC Pilot Scheme. Since the launch of the CDCC Pilot Scheme, the expenditure in the 2023-24 financial year and the estimated expenditure for the 2024-25 and 2025-26 financial years are as follows:

2023-24 Expenditure (\$ million)	2024-25 Estimated Expenditure (\$ million)	2025-26 Estimated Expenditure (\$ million)
10	43.1	178.2

In order to implement the policy direction of primary healthcare and related measures mentioned in the Blueprint, the elderly and women health services of the DH will be integrated into the DHC Networks of the Primary Healthcare Commission, while the EHVS will be integrated into the Strategic Purchasing Office of the HHBu. Service planning and resource allocation through strategic procurement of other public-private partnership projects of the DH, such as the Vaccination Subsidy Scheme, the Residential Care Home Vaccination Programme, the Colorectal Cancer Screening Programme, etc., will also be taken forward in phases.

- End -

CONTROLLING OFFICER'S REPLY**HHB002****(Question Serial No. 3122)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): (000) Operational expensesProgramme: (2) HealthControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

It is mentioned under Matters Requiring Special Attention in 2025-26 that the Government will continue to take forward and enhance the development of District Health Centres (DHCs) and District Health Centre Expresses (DHCEs) across the territory, and integrate the services of Woman Health Centres (WHCs) and Elderly Health Centres (EHCs) into the DHC Network. Please advise on:

- (1) the present numbers of DHCs and DHCEs in all districts and the respective average costs for setting up DHCs and DHCEs;
- (2) the specific service programmes currently provided by DHCs and DHCEs, the respective numbers of participants and the costs (including manpower, equipment, and consumables) of each service; and
- (3) the estimated funding requirement and manpower arrangement in the course of integrating the services of WHCs and EHCs into the DHC Network, and the projects to which the funds will be allocated.

Asked by: Hon CHAN Chun-ying (LegCo internal reference no.: 10)Reply:

(1) & (2)

The Government set up District Health Centres (DHCs) and interim DHC Expresses (DHCEs) of a smaller scale in all districts across the territory by the end of 2022, thereby attaining the interim goal of covering all 18 districts.

The cumulative numbers of members of each DHC/DHCE and the revised estimate (including service contracts, site maintenance and rental cost) for 2024-25 are set out in the table below:

DHC/DHCE Service Commencement Date	Cumulative Number of Members Note 1 (as at 31 December 2024) [Provisional Figures]	2024-25 Revised Estimates (million)
<i>DHC</i>		

DHC/DHCE Service Commencement Date	Cumulative Number of Members Note 1 (as at 31 December 2024) [Provisional Figures]	2024-25 Revised Estimates (million)
Kwai Tsing 24 September 2019	46 100	62
Sham Shui Po 30 June 2021	34 300	63
Tuen Mun 31 May 2022	38 100	80
Wong Tai Sin 30 June 2022	34 700	69
Southern 17 October 2022	23 900	58
Yuen Long 24 October 2022	42 500	73
Tsuen Wan 30 December 2022	26 000	78
<i>DHCE</i>		
Sai Kung 1 September 2021	10 600	14
Kowloon City 1 October 2021	11 300	14
Yau Tsim Mong 1 October 2021	9 600	14
Wan Chai 4 October 2021	6 800	15
North 18 October 2021	8 700	14
Islands 18 October 2021	6 400	13
Kwun Tong 21 October 2021	10 800	14
Tai Po 22 October 2021	7 800	14
Sha Tin 30 October 2021	13 300	14
Central and Western 30 October 2021	7 900	15
Eastern 30 October 2021	10 900	14
Total	349 900	638

Note:

- Figures are rounded to the nearest hundred.

The provisions for the service contracts of DHCs and DHCEs cover staff costs, rentals of DHC satellite centres/DHCE core centres and service points, set up costs, administrative

expenses and programme expenses under the DHC Scheme. The separate costs for each service are therefore not available.

Upon the upgrading of the 3 DHCEs in the Central and Western District, Eastern District and Yau Tsim Mong District to DHCs this year, the 11 existing DHCEs will gradually reduce from to 8, while the number of DHCs will increase to 10. The estimated expenditure for DHCs and DHCEs (including provisions for service contracts, site maintenance and rental cost) for 2025-26 are \$1.083 billion and \$213 million respectively.

(3)

The integration of women and elderly health services into the district health network is carried out by the Primary Healthcare Commission as part of its overall functions, and there is no separate staff establishment and expenditure on related work. Relevant information is therefore not available.

- End -

CONTROLLING OFFICER'S REPLY

HHB003

(Question Serial No. 3124)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It was mentioned in Matters Requiring Special Attention in 2025–26 that the Government would further promote the development of Chinese medicine (CM) in Hong Kong, including expanding Government-subsidised Integrated Chinese-Western Medicine services, enhancing funding support to the CM sector through the Chinese Medicine Development Fund, and taking forward more training programmes for nurturing CM talents. Please advise this Committee of:

- (1) the estimated expenditure on expanding Government-subsidised Integrated Chinese-Western Medicine services, and the proportion of funding allocation to various projects such as those related to integrated diagnosis and training and scientific research collaboration; and
- (2) the estimated amount of provision to be earmarked under the Chinese Medicine Development Fund to enhance funding support to the CM sector, the areas or projects (like CM development, establishment of CM clinics and upgrading of the CM industry) to be supported in addition to the efforts to take forward more training programmes for nurturing CM talents, and the respective expenditure on such work.

Asked by: Hon CHAN Chun-ying (LegCo internal reference no.: 12)

Reply:

(1)

To gather experience in the operation of integrated Chinese-Western medicine (ICWM) and Chinese medicine (CM) in-patient services, the Government has earlier commissioned the Hospital Authority (HA) to launch the ICWM services through a Pilot Programme, to provide ICWM treatment to in-patients under the three designated disease areas (namely stroke care, musculoskeletal pain management and cancer palliative care) through the 18 Chinese Medicine Clinics cum Training and Research Centres (CMCTRs). To dovetail with the policy direction of strengthening ICWM services, the HA regularised and further expanded the services to more hospital sites in early 2023, enabling more patients to benefit from such services.

Succeeding the implementation experience and effectiveness of the ICWM services, the HA piloted three new ICWM programmes on cancer care, respiratory diseases care and knee osteoarthritis care by phases starting from the latter half of 2023. Among them, the Cancer Care Pilot Programme, which was first launched in the latter half of 2023 in Kowloon West Cluster and New Territories West Cluster, was subsequently extended to the Hong Kong West Cluster and Hong Kong East Cluster in the third quarter of 2024 and the first quarter of 2025 respectively, and will continue to be extended to the three remaining clusters.

As at end-December 2024, the number of public hospitals providing ICWM services has increased from 8 to 26, with the number of designated hospital sites significantly increased to 61. The HA will continue to expand the ICWM services to cover more disease areas in which CM has an advantage, as well as hospital sites, so as to further leverage the strengths of CM and ICWM.

Regarding the budget estimate, the Government has earmarked \$473 million in 2025-26 for the HA to take forward initiatives for promoting CM development, which include operating the CMCTRs to provide Government-subsidised outpatient services and CM practitioner trainee programme, providing ICWM services, providing “evidence-based” CM training, operating the Toxicology Reference Laboratory, conducting quality assurance and central procurement of CM drugs, and enhancing and maintaining the CM Information System.

(2)

As the first dedicated fund set up to support CM development, the Chinese Medicine Development Fund (CMDf) has been injected with a total of \$1 billion since its official launch in June 2019. The CMDf aims to enhance the overall standards of the CM sector to promote the high-quality development of CM in Hong Kong on all fronts. Having regard to the diverse needs of stakeholders, the CMDf has launched various support programmes covering different areas to benefit CM personnel and organisations of different segments of the sector. As of end of February 2025, the CMDf has approved an accumulative total of about 8 900 funding applications, involving a total funding of about \$403 million (provisional figure) for the approved projects and benefiting more than 3 million members of the sector and the general public, with major achievements listed below:

- (a) Talent nurturing: Close to 3 500 Chinese medicine practitioners (CMPs) and CMs personnel have received subsidies to attend CM professional training programmes for continuously upskilling their professional knowledge and ability. The CMDf has supported programme providers to design and organise innovative training projects, benefitting over 41 300 practitioners. The CMDf has supported 85 CMPs and CMs personnel to participate in the Hong Kong Chinese Medicine Talent Training Programme co-organised by the National Administration of Traditional Chinese Medicine and Health Bureau (HHB) to cater for the need of establishing a talent pool;
- (b) Quality enhancement: The CMDf has supported more than 560 CM clinics and 220 Chinese herbal medicine retailers/wholesalers to upgrade their facilities and equipment with a view to enhancing service quality and the safety and quality control of CMs. The CMDf has also supported nearly 180 proprietary Chinese medicines (pCm) manufacturers/wholesalers to engage consultancy services or

technical support for over 760 pCm products, thereby levelling up the quality of Hong Kong-registered pCm products;

- (c) Market development: The CMDF has provided subsidies for 12 Hong Kong-registered pCm products for external use to be registered and sold on the Mainland through streamlined approval procedures to promote industry development;
- (d) Research and applied studies: The CMDF has supported the commencement of 72 CM research and applied studies projects which are instrumental in driving academic and clinical research as well as the professional and industry development of CM in Hong Kong; and
- (e) Publicity and promotion: The CMDF has supported more than 1 100 CM publicity and public education activities of various forms, targeting audiences such as kindergarten, primary and secondary school students, and elderly persons.

Following an additional injection of funds in the 2023-24 Budget, the CMDF has rolled out various new and enhanced initiatives to cater for the needs of the CM sector and align with its latest development. For example:

- (a) To facilitate Hong Kong pCms to explore the Mainland market and promote industry development, the CMDF launched the Greater Bay Area pCm Industry Development Support Scheme in February 2024 to provide subsidies for Hong Kong-registered pCms for external use to apply for registration in the Mainland through the streamlined approval procedures;
- (b) To dovetail with the phased service commencement of The Chinese Medicine Hospital of Hong Kong at the end of 2025, the CMDF invited organisations to submit applications for 6 talent training programmes relating to cross-disciplinary collaboration, healthcare administration and management under the Strategic Theme Commissioned Project Funding Programme from mid-2024. The approval process for the relevant commissioned training programmes was completed and the programmes are expected to commence in phases starting from mid-2025; and
- (c) To further fostering cultural inheritance and promotion of CM, the CMDF raised the funding ceiling of CM public promotion projects to \$2 million from April 2024 to enhance the scale and effectiveness of public education and promotion projects designed and implemented by the CM sector. The CMDF also invited organisations to submit applications under the Strategic Theme Commissioned Project Funding Programme for the development of CM teaching and learning resource kits for secondary and primary schools in mid-2024. The approval process for the relevant commissioned projects was completed and the projects is expected to commence in phases starting from mid-2025.

The HHB will continue to closely monitor the implementation of the CMDF in consultation with the Advisory Committee on CMDF, work with the CMDF's implementation agent (the Hong Kong Productivity Council) to maintain close liaison with the CM sector and relevant stakeholders, and introduce more enhancement measures as and when necessary.

The details and vetting criteria of the funding schemes as well as the amount of subsidy, progress and achievements of the approved projects have been uploaded to the CMDF website (www.cmdevfund.hk).

- End -

CONTROLLING OFFICER'S REPLY

HHB004

(Question Serial No. 3150)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Hospital Authority, through various talent exchange programmes, invites healthcare professionals, including those from the Mainland especially the Greater Bay Area, for professional and clinical exchange with local healthcare personnel to foster mutual professional enhancement and, in the long run, establish a regional healthcare talent pool. Please set out information on the manpower and estimated expenditures involved in the programmes.

Asked by: Hon CHAN Chun-ying (LegCo internal reference no.: 38)

Reply:

The Hospital Authority (HA) has all along been actively promoting the exchange with Mainland healthcare talents. Launched by the HA in the fourth quarter of 2022, the Greater Bay Area (GBA) Healthcare Talents Visiting Programmes aim to establish a sustainable exchange mechanism for facilitating professional exchange among healthcare personnel of various disciplines including doctors, nurses, allied health professionals and Chinese medicine (CM) practitioners in public healthcare systems of the GBA. The Chief Executive put forward the strengthening of two-way training and exchange of healthcare talents between Hong Kong and the Mainland in his 2023 Policy Address. In this regard, the HA is actively promoting the establishment of a two-way talent exchange mechanism with the GBA, Beijing, Shanghai and a number of other Mainland regions/cities. The HA will continue take forward various visiting programmes with a view to further extending the depth and breadth of talent exchange.

The table below sets out the figures on healthcare talents who visited Hong Kong through healthcare talents visiting programmes jointly launched by the HA and various Mainland regions/cities from 2022-23 to 2024-25 (as at 31 December 2024):

Group of grades ^{Note (1)}	2022-23	2023-24	2024-25 (as as 31 December 2024)
Doctors (GBA doctors)	-	13 (12)	48 (38)
Nurses	-	70	99
Allied health professionals	-	5	35
CM practitioners ^{Note (2)}	3	13	18

Note:

- (1) The nurses, allied health professionals and CM practitioners who joined the visits were all from GBA cities.
- (2) The figures refer to accumulative numbers of CM experts in the CM expert pool. After a CM expert joins the expert pool, the HA will arrange for his/her visits to Hong Kong on an ad hoc basis to provide clinical training under relevant training programme.

The table below sets out the figures on HA healthcare personnel of various disciplines who visited the Mainland for two-way exchange from 2022-23 to 2024-25 (as at 31 December 2024):

Group of grades	2022-23	2023-24	2024-25 (as at 31 December 2024)
Doctors	not applicable	-	8
Nurses		26	21
Allied health professionals		19	41
CM practitioners ^{Note (3)}		-	16

Note:

- (3) The CM Enhanced In-patient Training Programme with the GBA was launched in April 2024. The CM practitioners under training (non-HA staff members) are from the CM Clinics cum Training and Research Centres across the 18 districts. They will visit the Mainland in batches for receiving clinical training under the training programme.

The form of exchange of various programmes may vary to serve different target groups and achieve different objectives, and arrangements will be made for healthcare talents who come to Hong Kong to have exchange with HA's healthcare personnel in relevant clinical departments of different hospital clusters, it is therefore difficult to quantify separately the expenditure involved in such exchange programmes.

- End -

CONTROLLING OFFICER'S REPLY

HHB005

(Question Serial No. 1783)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the drug dispensing in Hong Kong, will the Government inform this Committee of:

1. the numbers of drug items dispensed in each of the past 5 years;
2. the expenditures on drugs dispensing by the Government over the past 5 years;

Asked by: Hon CHAN Hak-kan (LegCo internal reference no.: 20)

Reply:

In line with the Government's public healthcare policy to ensure that citizens are not denied adequate medical care due to lack of means, the Hospital Authority (HA) provides healthcare services and drugs or medical items, which are heavily subsidised by the Government, to patients based on their clinical needs and in accordance with the HA's treatment guidelines. The HA Drug Formulary currently includes about 1 500 types of drugs, encompassing approximately 2 700 items, to meet treatment needs.

Besides, the Government and the HA will press ahead with the implementation of the fees and charges reform for public healthcare announced recently, which aims to guide the public to make optimal use of healthcare resources through 3 aspects, namely reforming the subsidisation structure, reducing wastage and abuse, and enhancing healthcare protection. It also seeks to strengthen the healthcare protection on all fronts for patients who are "poor, acute, serious or critical", with a view to ensuring that the limited healthcare resources can be directed in a more targeted manner to assist those patients most in need, thereby enhancing the sustainability of the healthcare system so as to cope with the challenges posed by an ageing population, inflation of healthcare cost, etc., and serve as a safety net for all.

(1)

The numbers of drug items dispensed by the HA to patients (including general drugs, special drugs, self-financed items with safety net coverage and self-financed items without safety net coverage) over the past 5 years from 2020-21 to 2024-25 are tabulated below:

	2020-21	2021-22	2022-23	2023-24	2024-25*
Number of drug items (in 000's)	45 753.9	48 649.5	50 045.7	55 352.5	42 190.8

* Figure up to 31 December 2024

In addition, the numbers of drug items dispensed (excluding vaccines) by the clinic dispensaries under the Department of Health (DH) (in terms of the number of drug items contained in each prescription) over the past 5 years are tabulated below:

	2020-21	2021-22	2022-23	2023-24	2024-25
Number of drug items (in 000's)	1 297.3	1 208.8	1 296.7	1 255.4	1 286.8

(2)

The table below sets out the HA's expenditure on the procurement of drugs dispensed to patients (including drugs charged at standard fees and drugs purchased by patients at their own expenses) over the past 5 years:

	2020-21	2021-22	2022-23	2023-24	2024-25 (Projection)
Drug expenditure [^] (\$ million)	8,685	9,642	12,451	13,127	12,951

[^] excluding other expenditures (such as storage and repackaging)

The expenditures of the DH on drugs dispensed over the past 5 years are tabulated below:

	2020-21	2021-22	2022-23	2023-24	2024-25 (Projection)
Drug expenditure (\$ million)	461.8	434.7	441.2	449.0	462.4

- End -

CONTROLLING OFFICER'S REPLY

HHB006

(Question Serial No. 1792)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the public healthcare services in Hong Kong, will the Government inform this Committee of:

- (1) the respective attendances of accident and emergency (A&E) services and general outpatient services provided at public hospitals in various districts and their utilisation rates in the past year in table form;
- (2) the number of hospital beds and the average occupancy rate in each of the 18 districts;
- (3) the current ratios of the capacities of dental services to the numbers of local residents in all 18 districts;
- (4) the estimated number of additional hospital beds to be provided in the next 5 years;
- (5) the manpower shortage rates of doctors and nurses and their wastage rates, as well as the ratio of the number of incoming doctors to the number of wastage in the past year; and
- (6) the average waiting time for patients of the 5 categories at various A&E departments?

Asked by: Hon CHAN Hak-kan (LegCo internal reference no.: 29)

Reply:

(1)

Number of Accident and Emergency (A&E) attendances

At present, there are 18 public hospitals under the Hospital Authority (HA) providing A&E services for the critically ill or seriously injured people and victims of disasters. To ensure that citizens with urgent needs can receive timely services, A&E departments implement a patient triage system under which patients are classified into 5 categories, namely critical, emergency, urgent, semi-urgent and non-urgent based on their clinical conditions, and will receive treatment as prioritised by their urgency category. The table below sets out the A&E attendances under various triage categories at the above HA hospitals in 2024-25 (up to 31 December 2024).

Hospital cluster	Hospital	Number of A&E attendances				
		Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
HKEC	PYNEH	930	3 266	31 313	44 427	1 196
	RH	1 197	550	16 237	28 146	2 093
	SJH	49	81	1 526	4 686	140
HKWC	QMH	915	2 677	34 815	44 200	1 538
KCC	KWH	1 367	2 926	45 150	46 903	1 633
	QEH	3 259	2 826	70 054	58 383	4 644
KEC	TKOH	859	2 124	36 130	45 847	2 429
	UCH	2 090	3 463	52 802	47 553	3 916
KWC	CMC	779	2 155	34 252	36 115	1 546
	NLTH	268	800	14 615	43 511	842
	PMH	1 112	2 295	47 822	31 171	438
	YCH	1 348	1 667	33 656	49 578	170
NTEC	AHNH	445	1 568	20 511	46 262	1 621
	NDH	1 193	2 004	31 097	33 863	955
	PWH	1 319	5 250	36 030	73 604	1 002
NTWC	POH	610	2 294	21 532	39 389	3 920
	TMH	898	4 081	51 503	63 936	1 586
	TSWH	432	1 561	18 195	57 987	2 689
HA overall		19 070	41 588	597 240	795 561	32 358

The above attendances for A&E services under various triage categories in various hospitals under the HA exclude (i) first-time visits without triage categories, and (ii) follow-up visits to the A&E departments.

Please refer to the remarks for the catchment districts of each hospital cluster.

Number of general out-patient (GOP) attendances

There are 74 GOP clinics under the HA in Hong Kong, mainly providing community-based primary healthcare services to the citizens including the elderly, low-income persons and patients with chronic diseases. In 2024-25 (up to 31 December 2024), the utilisation rate of GOP consultation quotas is about 99%. The table below sets out the number of GOP attendances in each hospital cluster.

Hospital cluster	Number of GOP attendances (up to 31 December 2024)
HKEC	419 610
HKWC	300 813
KCC	896 099
KEC	721 686
KWC	852 497
NTEC	785 117
NTWC	727 062

Please refer to the remarks for the catchment districts of each hospital cluster.

(2)

The table below sets out the number of hospital beds and in-patient bed occupancy rate in each hospital cluster under the HA in 2024-25 (up to 31 December 2024).

Hospital cluster	Number of hospital beds (up to 31 December 2024)	In-patient bed occupancy rate (up to 31 December 2024)
HKEC	3 336	82%
HKWC	3 079	73%
KCC	6 093	86%
KEC	3 032	93%
KWC	5 082	92%
NTEC	5 266	91%
NTWC	4 928	87%
HA overall	30 816	87%

Please refer to the remarks for the catchment districts of each hospital cluster.

Note:

According to the HA's classification, day in-patients refer to those who are admitted to hospital for non-emergency treatment and discharged on the same day, while in-patients are those who are admitted to hospital via the A&E department or have stayed in hospital for more than 1 day. The numbers of both in-patients and day in-patients are both taken into account when calculating the number of hospital beds as well as that of discharges and deaths. The number of day in-patients, however, is excluded in calculating the in-patient bed occupancy rate.

(3)

Free emergency dental service (generally referred to as General Public (GP) Sessions) are provided by the Department of Health (DH) through designated sessions each week in its 11 government dental clinics. Dental service under the GP Sessions include treatment of acute dental diseases, prescriptions for pain relief, treatment of oral abscesses and tooth extraction. The dentists will also provide professional advice based on individual needs of patients. The table below sets out the number of discs allocated for GP Sessions in the 11 government dental clinics in 2024.

Dental clinic with GP Sessions	District	Number of discs allocated in 2024
Kowloon City Dental Clinic	Kowloon City	3 045
Kwun Tong Dental Clinic	Kwun Tong	2 016

Dental clinic with GP Sessions	District	Number of discs allocated in 2024
Kennedy Town Community Complex Dental Clinic	Central and Western	4 074
Fanling Health Centre Dental Clinic	North	1 275
Mona Fong Dental Clinic	Sai Kung	1 050
Tai Po Wong Siu Ching Dental Clinic	Tai Po	1 029
Tsuen Wan Dental Clinic	Tsuen Wan	4 200
Yan Oi Dental Clinic	Tuen Mun	1 008
Yuen Long Government Offices Dental Clinic	Yuen Long	2 079
Tai O Dental Clinic	Islands	176
Cheung Chau Dental Clinic	Islands	176
Total		20 128

As regards public hospitals, the dental services provided by the DH and the HA include hospital dental services and specialist dental services which mainly cover specialist oral maxillofacial surgery for hospital in-patients as well as patients with special oral care needs and dental emergency needs (such as trauma, tumours and cleft deformities, etc.). Most of these patients are referred internally by specialists of different clinical departments (such as Ear, Nose and Throat, Surgery, Internal Medicine, Paediatrics, and Oncology) for cross-specialty treatment. The DH and the HA do not maintain statistics on such referrals.

(4)

The HA plans and develops various public healthcare services including hospital beds provision on a cluster basis, and will take into account a number of factors such as the increase in service demand due to population growth and demographic changes, the rising prevalence of chronic diseases, technology advancement, manpower availability and complementary service arrangements among clusters. The HA will monitor the utilisation of various healthcare services and plan the provision of future healthcare services according to the population projections of various districts of Hong Kong and the development plans of the Government.

In 2016, the Government and the HA commenced the implementation of the First Hospital Development Plan (HDP) to carry out a total of 16 projects, including the redevelopment and expansion of 11 hospitals, the construction of a new acute hospital, 3 community health centres and 1 supporting services centre. It is aimed that upon completion of the First HDP, a total of 6 557 additional bed spaces^(Note) and 94 operating theatres will be provided, along with the creation of more room for increasing service quotas of specialist and general out-patient clinics.

The HA plans to provide 342 additional beds in 2025-26.

Note: The figures include the additional beds at Kai Tak New Acute Hospital, which are provided for the relocation of the services from Queen Elizabeth Hospital (QEH). Currently, QEH has around 1 940 beds and the reprovisioning of these beds will depend on the reallocation or redevelopment plan of its vacated buildings after its service relocation.

(5)

The HA delivers healthcare services through multi-disciplinary teams comprising doctors, nurses, allied health professionals and care-related support staff. The HA assesses its manpower requirements from time to time and flexibly deploys its staff to cope with service and operational needs.

The table below sets out the attrition (wastage) rates of full-time doctors and nurses in 2024-25 (rolling 12 months from January to December 2024).

Staff group	2024-25 (Rolling 12 months from January to December 2024)
Doctor	5.2%
Nurse	7.5%

Note:

- (1) Attrition (wastage) includes all types of cessation of service (including retirement) from the HA for permanent and contract staff on a headcount basis.
- (2) Rolling attrition (wastage) rate = (Total number of staff left the HA in the past 12 months / Average strength in the past 12 months) x 100%.
- (3) Attrition (wastage) excludes the number of staff under the arrangement of Extending Employment Beyond Retirement (EER) starting from January 2024. The figures prior to this month are for reference only and direct comparison with those under the current revised calculation method is not appropriate.
- (4) Doctors exclude Interns and Dental Officers.

The table below sets out the intake and attrition (wastage) of full-time doctors in 2024-25 (April to December 2024).

Staff group	Intake	Full-time attrition (wastage)
Doctor	672	244

Note:

- (1) Intake refers to the total number of permanent and contract staff joining the HA on a headcount basis during the period. Transfers, promotions and movements within the HA are not counted.
 - (2) The intake of doctors includes the number of Interns appointed as Residents.
 - (3) Intake excludes the number of staff under the arrangement of EER starting from January 2024. The figures prior to this month are for reference only and cannot be directly compared with those under the current revised calculation method.
 - (4) Attrition (wastage) includes all types of cessation of service (including retirement) from the HA for permanent and contract staff on a headcount basis.
 - (5) Attrition (wastage) excludes the number of staff under the arrangement of EER starting from January 2024. The figures prior to this month are for reference only and direct comparison with those under the current revised calculation method is not appropriate.
 - (6) Doctors exclude Interns and Dental Officers.
- (6)

To ensure that citizens with urgent needs can receive timely services, A&E departments implement a patient triage system under which patients are classified into 5 categories, namely critical, emergency, urgent, semi-urgent and non-urgent based on their clinical conditions, and will receive treatment as prioritised by their urgency category. The HA's performance targets specify that all critical patients (i.e. 100%) will receive immediate treatment, and emergency and urgent patients will be prioritised for treatment upon arrival at A&E departments, with the targets being that most emergency patients (95%) and urgent patients (90%) will be treated within 15 and 30 minutes. A&E departments are not GOP clinics. If there are a large number of semi-urgent or non-urgent patients in A&E departments, it may affect the provision of treatment for emergency and urgent patients. The HA has met its service targets for both Critical and Emergency patients, but the target achievement rate for Urgent cases is 76.6%, indicating that some urgent patients could not be treated within 30 minutes.

The table below sets out the average waiting time for A&E services in various triage categories at the A&E department of each HA hospital in 2024-25 (up to 31 December 2024). At present, patients triaged as critical, emergency and urgent are handled immediately and with priority according to the HA's performance targets. If the conditions of patients triaged as semi-urgent and non-urgent worsen while waiting, healthcare staff on site will assess whether the patients' triage category needs to be adjusted depending on the situation. In fact, since A&E departments aim to provide emergency medical services for patients with more urgent conditions, if A&E departments receive patients with more critical conditions, they will have to deploy healthcare staff to rescue the more critical patients and patients triaged as semi-urgent or non-urgent will need to wait for a longer period of time.

Hospital cluster	Hospital	Average waiting time (minute) for A&E services				
		Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
HKEC	PYNEH	0	5	33	185	216
	RH	0	9	24	139	210
	SJH	0	9	15	26	32

Hospital cluster	Hospital	Average waiting time (minute) for A&E services				
		Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
HKWC	QMH	0	9	29	132	175
KCC	KWH	0	6	33	204	217
	QEH	0	7	11	91	133
KEC	TKOH	0	7	26	166	216
	UCH	0	12	24	199	228
KWC	CMC	0	4	25	175	164
	NLTH	0	7	20	98	113
	PMH	0	9	29	221	219
	YCH	0	4	25	140	176
NTEC	AHNH	0	9	28	142	135
	NDH	0	9	29	212	254
	PWH	0	11	34	200	212
NTWC	POH	0	7	20	155	193
	TMH	0	6	21	194	228
	TSWH	0	5	15	172	209
HA overall		0	8	25	164	190

Remarks:

The catchment districts of each hospital cluster under the HA are as follows:

- HKEC – Eastern, Wan Chai, Islands (excluding Lantau Island)
- HKWC – Central and Western, Southern
- KCC – Kowloon City, Yau Tsim Mong, Wong Tai Sin
- KEC – Kwun Tong, Sai Kung
- KWC – Sham Shui Po, Kwai Tsing, Tsuen Wan, Lantau Island
- NTEC – Sha Tin, Tai Po, North
- NTWC – Tuen Mun, Yuen Long

Abbreviations:

Cluster

HKEC – Hong Kong East Cluster

HKWC – Hong Kong West Cluster

KCC – Kowloon Central Cluster

KEC – Kowloon East Cluster

KWC – Kowloon West Cluster

NTEC – New Territories East Cluster

NTWC – New Territories West Cluster

Hospital

PYNEH – Pamela Youde Nethersole Eastern Hospital

RH – Ruttonjee Hospital

SJH – St. John Hospital

QMH – Queen Mary Hospital

KWH – Kwong Wah Hospital

QEH – Queen Elizabeth Hospital

TKOH – Tseung Kwan O Hospital

UCH – United Christian Hospital
CMC – Caritas Medical Centre
NLTH – North Lantau Hospital
PMH – Princess Margaret Hospital
YCH – Yan Chai Hospital
AHNH – Alice Ho Miu Ling Nethersole Hospital
NDH – North District Hospital
PWH – Prince of Wales Hospital
POH – Pok Oi Hospital
TMH – Tuen Mun Hospital
TSWH – Tin Shui Wai Hospital

- End -

CONTROLLING OFFICER'S REPLY**HHB007****(Question Serial No. 0572)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (2) Health, (3) Subvention: Hospital AuthorityControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

On the needs of the public for hospital services and the resources required to meet those needs:
1. please tabulate by year the annual expenditure on healthcare, the expenditure of the Hospital Authority (HA), and the figures of HA's staffing provision in the past 5 years.

Asked by: Hon CHAN Han-pan (LegCo internal reference no.: 35)Reply:

The recurrent government expenditure under the Policy Area Group: Health in the past five years is as follows:

Policy Area Group	2020-21	2021-22	2022-23	2023-24	2024-25
	Actual expenditure				Revised estimate
	(\$billion)				
Health	87.6	98.3	127	103.9	109.2

The recurrent subvention to the Hospital Authority (HA) in the past five years is as follows:

2020-21	2021-22	2022-23	2023-24	2024-25
Actual expenditure				Revised estimate
(\$ billion)				
77.3	81.9	94.8	92.1	95.4

In addition, the Health Bureau compiles the Current Health Expenditure of the Hong Kong's Domestic Health Accounts (HKDHA) annually in accordance with the international guidelines given in *A System of Health Accounts 2011* published collaboratively by the Organisation for Economic Co-operation and Development, Eurostat and World Health Organization. The Current Health Expenditure captures all public and private expenditure for medical care, disease prevention, health promotion, rehabilitation, long-term care, community health activities, health administration and regulation etc. with the predominant objective of improving health. Relevant information is shown in an online interactive data dashboard of the website of the Health Bureau (www.healthbureau.gov.hk/statistics/en/dha.htm).

The manpower figures ⁽¹⁾ on full-time equivalent basis of the HA in the past 5 years are set out in the table below:

2020-21 (as at 31 March 2021)	2021-22 (as at 31 March 2022)	2022-23 (as at 31 March 2023)	2023-24 (as at 31 March 2024) ⁽²⁾	2024-25 (as at 31 December 2024) ⁽²⁾
88 690	89 812	90 040	90 785	93 698

Note:

1. The manpower figures above are calculated on full-time equivalent basis including permanent, contract and temporary staff in the HA.
2. The human resources management system in the HA was enhanced to enable auto-calculation of working hours for all temporary part-time (TPT) staff starting from January 2024. The full time equivalent for all TPT staff is now calculated based on their actual working hours instead of the estimated working hours in the past.

- End -

CONTROLLING OFFICER'S REPLY**HHB008****(Question Serial No. 0214)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (3) Subvention: Hospital AuthorityControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

In this Programme, the Hospital Authority (HA) mentioned that it will attract, motivate and retain staff:

1. Please list the numbers of doctors, nurses, and allied health professionals in public hospitals who were under the Extending Employment Beyond Retirement (EER) arrangement in the past 5 financial years, as well as the related expenditures;
2. Please list the numbers of staff whose employment was extended for the first, the second, the third, and more than the fourth time under the EER arrangement in the last financial year;
3. Regarding the Enhanced Home Loan Interest Subsidy Scheme (HLISS) launched by the HA in end-December 2022, please list the numbers of staff applying for the Scheme, the years of service of the applicants, and the amounts involved since its launch, broken down by department and rank;
4. Are there any cases in the Enhanced HLISS where successful applicants have their cases terminated due to resignation during the repayment period? If yes, what are the relevant numbers and outcomes? Has the HA evaluated the effectiveness of the Scheme in retaining staff? If yes, what are the details?

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 1)Reply:

1.

The number of staff serving on a full-time¹ (FT)/ part-time² (PT) basis after retirement as at December in the past 5 years (i.e. from 2020 to 2024) are tabulated below:

	2020	2021	2022		2023		2024	
	FT	FT	FT	PT	FT	PT	FT	PT
Doctors	79	91	103 ³	1	144 ³	214	181 ³	269
Nursing	156	182	263	4	427	378	565	502
Allied Health Professionals ⁴	19	28	57	1	86	79	113	104
Total	254	301	423	6	657	671	859	875

The total salary expenditures⁵ involved in the past 5 financial years were \$429.3 million (2020-21), \$512.8 million (2021-22), \$711.2 million (2022-23), \$980.7 million (2023-24) and \$1,298.6 million (full-year projection in 2024-25).

Note:

1. The number of staff refers to the number of existing full-time staff in each year ending 31 December whose employment was extended beyond retirement in different years in the past.
2. With effect from 1 December 2022, retired employees who have been offered part-time employment under the policy of Extending Employment Beyond Retirement (EER) will be arranged in accordance with the remuneration and terms of employment under the EER policy, and the category of “part-time staff under EER” will be separated from the category of “part-time staff” for ease of calculation. The number of staff refers to the number of existing part-time staff who have retired in different years and have been extended employment after retirement as at 31 December of each year.
3. Including 1 Dental Consultant.
4. The “Allied Health Professionals” group includes Radiographers, Medical Technologists/Medical Laboratory Technicians, Occupational Therapists, Physiotherapists, Pharmacists and Medical Social Workers, etc.
5. The total salary expenditure includes basic salary, allowance, gratuity and other on-costs (such as provision of housing benefit, and death and disability benefit). The figures for 2024-25 represent full-year projection. The salary expenditure for part-time staff under the EER policy is absorbed under the budget for existing vacancies.

2.

Main features of the EER Policy include, among others, commitment of extending employment up to age 65 after retirement. Under normal circumstances, employment period for staff on contract full-time terms is between 1 and 3 years under the EER policy. Renewal of contract will be subject to the existing renewal mechanism up to age 65. Subject to the service and operational needs, the duration of contract period can be adjusted according to the preference of the staff. As at December 2024, the year of retirement of the existing doctors, nursing staff and allied health professionals serving on a full-time basis after retirement are tabulated below:

Staff Group	Year of retirement of the existing staff serving on a full-time basis after retirement (as at December 2024)					
	2019-20 or before	2020-21	2021-22	2022-23	2023-24	2024-25
Doctors	19	24	25	37 ¹	42	34
Nursing	12	42	71	139	180	121
Allied Health Professionals ²	0	7	17	32	31	26
Total	31	73	113	208	253	181

Note:

1. It includes 1 Dental Consultant.
2. The “Allied Health Professionals” group includes Radiographers, Medical Technologists/Medical Laboratory Technicians, Occupational Therapists, Physiotherapists, Pharmacists and Medical Social Workers, etc.

3.

The Hospital Authority (HA)’s Home Loan Interest Subsidy Scheme (HLISS) was launched in late December 2022, with a total of 1 330 eligible applicants who were granted approval-in-principle as at 31 December 2024. The year of service of the relevant applicants was 15.67 years on average. The relevant staff may submit a formal loan application to the HA for property purchase or arrangement for property mortgage. The distribution of staff with approval-in-principle granted is as follows:

Staff Group	Number of Staff with Approval-in-Principle Granted
Doctors	131
Nursing	580
Allied Health Professionals	301
Administration and General Grades Staff	318
Total	1 330

As at 31 December 2024 since the commencement of the HLISS, a total of 201 staff drew down the staff loans, involving a total loan amount of about \$620 million.

4.

From the commencement of the HLISS to 31 December 2024, there were no cases where staff who had drawn down staff loans and had their cases terminated due to attrition during the repayment period. This reflects that the HLISS helps retain experienced staff to a considerable degree. The number of applications and the relevant statistical data of the HLISS are reported to the Human Resources Committee and Finance Committee under the HA Board on a regular basis, and the relevant arrangements are reviewed in a timely manner.

- End -

CONTROLLING OFFICER'S REPLY

HHB009

(Question Serial No. 0215)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the number of attendances at the accident and emergency (A&E) departments of public hospitals, please provide the following information:

1. a breakdown by age group of the numbers of influenza-related A&E attendances, admissions, medical ward admissions and transfers to intensive care units in each of the past 5 years, along with the longest and average lengths of stay for each category;
2. a breakdown by age group of the numbers of severe and fatal cases of influenza admissions in each of the past 5 years;
3. a breakdown by winter and summer influenza seasons of the numbers and percentages of additional staff and hospital beds deployed as a result of the service demand surge special measures, along with the expenditures involved, in the past 5 years.

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 2)

Reply:

1.

The table below sets out the numbers of inpatient admissions with primary diagnosis of influenza via Accident and Emergency (A&E) Departments of the hospitals under the Hospital Authority (HA), the average length of stay, the 90th percentile of the length of stay, and the numbers of admissions to selected specialty wards between 2020-21 and 2024-25 (up to 31 December 2024).

Year	Age group	Inpatient admissions with primary diagnosis of influenza via A&E Departments			
		Number of admissions	Length of stay ^{1,2} (days)		Number of admissions to selected specialty wards ³
			Average	90th percentile	
2020-21	<18 years old	9	1.8	3	9
	18-64 years old	5	2.2	4	5
	65 years old or above	3	4.3	9	3
	All ages	17	2.4	5	17
2021-22	<18 years old	6	1.7	4	6
	18-64 years old	3	4.3	5	3
	65 years old or above	4	6.5	14	4
	All ages	13	3.8	11	13
2022-23	<18 years old	261	2.1	3	260
	18-64 years old	178	2.9	6	173
	65 years old or above	150	5.4	12	149
	All ages	589	3.2	6	582
2023-24	<18 years old	5 479	2.1	4	5 444
	18-64 years old	3 800	3.1	5	3 679
	65 years old or above	6 579	4.9	9	6 539
	All ages	15 858	3.5	6	15 662
2024-25 (up to 31 December 2024)	<18 years old	2 062	2.1	3	2 053
	18-64 years old	1 972	3.4	6	1 902
	65 years old or above	4 508	4.8	9	4 470
	All ages	8 542	3.8	7	8 425

Note:

1. The length of stay of inpatients is calculated at the time of discharge. The average length of stay of inpatients is derived by dividing the sum of length of stay of inpatients by the corresponding number of inpatients discharged and treated. The 90th percentile reflects a relatively long length of stay of inpatients.
2. The length of stay of inpatients may not be directly related to the principal diagnosis and may be subject to other clinical conditions requiring hospitalisation.
3. Selected specialty wards include the wards of Emergency Medicine, Adult Medicine, Adult Intensive Care Units (ICUs), Adult High Dependency Units (HDUs), as well as Paediatrics

and Neonatology (including Neonatal ICUs, Special Care Baby Units and Paediatric ICUs).

4. In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, attendance situation at HA's A&E Department was impacted. This should be taken into consideration when comparing the service throughput of the HA in relevant years. As the city returned to normalcy starting from early 2023, the relevant impact receded gradually.

The HA does not maintain statistics on the number of A&E attendances with a primary diagnosis of influenza.

2.

The table below sets out the numbers of cases in which patients with primary diagnosis of influenza were admitted or transferred to ICUs via A&E Departments of the hospitals under the HA, as well as the number of deaths between 2020-21 and 2024-25 (up to 31 December 2024).

Year	Age group	Inpatient admissions with primary diagnosis of influenza via A&E Departments	
		Number of admissions or transfers to ICUs ¹	Number of deaths
2020-21	<18 years old	0	0
	18-64 years old	0	1
	65 years old or above	0	0
	All ages	0	1
2021-22	<18 years old	0	0
	18-64 years old	0	0
	65 years old or above	0	0
	All ages	0	0
2022-23	<18 years old	0	0
	18-64 years old	4	0
	65 years old or above	6	5
	All ages	10	5
2023-24	<18 years old	30	0
	18-64 years old	73	27
	65 years old or above	72	190
	All ages	175	217
2024-25 (up to 31 December 2024)	<18 years old	9	1
	18-64 years old	54	19
	65 years old or above	42	127

Year	Age group	Inpatient admissions with primary diagnosis of influenza via A&E Departments	
		Number of admissions or transfers to ICUs ¹	Number of deaths
	All ages	105	147

Note:

1. ICUs also include Adult ICUs managed by other specialties (excluding HDUs), and Neonatal and Paediatric ICUs.
2. In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, attendance situation at HA's A&E Department was impacted. This should be taken into consideration when comparing the service throughput of the HA in relevant years. As the city returned to normalcy starting from early 2023, the relevant impact receded gradually.

Note [Parts 1 and 2]:

1. The sum of the breakdowns may not be equal to the total number of admissions for all ages due to some inpatient cases with unknown date of birth.

3.

To meet the increasing service demand arising from an ageing and growing population, the HA opened new hospital beds in 2019-20, 2020-21, 2021-22, 2022-23 and 2023-24, which is crucial to alleviate hospitals' pressure especially during the demand surge periods.

The table below sets out the numbers of hospital beds opened by the HA in the past 5 years.

Number of new hospital beds opened				
2019-20	2020-21	2021-22	2022-23	2023-24
506	415	319	399	103

The hospitals add temporary beds during the demand surge periods to cope with the increased demand. For example, in January 2024, the HA's average daily number of temporary beds was around 1 170.

In addition, the HA adopts various manpower measures (such as implementing the Special Honorarium Scheme, recruiting part-time and temporary healthcare staff, and engaging agency nurses and supporting staff through existing agency service contractors) to meet the service demand during surge periods.

The table below sets out the expenditure on personal emoluments involved in the special measures to meet the service demand during the demand surge periods in the past 5 years.

Expenditure (\$ million)	2019-20	2020-21	2021-22	2022-23	2023-24
Doctors	79	123	103	178	164
Nurses	160	209	221	337	294
Allied Health Professionals	17	22	27	45	36

Expenditure (\$ million)	2019-20	2020-21	2021-22	2022-23	2023-24
Supporting Staff	60	79	71	125	93
Total	316	433	422	685	587

Apart from the above personal emoluments, there were also expenditures on engaging agency staff. The relevant expenditures in 2019-20, 2020-21, 2021-22, 2022-23 and 2023-24 were about \$50 million, \$56 million, \$38 million, \$67 million and \$61 million respectively.

- End -

CONTROLLING OFFICER'S REPLY

HHB010

(Question Serial No. 0216)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the number of general outpatient attendance, please inform this Committee of:

1. the staffing establishment and expenditure of each of the general outpatient clinics (GOPCs) under the Hospital Authority, with a breakdown by hospital clusters;
2. the numbers of consultation quotas, numbers of attendance and utilisation rates at the GOPCs in each cluster over the past 3 financial years, with a breakdown by weekdays, holidays, weekday evenings and holiday evenings; and
3. the anticipated timeline, details and administrative expenditure for the Government's plan to reposition the GOPCs to focus on taking care of low-income persons and the socially disadvantaged groups, and whether such a plan will lead to a reduction or adjustment in the existing service quotas.

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 4)

Reply:

(1) & (2)

Users of the General Out-patient Clinics (GOPCs) service under the Hospital Authority (HA) are mainly the elderly, low-income individuals, and patients with chronic diseases. Patients under the care of the GOPCs comprise two major categories: patients with chronic diseases in stable medical condition, such as patients with diabetes mellitus or hypertension; and episodic disease patients with relatively mild symptoms, such as those suffering from influenza or cold. Currently, the HA manages a total of 74 GOPCs in Hong Kong. The attendances, the consultation quota utilisation rates, and services costs of the GOPCs in the past 3 financial years are set out in the tables below:

GOPCs' service statistics in each cluster in the past 3 financial years

Cluster	2022-23		2023-24		2024-25 (as at 31 December 2024)	
	Attendance [^] (Attendance for evening out-patient services)	Consultation quota utilisation rate (Utilisation rate of evening out- patient services)	Attendance [^] (Attendance for evening out-patient services)	Consultation quota utilisation rate (Utilisation rate of evening out- patient services)	Attendance [^] (Attendance for evening out-patient services)	Consultation quota utilisation rate (Utilisation rate of evening out- patient services)
Hong Kong East	466 622 (33 574)	92% (99%)	562 176 (53 619)	95% (99%)	419 610 (41 231)	94% (99%)
Hong Kong West	325 565 (22 222)	97% (99%)	393 380 (33 251)	99% (100%)	300 813 (25 710)	99% (100%)
Kowloon Central	914 158 (91 067)	97% (99%)	1 105 808 (133 004)	99% (100%)	896 099 (108 920)	99% (100%)
Kowloon East	738 718 (40 859)	98% (99%)	887 088 (56 388)	99% (100%)	721 686 (58 414)	100% (100%)
Kowloon West	923 256 (52 677)	97% (98%)	1 083 957 (75 450)	98% (99%)	852 497 (57 034)	98% (100%)
New Territories East	841 454 (54 920)	97% (97%)	1 017 184 (102 084)	98% (99%)	785 117 (79 098)	99% (99%)
New Territories West	785 575 (69 832)	99% (99%)	958 490 (116 794)	99% (99%)	727 062 (74 519)	100% (100%)

[^] The attendance includes the attendance for evening out-patient services and covers medical consultations, nurse and allied health services at the GOPCs.

Service costs of GOPCs in the past 3 financial years

Year	Service costs of GOPCs (\$ million)
2022-23	3,444
2023-24	4,399
2024-25 (revised estimate)	4,230

Note:

- GOPC service costs include direct staff costs (such as doctors and nurses) for providing services to patients, expenditure incurred for various clinical support services (such as pharmacy, diagnostic radiology and pathology tests) and other operating costs (such as utility expenses as well as repair and maintenance of medical equipment).
- In view of the Coronavirus Disease 2019 (COVID-19) epidemic outbreak in Hong Kong in early 2020, the HA has adjusted its services to cope with the outbreak. This should

be taken into consideration when comparing the service volume of the HA in the relevant years. With the subsiding of local COVID-19 epidemic situation and cessation of anti-epidemic measures in early 2023, the HA has been gradually resuming provision of all of its public healthcare services to tie in with the Government's resumption of normalcy measures. As the costing information for 2022-23 has reflected the impact of the COVID-19 epidemic outbreak on costs (if any), the costing information for different years may not be directly comparable.

There are 14 GOPCs under the HA providing services on Sundays and public holidays. The number of consultation quotas will be adjusted according to service demand. For example, during peak influenza seasons and consecutive long holidays, each of the GOPCs will flexibly deploy manpower and resources to strengthen their services. The service figures vary with service demand. The HA does not maintain a breakdown of the estimates of consultation quotas to be provided by each of the GOPCs on Sundays and public holidays.

Services of GOPCs are provided through a multi-disciplinary team approach. The staff and manpower will be flexibly deployed and adjusted in different consultation sessions across the clinics based on the service volume and operational situation. Hence, there is no fixed staffing establishment for each consultation session of each of the GOPCs.

(3)

The Government is committed to strengthening prevention-focused primary healthcare services in accordance with the reform measures proposed in the Primary Healthcare Blueprint (Blueprint). The public healthcare system has always been a basic safety net for the underprivileged groups. The Government will reposition the GOPC services under the HA to give priority to the underprivileged, in particular low-income families and the elderly in need, and provide comprehensive primary healthcare services through the family medicine service model. The latest initiatives include the integration of primary healthcare services under the Department of Health to introduce women's health services at GOPCs to provide comprehensive preventive and healthcare services to low-income women with effect from 24 January 2025, and the expansion of the Chronic Disease Co-Care Pilot Scheme (CDCC Pilot Scheme) in phases with effect from 28 March 2025 to provide screening services and management services of "3-Highs" (i.e. diabetes mellitus, hypertension and hyperlipidemia). The first phase will be piloted in 7 GOPCs, with plans to add 6 other GOPCs by the end of June 2025, and the services will be extended to designated GOPC service points across all 18 districts by the fourth quarter of 2025. The Government will increase the manpower and resources of the GOPCs, enabling the HA to enhance preventive care services for the socially disadvantaged groups and cope with service demand.

At the same time, the Government is further developing the community health system based on the District Health Centre (DHC) model and proactively strengthening the CDCC Pilot Scheme and the family doctor system, so as to enhance the capacity of the private sector to provide primary healthcare services and provide more choices to those who can afford them. This will help divert the pressure from the public healthcare system, so that GOPCs can better focus their manpower and resources on caring for the underprivileged. The HA will closely monitor the utilisation of services at various clinics, and assess the service demand of the clinics, and flexibly deploy manpower and other resources to ensure that the services will not be affected. Overall, this reform aims to redress the imbalance between the public and

private healthcare sectors and enhance the sustainability of our healthcare system through strategic allocation of healthcare resources, with a view to achieving the goal of “early prevention, early detection and early treatment”.

- End -

CONTROLLING OFFICER'S REPLY

HHB011

(Question Serial No. 0218)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the healthcare manpower of the Hospital Authority (HA), please set out the following:

1. the “intake”, “resignation” and “retirement” numbers of full-time doctors, full-time nurses and allied health professionals in each hospital cluster of the HA in the past 3 years (by major speciality and rank);
2. the strength and establishment of full-time doctors, full-time nurses and allied health professionals in each hospital cluster of the HA in the past 3 years (by major speciality and rank);
3. the manpower of doctors and nurses in public hospitals by length of service; and
4. the attrition rates (excluding retirement) of doctors and nurses in public hospitals by length of service.

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 22)

Reply:

1. and 2.

The Hospital Authority (HA) delivers healthcare services through a multi-disciplinary team approach involving doctors, nurses, allied health professionals and care-related support staff. The HA assesses its manpower situation from time to time and flexibly deploys its staff to meet service and operational needs.

The tables below set out the manpower strength, intake number and full-time attrition (wastage) number of doctors by major specialty in each hospital cluster of the HA from 2022-23 to 2024-25 (April – December 2024):

2022-23

Cluster	Major Specialty	Manpower Strength (As at 31.3.2023)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
HKEC	Accident & Emergency	56	9	1	10
	Anaesthesia	39	3	0	2
	Family Medicine	56	4	1	4
	Intensive Care Unit	17	5	0	0
	Medicine	163	15	4	19
	Neurosurgery	14	1	0	1
	Obstetrics & Gynaecology	21	1	0	1
	Ophthalmology	24	5	0	1
	Orthopaedics & Traumatology	38	4	0	0
	Paediatrics	29	2	0	3
	Pathology	23	2	0	0
	Psychiatry	43	5	0	3
	Radiology	45	3	0	2
	Surgery	54	10	0	2
	Others	31	5	0	4
	Total	651	74	6	52
HKWC	Accident & Emergency	26	2	1	4
	Anaesthesia	67	5	0	5
	Cardiothoracic Surgery	13	2	1	0
	Family Medicine	45	4	0	2
	Intensive Care Unit	14	2	0	3
	Medicine	165	16	1	8
	Neurosurgery	13	2	0	0
	Obstetrics & Gynaecology	26	3	1	3
	Ophthalmology	15	1	0	1
	Orthopaedics & Traumatology	39	2	0	1
	Paediatrics	36	4	2	1
	Pathology	35	6	0	3
	Psychiatry	25	2	0	4
	Radiology	30	3	2	4
	Surgery	84	5	0	3
	Others	32	4	0	4
	Total	666	63	8	46
KCC	Accident & Emergency	85	5	2	5
	Anaesthesia	111	6	3	4
	Cardiothoracic Surgery	20	2	0	2
	Family Medicine	113	6	1	6

Cluster	Major Specialty	Manpower Strength (As at 31.3.2023)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Intensive Care Unit	23	2	0	0
	Medicine	293	21	3	12
	Neurosurgery	36	3	1	1
	Obstetrics & Gynaecology	55	4	0	2
	Ophthalmology	37	4	1	3
	Orthopaedics & Traumatology	66	2	0	2
	Paediatrics	178	17	1	6
	Pathology	60	6	0	3
	Psychiatry	42	2	1	4
	Radiology	86	9	1	2
	Surgery	123	17	2	10
	Others	56	5	0	3
	Total	1 383	111	16	65
KEC	Accident & Emergency	72	3	2	5
	Anaesthesia	53	1	0	2
	Family Medicine	96	14	2	8
	Intensive Care Unit	14	0	0	0
	Medicine	196	20	1	11
	Obstetrics & Gynaecology	33	3	0	1
	Ophthalmology	22	2	0	1
	Orthopaedics & Traumatology	58	4	0	1
	Paediatrics	44	0	0	1
	Pathology	31	2	1	1
	Psychiatry	44	0	0	3
	Radiology	36	5	0	2
	Surgery	64	6	0	4
	Others	33	4	0	5
	Total	796	64	6	45
KWC	Accident & Emergency	124	12	3	6
	Anaesthesia	67	4	1	9
	Family Medicine	118	8	1	7
	Intensive Care Unit	32	3	0	1
	Medicine	245	27	4	6
	Neurosurgery	15	1	0	0
	Obstetrics & Gynaecology	23	2	0	7
	Ophthalmology	25	7	0	3
	Orthopaedics & Traumatology	75	5	0	1
	Paediatrics	59	3	1	1

Cluster	Major Specialty	Manpower Strength (As at 31.3.2023)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Pathology	51	7	0	6
	Psychiatry	75	10	1	1
	Radiology	46	4	2	1
	Surgery	105	9	0	5
	Others	49	6	1	5
	Total	1 110	108	14	59
NTEC	Accident & Emergency	82	3	1	4
	Anaesthesia	64	9	0	4
	Cardiothoracic Surgery	13	2	0	2
	Family Medicine	106	9	1	8
	Intensive Care Unit	30	2	0	3
	Medicine	238	18	3	10
	Neurosurgery	13	2	0	1
	Obstetrics & Gynaecology	34	2	0	1
	Ophthalmology	27	1	0	2
	Orthopaedics & Traumatology	70	4	0	2
	Paediatrics	58	1	0	3
	Pathology	45	7	3	0
	Psychiatry	71	6	0	3
	Radiology	47	3	0	3
	Surgery	89	14	0	5
	Others	58	4	0	1
	Total	1 045	87	8	52
NTWC	Accident & Emergency	95	4	0	5
	Anaesthesia	58	2	0	3
	Cardiothoracic Surgery	2	0	0	0
	Family Medicine	90	6	1	4
	Intensive Care Unit	24	2	0	2
	Medicine	185	17	0	6
	Neurosurgery	13	2	1	0
	Obstetrics & Gynaecology	33	4	0	4
	Ophthalmology	27	2	1	0
	Orthopaedics & Traumatology	53	2	0	5
	Paediatrics	41	5	2	3
	Pathology	26	3	0	2
	Psychiatry	81	11	2	1
	Radiology	41	2	1	3
	Surgery	75	7	2	5

Cluster	Major Specialty	Manpower Strength (As at 31.3.2023)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Others	38	3	0	4
	Total	881	72	10	47

2023-24

Cluster	Major Specialty	Manpower Strength (As at 31.3.2024)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
HKEC	Accident & Emergency	62	8	0	3
	Anaesthesia	40	4	0	3
	Family Medicine	55	4	0	6
	Intensive Care Unit	21	6	0	0
	Medicine	176	28	1	9
	Neurosurgery	13	2	0	1
	Obstetrics & Gynaecology	23	3	0	1
	Ophthalmology	24	3	0	2
	Orthopaedics & Traumatology	38	1	0	1
	Paediatrics	31	3	0	0
	Pathology	23	1	0	0
	Psychiatry	44	9	0	5
	Radiology	48	5	0	2
	Surgery	53	6	0	2
	Others	32	3	0	0
	Total	683	86	1	35
HKWC	Accident & Emergency	33	8	0	0
	Anaesthesia	59	3	0	12
	Cardiothoracic Surgery	14	6	0	5
	Family Medicine	45	1	0	1
	Intensive Care Unit	16	2	0	1
	Medicine	168	14	1	6
	Neurosurgery	13	2	0	0
	Obstetrics & Gynaecology	30	5	0	1
	Ophthalmology	17	2	0	2
	Orthopaedics & Traumatology	35	1	0	1
	Paediatrics	38	5	0	2
	Pathology	34	0	0	1
	Psychiatry	27	3	0	1
	Radiology	38	6	0	0

Cluster	Major Specialty	Manpower Strength (As at 31.3.2024)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Surgery	86	9	0	9
	Others	33	5	0	2
	Total	687	72	1	44
KCC	Accident & Emergency	91	8	1	3
	Anaesthesia	113	10	0	7
	Cardiothoracic Surgery	19	1	0	0
	Family Medicine	121	11	0	8
	Intensive Care Unit	25	2	0	1
	Medicine	305	30	0	10
	Neurosurgery	37	6	0	1
	Obstetrics & Gynaecology	57	5	0	2
	Ophthalmology	41	5	0	5
	Orthopaedics & Traumatology	70	4	0	4
	Paediatrics	180	11	0	9
	Pathology	62	7	0	1
	Psychiatry	46	8	0	1
	Radiology	95	9	1	1
	Surgery	140	22	1	3
	Others	61	9	0	4
	Total	1 461	148	3	60
KEC	Accident & Emergency	73	6	0	6
	Anaesthesia	56	4	0	6
	Family Medicine	100	11	2	8
	Intensive Care Unit	14	0	0	0
	Medicine	202	22	0	11
	Obstetrics & Gynaecology	32	3	0	3
	Ophthalmology	22	2	0	1
	Orthopaedics & Traumatology	57	3	0	2
	Paediatrics	41	2	0	4
	Pathology	32	2	0	1
	Psychiatry	45	4	0	4
	Radiology	37	1	0	2
	Surgery	69	8	0	1
	Others	32	2	0	4
	Total	815	70	2	53
KWC	Accident & Emergency	131	13	0	10
	Anaesthesia	71	5	0	4
	Family Medicine	124	9	0	7

Cluster	Major Specialty	Manpower Strength (As at 31.3.2024)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Intensive Care Unit	33	2	0	0
	Medicine	251	17	1	6
	Neurosurgery	18	4	0	0
	Obstetrics & Gynaecology	29	5	0	0
	Ophthalmology	27	2	0	1
	Orthopaedics & Traumatology	76	3	1	0
	Paediatrics	56	1	0	2
	Pathology	54	3	1	0
	Psychiatry	79	6	0	2
	Radiology	50	3	0	0
	Surgery	98	9	0	7
	Others	50	5	1	0
	Total	1 146	87	4	39
NTEC	Accident & Emergency	90	7	0	2
	Anaesthesia	66	11	0	6
	Cardiothoracic Surgery	14	1	0	0
	Family Medicine	104	7	0	8
	Intensive Care Unit	27	4	0	3
	Medicine	242	18	2	11
	Neurosurgery	13	1	0	0
	Obstetrics & Gynaecology	34	3	0	2
	Ophthalmology	29	4	0	0
	Orthopaedics & Traumatology	70	5	0	3
	Paediatrics	55	3	0	3
	Pathology	43	2	0	4
	Psychiatry	69	5	0	2
	Radiology	54	7	0	2
	Surgery	101	16	0	2
	Others	60	4	0	2
	Total	1 072	98	2	50
NTWC	Accident & Emergency	88	7	1	9
	Anaesthesia	65	5	0	2
	Cardiothoracic Surgery	3	1	0	0
	Family Medicine	96	10	0	3
	Intensive Care Unit	25	1	0	0
	Medicine	191	25	0	11
	Neurosurgery	14	2	0	0
	Obstetrics & Gynaecology	34	2	0	1

Cluster	Major Specialty	Manpower Strength (As at 31.3.2024)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Ophthalmology	28	3	2	0
	Orthopaedics & Traumatology	55	4	0	1
	Paediatrics	39	4	0	4
	Pathology	29	3	0	2
	Psychiatry	88	9	0	2
	Radiology	47	5	0	0
	Surgery	80	13	1	6
	Others	45	5	0	1
	Total	928	99	4	42

2024-25

Cluster	Major Specialty	Manpower Strength (As at 31.12.2024)	Intake No. (April – December 2024) (Include FT and PT)	Full-time Attrition (Wastage) No. (April – December 2024)	
				Retirement	Non-retirement
HKEC	Accident & Emergency	71	7	0	3
	Anaesthesia	44	2	0	0
	Clinical Oncology	23	2	0	0
	Ear, Nose & Throat/Otorhinolaryngology	12	1	0	0
	Family Medicine	59	8	1	1
	Intensive Care Unit	19	1	0	0
	Medicine	195	29	0	7
	Neurosurgery	16	4	0	0
	Obstetrics & Gynaecology	22	1	0	2
	Ophthalmology	25	1	0	2
	Orthopaedics & Traumatology	39	2	1	1
	Paediatrics	28	1	0	2
	Pathology	24	2	0	1
	Psychiatry	49	5	0	1
	Radiology	52	5	0	2
	Surgery	58	9	0	2
	Others	1	0	0	0
	Total	735	80	2	24
HKWC	Accident & Emergency	34	1	0	1
	Anaesthesia	70	14	0	4
	Cardiothoracic Surgery	17	2	0	0

Cluster	Major Specialty	Manpower Strength (As at 31.12.2024)	Intake No. (April – December 2024) (Include FT and PT)	Full-time Attrition (Wastage) No. (April – December 2024)	
				Retirement	Non-retirement
	Clinical Oncology	21	2	0	0
	Ear, Nose & Throat/Otorhinolaryngology	16	2	0	0
	Family Medicine	46	1	0	0
	Intensive Care Unit	16	1	1	0
	Medicine	183	22	0	5
	Neurosurgery	14	2	0	0
	Obstetrics & Gynaecology	28	2	0	4
	Ophthalmology	19	3	0	0
	Orthopaedics & Traumatology	37	4	1	0
	Paediatrics	38	4	1	1
	Pathology	37	2	1	1
	Psychiatry	29	4	0	2
	Radiology	41	4	0	1
	Surgery	102	17	0	2
	Total	749	87	4	21
KCC	Accident & Emergency	94	3	0	0
	Anaesthesia	117	12	0	5
	Cardiothoracic Surgery	21	1	0	0
	Clinical Oncology	34	3	0	0
	Ear, Nose & Throat/Otorhinolaryngology	19	0	0	0
	Family Medicine	122	7	0	6
	Intensive Care Unit	26	3	0	1
	Medicine	323	24	1	7
	Neurosurgery	42	7	0	0
	Obstetrics & Gynaecology	60	5	0	1
	Ophthalmology	46	5	0	2
	Orthopaedics & Traumatology	74	5	0	2
	Paediatrics	182	15	0	11
	Pathology	64	3	0	3
	Psychiatry	46	2	0	1
	Radiology	95	8	0	6
	Surgery	145	12	0	4
	Others	12	0	0	0
	Total	1 522	115	1	49

Cluster	Major Specialty	Manpower Strength (As at 31.12.2024)	Intake No. (April – December 2024) (Include FT and PT)	Full-time Attrition (Wastage) No. (April – December 2024)	
				Retirement	Non-retirement
KEC	Accident & Emergency	78	6	0	1
	Anaesthesia	56	7	1	2
	Clinical Oncology	15	2	0	0
	Ear, Nose & Throat/Otorhinolaryngology	13	0	0	3
	Family Medicine	102	12	0	6
	Intensive Care Unit	26	0	0	0
	Medicine	212	30	0	3
	Obstetrics & Gynaecology	32	2	0	2
	Ophthalmology	24	4	0	2
	Orthopaedics & Traumatology	56	1	0	2
	Paediatrics	43	2	0	1
	Pathology	33	1	0	2
	Psychiatry	46	1	0	1
	Radiology	40	4	0	1
	Surgery	76	9	0	3
	Others	5	0	0	0
	Total	857	81	1	29
KWC	Accident & Emergency	132	15	2	7
	Anaesthesia	75	4	1	3
	Clinical Oncology	29	1	0	0
	Ear, Nose & Throat/Otorhinolaryngology	19	1	0	0
	Family Medicine	131	9	0	2
	Intensive Care Unit	36	3	0	1
	Medicine	265	19	0	7
	Neurosurgery	19	1	0	0
	Obstetrics & Gynaecology	29	1	0	1
	Ophthalmology	26	0	0	0
	Orthopaedics & Traumatology	77	2	0	1
	Paediatrics	57	2	0	2
	Pathology	53	2	0	3
	Psychiatry	79	4	0	1
	Radiology	49	2	1	1
	Surgery	112	15	1	1
	Others	1	0	0	0
	Total	1 190	81	5	30

Cluster	Major Specialty	Manpower Strength (As at 31.12.2024)	Intake No. (April – December 2024) (Include FT and PT)	Full-time Attrition (Wastage) No. (April – December 2024)	
				Retirement	Non-retirement
NTEC	Accident & Emergency	94	7	2	2
	Anaesthesia	77	8	0	0
	Cardiothoracic Surgery	14	0	0	0
	Clinical Oncology	41	4	0	0
	Ear, Nose & Throat/Otorhinolaryngology	19	0	0	0
	Family Medicine	112	11	0	2
	Intensive Care Unit	31	5	0	1
	Medicine	253	29	0	12
	Neurosurgery	15	0	0	0
	Obstetrics & Gynaecology	34	4	0	3
	Ophthalmology	31	6	0	1
	Orthopaedics & Traumatology	76	9	1	1
	Paediatrics	58	7	0	2
	Pathology	46	6	0	3
	Psychiatry	74	6	0	2
	Radiology	56	5	0	1
	Surgery	102	13	0	3
	Others	5	3	0	1
	Total	1 139	123	3	34
NTWC	Accident & Emergency	92	11	0	2
	Anaesthesia	69	8	0	3
	Cardiothoracic Surgery	3	1	0	0
	Clinical Oncology	29	2	0	1
	Ear, Nose & Throat/Otorhinolaryngology	16	0	0	0
	Family Medicine	102	9	0	4
	Intensive Care Unit	24	3	0	0
	Medicine	205	26	0	9
	Neurosurgery	16	2	0	0
	Obstetrics & Gynaecology	34	2	1	1
	Ophthalmology	27	1	0	3
	Orthopaedics & Traumatology	57	4	0	2
	Paediatrics	40	4	0	3
	Pathology	29	3	0	2
	Psychiatry	92	4	0	1
	Radiology	47	4	0	5

Cluster	Major Specialty	Manpower Strength (As at 31.12.2024)	Intake No. (April – December 2024) (Include FT and PT)	Full-time Attrition (Wastage) No. (April – December 2024)	
				Retirement	Non-retirement
	Surgery	92	15	0	3
	Others	1	0	0	0
	Total	977	99	1	39

Note:

- (1) The manpower figures above are calculated on full-time equivalent basis including permanent, contract and temporary staff in the HA. Individual figures may not add up to the total due to rounding.
- (2) Doctors exclude Interns and Dental Officers.
- (3) Starting from January 2024, full-time equivalent for temporary part-time staff is calculated based on their actual working hours. The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.
- (4) Starting from 2024-25, Ear, Nose & Throat/Otorhinolaryngology and Clinical Oncology will no longer be classified in the category of “Others”. The related figures of this category before 2024-25 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.
- (5) Intake refers to the total number of permanent and contract staff joining the HA on headcount basis during the period. Transfer, promotion and staff movement within the HA are not regarded as Intake.
- (6) The Intake of Doctors includes the number of Interns appointed as Residents.
- (7) Attrition (Wastage) includes all types of cessation of service from the HA (including retirement) for permanent and contract staff on headcount basis.
- (8) From January 2024 onwards, the HA excludes those staff under the Extending Employment Beyond Retirement (EER) arrangement when compiling the statistics of Attrition (Wastage). The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.
- (9) From January 2024 onwards, the HA excludes those staff under the EER arrangement when compiling the statistics of Intake. The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.

The tables below set out the manpower strength, intake number and full-time attrition (wastage) number of nurses by major specialty in each hospital cluster of the HA from 2022-23 to 2024-25 (April – December 2024):

2022-23

Cluster	Major Specialty	Manpower Strength (As at 31.3.2023)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
HKEC	Accident & Emergency	141	16	1	24
	Intensive Care Unit	139	13	1	19

Cluster	Major Specialty	Manpower Strength (As at 31.3.2023)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Medicine	1 008	101	11	89
	Obstetrics & Gynaecology	119	4	2	5
	Orthopaedics & Traumatology	133	4	1	7
	Paediatrics	115	10	2	10
	Psychiatry	283	25	6	13
	Surgery	241	25	4	21
	Others	840	70	14	64
	Total	3 018	268	42	252
HKWC	Accident & Emergency	58	7	2	6
	Intensive Care Unit	87	2	1	11
	Medicine	783	73	23	70
	Obstetrics & Gynaecology	142	6	4	16
	Orthopaedics & Traumatology	71	3	3	8
	Paediatrics	150	2	1	19
	Psychiatry	136	10	3	8
	Surgery	456	24	9	53
	Others	1 017	125	22	75
	Total	2 899	252	68	266
KCC	Accident & Emergency	199	10	0	20
	Intensive Care Unit	158	3	2	15
	Medicine	1 449	96	26	144
	Obstetrics & Gynaecology	284	7	13	21
	Orthopaedics & Traumatology	187	9	0	10
	Paediatrics	538	72	10	59
	Psychiatry	281	32	15	8
	Surgery	491	35	11	42
	Others	2 596	282	39	212
	Total	6 184	546	116	531
KEC	Accident & Emergency	172	12	1	15
	Intensive Care Unit	183	6	4	26
	Medicine	1 260	101	10	68
	Obstetrics & Gynaecology	121	10	0	20
	Orthopaedics & Traumatology	214	21	0	13
	Paediatrics	158	8	0	14
	Psychiatry	210	18	3	9
	Surgery	238	23	0	20
	Others	1 008	72	9	65
	Total	3 562	271	27	250

Cluster	Major Specialty	Manpower Strength (As at 31.3.2023)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
KWC	Accident & Emergency	293	16	9	31
	Intensive Care Unit	188	3	6	17
	Medicine	1 273	75	14	106
	Obstetrics & Gynaecology	119	5	7	12
	Orthopaedics & Traumatology	246	4	2	9
	Paediatrics	192	8	2	15
	Psychiatry	744	93	28	43
	Surgery	387	18	10	26
	Others	1 595	220	20	149
	Total	5 038	442	98	408
NTEC	Accident & Emergency	229	15	1	22
	Intensive Care Unit	220	17	1	20
	Medicine	1 611	155	18	135
	Obstetrics & Gynaecology	210	18	5	23
	Orthopaedics & Traumatology	263	23	5	25
	Paediatrics	230	23	4	32
	Psychiatry	396	34	10	18
	Surgery	489	32	3	39
	Others	1 217	70	34	90
	Total	4 865	387	81	404
NTWC	Accident & Emergency	230	23	2	30
	Intensive Care Unit	158	19	1	17
	Medicine	912	95	4	101
	Obstetrics & Gynaecology	138	11	6	18
	Orthopaedics & Traumatology	155	6	2	12
	Paediatrics	169	4	2	19
	Psychiatry	737	45	24	34
	Surgery	193	13	2	22
	Others	1 301	123	7	89
	Total	3 992	339	50	342

2023-24

Cluster	Major Specialty	Manpower Strength (As at 31.3.2024)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
HKEC	Accident & Emergency	146	17	0	14
	Intensive Care Unit	138	16	0	12
	Medicine	1 029	108	7	67

Cluster	Major Specialty	Manpower Strength (As at 31.3.2024)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Obstetrics & Gynaecology	110	1	1	10
	Orthopaedics & Traumatology	140	13	1	12
	Paediatrics	107	5	1	9
	Psychiatry	291	21	3	8
	Surgery	255	30	1	20
	Others	814	49	11	65
	Total	3 031	260	25	217
HKWC	Accident & Emergency	55	5	0	9
	Intensive Care Unit	80	5	3	10
	Medicine	784	69	10	65
	Obstetrics & Gynaecology	136	6	1	17
	Orthopaedics & Traumatology	73	5	0	7
	Paediatrics	155	16	1	10
	Psychiatry	142	7	0	5
	Surgery	458	66	6	42
	Others	986	95	9	62
	Total	2 869	274	30	227
KCC	Accident & Emergency	201	15	2	22
	Intensive Care Unit	149	1	2	11
	Medicine	1 508	127	15	123
	Obstetrics & Gynaecology	279	7	2	22
	Orthopaedics & Traumatology	183	11	3	10
	Paediatrics	520	36	7	60
	Psychiatry	286	20	3	14
	Surgery	480	36	4	43
	Others	2 119	270	32	169
	Total	5 725	523	70	474
KEC	Accident & Emergency	167	7	2	5
	Intensive Care Unit	190	8	1	12
	Medicine	1 220	110	3	62
	Obstetrics & Gynaecology	117	6	3	5
	Orthopaedics & Traumatology	208	21	1	8
	Paediatrics	163	18	0	7
	Psychiatry	222	14	1	5
	Surgery	234	27	0	10
	Others	1 029	65	6	51
	Total	3 548	276	17	165

Cluster	Major Specialty	Manpower Strength (As at 31.3.2024)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
KWC	Accident & Emergency	301	33	3	27
	Intensive Care Unit	191	13	2	10
	Medicine	1 258	142	8	78
	Obstetrics & Gynaecology	124	8	1	4
	Orthopaedics & Traumatology	232	15	0	17
	Paediatrics	188	19	2	11
	Psychiatry	722	73	6	24
	Surgery	421	58	5	32
	Others	1 400	107	16	115
	Total	4 838	468	43	318
NTEC	Accident & Emergency	234	23	1	17
	Intensive Care Unit	214	18	0	20
	Medicine	1 541	146	6	98
	Obstetrics & Gynaecology	207	16	1	12
	Orthopaedics & Traumatology	258	30	3	13
	Paediatrics	237	34	3	27
	Psychiatry	393	31	3	11
	Surgery	472	32	2	30
	Others	1 188	69	15	63
	Total	4 744	399	34	291
NTWC	Accident & Emergency	217	28	3	24
	Intensive Care Unit	157	21	0	20
	Medicine	931	85	9	58
	Obstetrics & Gynaecology	138	3	1	8
	Orthopaedics & Traumatology	154	6	1	10
	Paediatrics	170	20	1	16
	Psychiatry	750	55	9	31
	Surgery	202	17	1	9
	Others	1 351	99	6	67
	Total	4 071	334	31	243

2024-25

Cluster	Major Specialty	Manpower Strength (As at 31.12.2024)	Intake No. (April – December 2024 (Include FT and PT)	Full-time Attrition (Wastage) No. (April – December 2024)	
				Retirement	Non-retirement
HKEC	Accident & Emergency	142	8	0	11

Cluster	Major Specialty	Manpower Strength (As at 31.12.2024)	Intake No. (April – December 2024 (Include FT and PT)	Full-time Attrition (Wastage) No. (April – December 2024)	
				Retirement	Non-retirement
	Intensive Care Unit	143	14	0	9
	Medicine	1 004	95	4	60
	Obstetrics & Gynaecology	109	2	1	4
	Orthopaedics & Traumatology	136	10	2	7
	Paediatrics	112	15	0	6
	Psychiatry	294	16	0	11
	Surgery	265	30	1	10
	Others	860	47	9	44
	Total	3 067	237	17	162
HKWC	Accident & Emergency	60	9	0	4
	Intensive Care Unit	79	1	3	5
	Medicine	795	51	9	45
	Obstetrics & Gynaecology	139	8	0	6
	Orthopaedics & Traumatology	81	10	1	2
	Paediatrics	156	8	0	5
	Psychiatry	142	1	2	4
	Surgery	485	52	5	28
	Others	986	96	6	46
	Total	2 924	236	26	145
KCC	Accident & Emergency	201	17	2	10
	Intensive Care Unit	147	5	4	8
	Medicine	1 508	119	19	73
	Obstetrics & Gynaecology	279	2	8	7
	Orthopaedics & Traumatology	187	5	2	3
	Paediatrics	537	46	6	22
	Psychiatry	299	24	2	17
	Surgery	484	46	5	20
	Others	2 329	264	24	98
	Total	5 970	528	72	258
KEC	Accident & Emergency	164	7	2	6
	Intensive Care Unit	204	3	0	10
	Medicine	1 217	105	3	47
	Obstetrics & Gynaecology	106	11	0	8
	Orthopaedics & Traumatology	204	17	0	10
	Paediatrics	162	12	0	7
	Psychiatry	227	5	0	3
	Surgery	231	29	0	13

Cluster	Major Specialty	Manpower Strength (As at 31.12.2024)	Intake No. (April – December 2024 (Include FT and PT)	Full-time Attrition (Wastage) No. (April – December 2024)	
				Retirement	Non-retirement
	Others	1 084	38	1	37
	Total	3 599	227	6	141
KWC	Accident & Emergency	327	20	1	15
	Intensive Care Unit	196	12	3	14
	Medicine	1 341	134	4	68
	Obstetrics & Gynaecology	114	2	1	8
	Orthopaedics & Traumatology	234	26	0	11
	Paediatrics	199	22	1	9
	Psychiatry	722	40	3	17
	Surgery	473	76	3	21
	Others	1 390	112	9	73
	Total	4 994	444	25	236
NTEC	Accident & Emergency	243	21	1	9
	Intensive Care Unit	228	15	0	10
	Medicine	1 518	165	7	53
	Obstetrics & Gynaecology	212	11	1	10
	Orthopaedics & Traumatology	251	18	3	14
	Paediatrics	245	23	1	10
	Psychiatry	420	41	2	5
	Surgery	445	44	2	33
	Others	1 245	58	17	43
	Total	4 808	396	34	187
NTWC	Accident & Emergency	235	36	0	19
	Intensive Care Unit	153	17	1	13
	Medicine	961	112	3	49
	Obstetrics & Gynaecology	138	4	1	6
	Orthopaedics & Traumatology	153	5	0	4
	Paediatrics	177	18	0	14
	Psychiatry	770	53	5	21
	Surgery	213	22	2	5
	Others	1 338	39	10	37
	Total	4 138	306	22	168

Note:

- (1) The manpower figures above are calculated on full-time equivalent basis including permanent, contract and temporary staff in the HA. Individual figures may not add up to the total due to rounding.

- (2) Starting from January 2024, full-time equivalent for temporary part-time staff is calculated based on their actual working hours. The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.
- (3) Intake refers to the total number of permanent and contract staff joining the HA on headcount basis during the period. Transfer, promotion and staff movement within the HA are not regarded as Intake.
- (4) Attrition (Wastage) includes all types of cessation of service (including retirement) from the HA for permanent and contract staff on headcount basis.
- (5) From January 2024 onwards, the HA excludes those staff under the EER arrangement when compiling the statistics of Attrition (Wastage). The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.
- (6) From January 2024 onwards, the HA excludes those staff under the EER arrangement when compiling the statistics of Intake. The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.
- (7) The strength of nurses includes senior nursing officers, department operations managers, nurse consultants, associate nurse consultants, ward managers, nursing officers, advanced practice nurses, registered nurses, enrolled nurses, nursing trainees, etc.

The tables below set out the manpower strength, intake number and full-time attrition (wastage) number of allied health professionals by major grade in each hospital cluster of the HA from 2022-23 to 2024-25 (April – December 2024):

2022-23

Cluster	Major Grade	Manpower Strength (As at 31.3.2023)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
HKEC	Medical Laboratory Technologist	143	15	3	14
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	126	9	1	8
	Social Workers	50	4	0	2
	Occupational Therapist	98	15	3	11
	Physiotherapist	144	21	0	6
	Pharmacist	89	8	0	4
	Dispenser	165	14	3	5
	Others	114	5	2	3
	Total	928	91	12	53
HKWC	Medical Laboratory Technologist	262	28	8	22
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	130	9	3	7
	Social Workers	55	10	2	6
	Occupational Therapist	93	8	1	8
	Physiotherapist	119	18	2	17

Cluster	Major Grade	Manpower Strength (As at 31.3.2023)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Pharmacist	82	10	0	2
	Dispenser	145	10	0	5
	Others	146	25	3	11
	Total	1 032	118	19	78
KCC	Medical Laboratory Technologist	467	35	16	24
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	248	25	6	27
	Social Workers	93	7	0	5
	Occupational Therapist	176	26	0	19
	Physiotherapist	259	40	5	31
	Pharmacist	158	18	3	4
	Dispenser	308	16	3	13
	Others	230	30	3	19
	Total	1 937	197	36	142
KEC	Medical Laboratory Technologist	177	16	1	7
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	112	4	2	4
	Social Workers	57	6	2	4
	Occupational Therapist	115	13	0	13
	Physiotherapist	165	23	3	14
	Pharmacist	85	8	1	1
	Dispenser	160	7	3	4
	Others	135	16	3	9
	Total	1 007	93	15	56
KWC	Medical Laboratory Technologist	253	26	6	13
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	196	15	4	13
	Social Workers	72	11	2	3
	Occupational Therapist	200	21	0	25
	Physiotherapist	181	37	3	26
	Pharmacist	140	14	2	2
	Dispenser	269	21	2	8
	Total	1 482	166	23	101
	Others	171	21	4	11
	Total	1 482	166	23	101

Cluster	Major Grade	Manpower Strength (As at 31.3.2023)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
NTEC	Medical Laboratory Technologist	300	20	5	9
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	210	17	2	13
	Social Workers	42	10	0	4
	Occupational Therapist	171	25	1	17
	Physiotherapist	211	22	1	28
	Pharmacist	119	10	1	4
	Dispenser	256	12	3	4
	Others	170	18	2	10
	Total	1 479	134	15	89
NTWC	Medical Laboratory Technologist	203	24	7	16
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	173	16	2	4
	Social Workers	42	5	1	4
	Occupational Therapist	142	26	0	21
	Physiotherapist	162	25	0	16
	Pharmacist	101	9	2	4
	Dispenser	209	15	8	6
	Others	161	16	3	12
	Total	1 192	136	23	83

2023-24

Cluster	Major Grade	Manpower Strength (As at 31.3.2024)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
HKEC	Medical Laboratory Technologist	145	13	6	1
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	133	13	1	4
	Social Workers	56	12	0	2
	Occupational Therapist	109	18	1	11
	Physiotherapist	153	26	1	11
	Pharmacist	90	9	0	7
	Dispenser	166	17	3	7
	Others	120	9	0	9
	Total	971	117	12	52

Cluster	Major Grade	Manpower Strength (As at 31.3.2024)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
HKWC	Medical Laboratory Technologist	269	26	5	10
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	135	6	1	2
	Social Workers	62	9	2	3
	Occupational Therapist	97	8	3	2
	Physiotherapist	126	15	2	15
	Pharmacist	88	4	2	1
	Dispenser	143	5	3	3
	Others	147	14	0	11
	Total	1 066	87	18	47
KCC	Medical Laboratory Technologist	492	40	13	22
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	245	14	1	18
	Social Workers	97	6	1	5
	Occupational Therapist	175	24	1	20
	Physiotherapist	274	47	6	26
	Pharmacist	164	14	0	5
	Dispenser	313	29	2	11
	Others	230	16	4	8
	Total	1 988	190	28	115
KEC	Medical Laboratory Technologist	190	20	3	8
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	113	2	0	0
	Social Workers	65	9	1	1
	Occupational Therapist	119	16	1	9
	Physiotherapist	173	24	0	20
	Pharmacist	90	5	0	0
	Dispenser	164	13	1	2
	Others	141	16	0	8
	Total	1 054	105	6	48
KWC	Medical Laboratory Technologist	259	17	0	12
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	197	11	2	8
	Social Workers	69	14	0	12

Cluster	Major Grade	Manpower Strength (As at 31.3.2024)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Occupational Therapist	214	29	0	16
	Physiotherapist	201	27	1	13
	Pharmacist	145	13	3	8
	Dispenser	283	14	1	8
	Others	176	11	3	6
	Total	1 544	136	10	83
NTEC	Medical Laboratory Technologist	308	21	3	10
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	214	13	5	10
	Social Workers	47	10	2	5
	Occupational Therapist	181	22	1	12
	Physiotherapist	241	44	1	22
	Pharmacist	123	10	1	4
	Dispenser	264	21	6	9
	Others	170	14	2	7
	Total	1 549	155	21	79
NTWC	Medical Laboratory Technologist	216	25	1	13
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	178	15	1	8
	Social Workers	48	9	0	5
	Occupational Therapist	148	22	1	18
	Physiotherapist	173	34	0	24
	Pharmacist	107	8	1	1
	Dispenser	214	13	1	4
	Others	159	8	2	7
	Total	1 242	134	7	80

2024-25

Cluster	Major Grade	Manpower Strength (As at 31.12.2024)	Intake No. (April – December 2024) (Include FT and PT)	Full-time Attrition (Wastage) No. (April – December 2024)	
				Retirement	Non-retirement
HKEC	Medical Laboratory Technologist	154	11	1	1

Cluster	Major Grade	Manpower Strength (As at 31.12.2024)	Intake No. (April – December 2024) (Include FT and PT)	Full-time Attrition (Wastage) No. (April – December 2024)	
				Retirement	Non-retirement
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	147	13	0	3
	Social Workers	58	2	0	2
	Occupational Therapist	112	10	0	8
	Physiotherapist	163	22	2	11
	Pharmacist	96	6	0	3
	Dispenser	173	12	1	5
	Others	121	9	0	6
	Total	1 022	85	4	39
HKWC	Medical Laboratory Technologist	283	28	2	14
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	137	5	2	3
	Social Workers	59	3	1	4
	Occupational Therapist	95	6	1	5
	Physiotherapist	134	23	3	7
	Pharmacist	91	5	0	2
	Dispenser	145	8	2	1
	Others	152	11	0	7
	Total	1 097	89	11	43
KCC	Medical Laboratory Technologist	504	34	2	13
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	255	16	4	5
	Social Workers	95	3	1	2
	Occupational Therapist	181	24	2	12
	Physiotherapist	297	43	3	12
	Pharmacist	169	12	0	9
	Dispenser	316	19	3	10
	Others	243	18	1	8
	Total	2 060	169	16	71
KEC	Medical Laboratory Technologist	196	23	6	6
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	117	5	0	1
	Social Workers	67	6	0	7

Cluster	Major Grade	Manpower Strength (As at 31.12.2024)	Intake No. (April – December 2024) (Include FT and PT)	Full-time Attrition (Wastage) No. (April – December 2024)	
				Retirement	Non-retirement
	Occupational Therapist	123	15	0	14
	Physiotherapist	190	31	2	8
	Pharmacist	94	6	0	1
	Dispenser	168	9	4	4
	Others	144	10	0	6
	Total	1 100	105	12	47
KWC	Medical Laboratory Technologist	273	23	4	7
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	201	15	3	6
	Social Workers	68	6	0	7
	Occupational Therapist	224	16	0	6
	Physiotherapist	213	35	1	22
	Pharmacist	152	12	1	4
	Dispenser	289	19	2	5
	Others	180	14	0	7
	Total	1 600	140	11	64
NTEC	Medical Laboratory Technologist	322	25	0	8
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	237	23	1	4
	Social Workers	48	3	0	1
	Occupational Therapist	191	19	0	6
	Physiotherapist	262	36	2	9
	Pharmacist	129	9	0	3
	Dispenser	269	15	4	10
	Others	171	10	2	9
	Total	1 629	140	9	50
NTWC	Medical Laboratory Technologist	224	8	2	0
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	177	10	0	7
	Social Workers	49	3	0	2
	Occupational Therapist	157	19	0	8
	Physiotherapist	194	36	0	10
	Pharmacist	111	8	0	4
	Dispenser	220	10	1	1

Cluster	Major Grade	Manpower Strength (As at 31.12.2024)	Intake No. (April – December 2024) (Include FT and PT)	Full-time Attrition (Wastage) No. (April – December 2024)	
				Retirement	Non-retirement
	Others	162	7	0	4
	Total	1 294	101	3	36

Note:

- (1) The manpower figures above are calculated on full-time equivalent basis including permanent, contract and temporary staff in the HA. Individual figures may not add up to the total due to rounding.
- (2) Starting from January 2024, full-time equivalent for temporary part-time staff is calculated based on their actual working hours. The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.
- (3) Intake refers to the total number of permanent and contract staff joining the HA on headcount basis during the period. Transfer, promotion and staff movement within the HA are not regarded as Intake.
- (4) Attrition (Wastage) includes all types of cessation of service (including retirement) from the HA for permanent and contract staff on headcount basis.
- (5) Pharmacists includes Interns appointed as Resident Pharmacists.
- (6) For allied health professionals, the category of “Others” includes audiology technicians, bioinformatician, clinical psychologists, dental technicians, dietitians, genetic counsellors, mould laboratory technicians, optometrists, orthoptists, physicists, podiatrists, prosthetists & orthotists, scientific officers (medical)-pathology, scientific officers (medical)-audiology, scientific officers (medical)-radiology, scientific officers (medical)-radiotherapy and speech therapists.
- (7) From January 2024 onwards, those staff under the EER arrangement are excluded from the statistics of Attrition (Wastage). The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.
- (8) From January 2024 onwards, the HA excludes those staff under the EER arrangement when compiling the statistics of Intake. The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.

3.

The table below sets out, by year of service, the number of doctors and nurses in 2024-25 (up to 31 December 2024):

Year of Service	2024-25 (up to 31 December 2024)	
	Doctors	Nurses
< 1 year	438	4 141
1 - < 6 years	2 829	11 249
6 - < 11 years	1 812	6 218
11 - < 16 years	922	3 338
16 - < 21 years	614	1 334
21 - < 26 years	459	689

Year of Service	2024-25 (up to 31 December 2024)	
	Doctors	Nurses
26 - < 31 years	453	3 611
31 years or above	260	2 883

Note:

- (1) The manpower figure is calculated on headcount basis including permanent, contract and temporary staff in the HA.
- (2) Doctors exclude Interns and Dental Officers.
- (3) The strength of nurses includes senior nursing officers, department operations managers, nurse consultants, associate nurse consultants, ward managers, nursing officers, advanced practice nurses, registered nurses, enrolled nurses, nursing trainees, etc.

4.

The table below sets out, by year of service, the non-retirement attrition (wastage) of doctors and nurses in 2024-25 (rolling 12 months from January to December 2024):

Year of Service	Doctors	Nurses
< 1 year	40	263
1 - < 6 years	91	764
6 - < 11 years	77	358
11 - < 16 years	55	160
16 - < 21 years	36	42
21 - < 26 years	15	26
26 - < 31 years	9	97
31 years or above	4	52

Note:

- (1) Attrition (Wastage) includes all types of cessation of service (including retirement) from the HA for permanent and contract staff on headcount basis.
- (2) Doctors exclude Interns and Dental Officers.

Abbreviations

Cluster

HKEC – Hong Kong East Cluster

HKWC – Hong Kong West Cluster

KCC – Kowloon Central Cluster

KEC – Kowloon East Cluster

KWC – Kowloon West Cluster

NTEC – New Territories East Cluster

NTWC – New Territories West Cluster

Others

FT – full-time

PT – part-time

- End -

CONTROLLING OFFICER'S REPLY**HHB012****(Question Serial No. 1722)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: ()Controlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

Regarding the coordination of mental health policies and measures, please inform this Committee of:

1. the number of persons served by year since the launch of the “18111 - Mental Health Support Hotline” in end-2023;
2. the average call duration for the hotline after callers are connected; the number of calls not answered immediately, and the longest and average time for callbacks;
3. the number of high-risk or referral cases identified by the hotline; the number of those cases referred to relevant departments for follow-up (please list the departments referred to and the number of referrals in tabular form).

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 52)

Reply:

(1)

The Health Bureau has launched the “18111 - Mental Health Support Hotline” (the Hotline) to provide one-stop, round-the-clock support for people with mental health needs, rendering emotional and mental health support to people from all backgrounds and of all ages. Callers will be provided with service information or referred to appropriate service providers based on their individual needs.

Since the launch of the Hotline on 27 December 2023 and up to 28 February 2025, a total of around 139 100 calls were received and provided with immediate support. The number of calls received by year is as follows:

Year	Number of Calls Received
2023 (from 27 December to 31 December)	Approximately 1 900
2024	Approximately 120 800
2025 (as at 28 February)	Approximately 16 400

(2)

After callers were connected to the Hotline, the average call duration was about 9 minutes. Most of the incoming calls from the public have been answered in a timely manner and, if necessary, callers may also choose to leave a message. The accumulated number of callers' messages left on the Hotline is less than 200 (accounting for 0.14% of the total number of calls received), of which 99% were returned within 30 minutes, and the callers were successfully connected.

(3)

As at 28 February 2025, the Hotline has referred a total of 414 cases to various service providers. Details of the referrals are tabulated below:

Service Provider	Number of referrals
Integrated Community Centre for Mental Wellness	209
Other support hotlines (e.g. Mental Health Hotline, Suicide Prevention Services)	103
Other organisations/services (e.g. The Samaritan Befrienders Hong Kong, The Comfort Care Concern Group, Youth Outreach)	86
999 emergency services	16
Total	414

- End -

CONTROLLING OFFICER'S REPLY**HHB013****(Question Serial No. 1723)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (2) HealthControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

Regarding the enhancement of the development of District Health Centres (DHCs) and District Health Centre Expresses, please set out:

1. the number of members of all DHCs, as well as the number of attendances at the satellite centres for each DHC, broken down by type of service, over the past 3 years;
2. the expenditures involved in setting up additional satellite centres for DHCs; and
3. whether service indicators such as minimum attendance have been set in these additional satellite centres; if yes, the relevant indicators; if not, the reasons for that.

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 54)Reply:

(1)

The cumulative numbers of members and attendances of all the District Health Centres (DHCs) and District Health Centre Expresses (DHCEs) are set out in the table below:

DHC/DHCE Service Commencement Date	Cumulative Number of members ^{Note 1} (as at 31 December 2024) [Provisional Figures]	Cumulative Number of Attendances ^{Note 1, 2, 3, 4} (as at 31 December 2024) [Provisional figures]	
		Category 1 Service/Activity ^{Note 5}	Category 2 Service/Activity ^{Note 6}
<i>DHC</i>			
Kwai Tsing 24 September 2019	46 100	241 800	256 500
Sham Shui Po 30 June 2021	34 300	124 500	172 100

Tuen Mun 31 May 2022	38 100	157 400	186 700
Wong Tai Sin 30 June 2022	34 700	79 300	121 600
Southern 17 October 2022	23 900	105 000	70 400
Yuen Long 24 October 2022	42 500	101 600	153 500
Tsuen Wan 30 December 2022	26 000	88 000	87 700
DHCE			
Sai Kung 1 September 2021	10 600	38 000	47 000
Kowloon City 1 October 2021	11 300	18 800	38 500
Yau Tsim Mong 1 October 2021	9 600	19 600	28 900
Wan Chai 4 October 2021	6 800	29 200	23 900
North 18 October 2021	8 700	21 500	32 200
Islands 18 October 2021	6 400	17 500	18 300
Kwun Tong 21 October 2021	10 800	19 900	29 300
Tai Po 22 October 2021	7 800	17 600	27 300
Sha Tin 30 October 2021	13 300	22 600	48 800
Central and Western 30 October 2021	7 900	22 400	27 900
Eastern 30 October 2021	10 900	20 200	34 500
Total	349 900	2 549 900	

Note:

1. Figures are rounded to the nearest hundred.
2. The figures only include service figures captured from the DHC/DHCE information system, and do not include those relating to medical laboratory tests.
3. As different services are provided by the 11 DHCEs, the attendance figures are not directly comparable.
4. The service figures above have included services provided by DHCs/DHCEs for participants of the Chronic Disease Co-care Pilot Scheme which was launched on 13 November 2023.
5. Category 1 service/activity includes health promotion and education.
6. Category 2 service/activity includes health risk assessment, screening for diabetes mellitus and hypertension, chronic disease management and community rehabilitation programme.

(2)

Currently, the provisions for the service contracts of DHCs and DHCEs cover staff costs, rental costs for the satellite centres of DHCs/DHCEs, setup costs, administrative costs, and expenditures for organising activities under the DHC Scheme.

The 2024-25 revised estimates (including provisions for service contracts, site maintenance and rental cost) of each DHC/ DHCE are set out in the table below:

DHC/DHCE Service Commencement Date	2024-25 Revised Estimates (\$ million)
<i>DHC</i>	
Kwai Tsing 24 September 2019	62
Sham Shui Po 30 June 2021	63
Tuen Mun 31 May 2022	80
Wong Tai Sin 30 June 2022	69
Southern 17 October 2022	58
Yuen Long 24 October 2022	73
Tsuen Wan 30 December 2022	78
<i>DHCE</i>	
Sai Kung 1 September 2021	14
Kowloon City 1 October 2021	14
Yau Tsim Mong 1 October 2021	14
Wan Chai 4 October 2021	15
North 18 October 2021	14
Islands 18 October 2021	13
Kwun Tong 21 October 2021	14
Tai Po 22 October 2021	14
Sha Tin 30 October 2021	14
Central and Western	15

DHC/DHCE Service Commencement Date	2024-25 Revised Estimates (\$ million)
30 October 2021	
Eastern 30 October 2021	14
Total	638

Upon the upgrading of the 3 DHCEs in the Central and Western District, Eastern District and Yau Tsim Mong District to DHCs this year, the 11 existing DHCEs will gradually reduce to 8, while the number of DHCs will increase to 10. The estimated expenditure for DHCs and DHCEs (including provisions for service contracts, site maintenance and rental cost) for 2025-26 are \$1.083 billion and \$213 million respectively.

(3)

The Government has set performance indicator targets for each DHC/DHCE, which are clearly stated in the tender documents open to public inspection. Service operators will provide services according to the targets set out in the contracts, which are not to be disclosed in accordance with the terms of contracts. As at 31 December 2024, DHCs/DHCEs in all districts met the performance targets.

- End -

CONTROLLING OFFICER'S REPLY

HHB014

(Question Serial No. 1727)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding Public-Private Partnership [PPP] programmes,

1. please set out the total expenditure on the programmes in each of the past 3 years, as well as the expenditure on each programme, the number of attendances and the average subsidy amount per patient;
2. the expenditure on each programme has been supported by the returns of the Hospital Authority Public-Private Partnership Fund and it is understood that resources of the fund needs to be ploughed back to the Treasury. Has the Bureau assessed what limitations this might impose on the sustainable development of the PPP programmes and how will the Bureau cope with the service expenses of the programmes in the future?

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 53)

Reply:

1.

In the past 3 years, the Hospital Authority (HA) continued to operate a series of Public-Private Partnership (PPP) programmes, including the Cataract Surgeries Programme (CSP), Haemodialysis PPP Programme (HD PPP), Project on Enhancing Radiological Investigation Services through Collaboration with the Private Sector (Radi Collaboration), General Outpatient Clinic PPP Programme (GOPC PPP)/Co-care Service Model (Co-care), Colon Assessment PPP Programme (Colon PPP) and Glaucoma PPP Programme (Glaucoma PPP).

To cope with the COVID-19 epidemic since early 2020, the HA has expanded the service scope of some of the initial PPP Programmes, including expanding the service group of the Radi Collaboration to cover all eligible cancer patients, increasing the service quota of the HD PPP, as well as extending the Colon PPP to cover the colonoscopy cases that were delayed due to the epidemic (Colon PPP Surge Special). Furthermore, the HA has also launched new PPP initiatives as contingency COVID-19 PPPs to divert suitable patients from public hospitals to the private sector for treatment. These initiatives include the Trauma Operative

Service Collaboration Programme (Trauma Collaboration), Breast Cancer Operative Service Collaboration Programme (Breast Cancer Collaboration), Radiation Therapy Service PPP Programme (RT PPP) and Oesophago-Gastro-Duodenoscopy Collaboration Programme (OGD Collaboration). The HA will make timely adjustments to the arrangements of the PPP programmes in the light of actual need and effectiveness of the programmes. Among the above 4 contingency PPP programmes, Trauma Collaboration, Breast Cancer Collaboration and RT PPP are still being run by the HA whereas OGD Collaboration has ceased operation. On another front, the HA launched the Investigation PPP Programme (Investigation PPP) in March 2024, under which laboratory services, including testing of blood, urine and sputum and electrocardiogram, are provided to GOPC PPP patients by designated private laboratories.

Service provisions by PPP programme in the past 3 years are tabulated below:

Programme	2022-23 Actual Provision	2023-24 Actual Provision	2024-25 Planned Provision
CSP (surgeries)	2 914	4 850	5 000
HD PPP ¹ (places)	376	426	441
Radi Collaboration ² (scans)	56 148	70 629	56 000
GOPC PPP/Co-care (participating patients)	49 384	54 716	56 280
Colon PPP & Surge Special ³ (colonoscopies)	2 924	1 780	2 200
Glaucoma PPP (participating patients)	2 686	2 673	2 700
Trauma Collaboration ⁴ (patients)	586	647	700
Breast Cancer Collaboration ⁵ (patients)	379	356	430
RT PPP ⁶ (patients)	98	155	100
OGD Collaboration ⁷ (patients)	1 151	N/A	N/A
Investigation PPP ⁸ (investigations)	N/A	4	112 560

The expenditures by HA's PPP programme in the past 3 years are tabulated below:

Programme	2022-23 Actual Expenditure ⁹ (\$ million)	2023-24 Actual Expenditure ⁹ (\$ million)	2024-25 Projected Expenditure ⁹ (\$ million)
CSP	25.3	40.8	41.8
HD PPP	89.5	102.8	114.8

Programme	2022-23 Actual Expenditure⁹ (\$ million)	2023-24 Actual Expenditure⁹ (\$ million)	2024-25 Projected Expenditure⁹ (\$ million)
Radi Collaboration	167.9	214.9	232.1
GOPC PPP/Co-care	101.8	127.2	127.7
Colon PPP & Surge Special	33.9	31.4	32.0
Glaucoma PPP	6.4	7.7	9.9
Trauma Collaboration	40.1	49.2	54.1
Breast Cancer Collaboration	26.8	27.7	34.5
RT PPP	4.7	7.5	5.4
OGD Collaboration	8.9	N/A	N/A
Investigation PPP	N/A	-	15.7

The expenditures involved in implementing the PPP programmes, including payments to service providers, spending on service and administrative support, and clinical and information technology, in the past 3 years are as follows:

Year	2022-23 Actual	2023-24 Actual	2024-25 Projected
Expenditure (\$ million)	530.4	656.2	718.9

Notes:

1. HD PPP benefited 416 patients and 500 patients in 2022-23 and 2023-24 (on a full-year basis) respectively.
2. The HA, in the light of service demand, increased the actual service provisions under the Radi Collaboration in 2023-24, with adjustments made to such service provisions based on demand in 2024-25.
3. In view of the development of the COVID-19 epidemic, the Surge Special was introduced for Colon PPP between April and August 2022 to cope with the colonoscopy cases that were delayed or cancelled due to the epidemic.
4. Launched in April 2020 as a PPP programme in response to the COVID-19 epidemic, Trauma Collaboration continued as a PPP programme.
5. Launched in June 2020 as a COVID-19 PPP, Breast Cancer Collaboration continued as a PPP programme.
6. First launched in February 2020 and ended in February 2021, RT PPP was then re-activated in July 2022 as a PPP programme.
7. First launched in June 2020 and ended in April 2021, OGD Collaboration was then re-activated in March 2022 and ended in August 2022.
8. Launched in late March 2024, Investigation PPP is applicable to GOPC PPP/Co-care.

9. Spending on information technology and administration support is excluded.

The average subsidy amounts under the PPP programmes in the past 3 years are tabulated below:

Programme	Average Subsidy Amount
CSP (each surgery)	a fixed subsidy of \$8,000
HD PPP (each place)	about \$240,000 to \$260,000 annually
Radi Collaboration (each scan)	about \$3,000 to \$4,100
GOPC PPP/Co-care (each patient)	a subsidy capped at \$3,660 annually
Colon PPP & Surge Special (each colonoscopy)	a fixed subsidy of \$6,800 (without polypectomy) or \$7,500 (with polypectomy)
Glaucoma PPP (each patient)	a subsidy capped at \$5,350 annually
Trauma Collaboration (each patient)	about \$68,000 to \$77,000
Breast Cancer Collaboration (each patient)	about \$71,000 to \$80,000
RT PPP (each patient)	about \$48,000 to \$54,000
OGD Collaboration (each patient)	about \$7,700
Investigation PPP (each investigation)	about \$140 to \$250

2.

In 2016, the Government allocated to the HA \$10 billion for setting up the HA PPP Fund to generate investment returns for implementing clinical PPP initiatives so as to alleviate pressure on the public healthcare system. To dovetail with the Government's healthcare policies, enhance healthcare system operational efficiency and address service demands more effectively, the Health Bureau established the Strategic Purchasing Office in 2022 to develop and roll out a common platform for strategic purchasing, facilitating integrated purchasing of healthcare services, including consolidation of existing HA's and the Department of Health's PPP programmes. With the development of the healthcare reform, the Government is reviewing various PPP programmes, integrating those programmes aimed at relieving short-term pressure back into HA's routine services, and the Strategic Purchasing Office will refine and consolidate those PPP programmes with long-term development needs so that such programmes can be managed and developed under the model of strategic purchasing.

The 2025-26 Budget puts forward bringing back the unspent balance of six seed capital funds, including the HA PPP Fund, to the Government's accounts after setting aside resources to meet the necessary expenditure of these funds for the next 5 years so that their sustainable

operation will not be affected. This will provide a more comprehensive picture of the Government's fiscal position and enable better use of its financial resources. To this end, the HA has reviewed the latest financial position of the HA PPP Fund and projected the cash flow requirements for the next 5 years having regard to the past expenditure, needs of relevant programmes and the related development strategies, and set aside resources to meet the necessary expenditure for the next 5 years.

- End -

CONTROLLING OFFICER'S REPLY

HHB015

(Question Serial No. 1752)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the number of beds in public hospitals:

- I. please set out the population and the population aged 65 or above in each hospital cluster of the Hospital Authority (HA) in the past 3 years;
- II. please set out the number of general beds, the ratio of bed per 1 000 population and the ratio of bed per 1 000 population aged 65 or above in each hospital cluster of the HA in the past 3 years; and
- III. will the Government consider formulating indicators on the ratio of bed to population in the clusters to improve the future service planning; if yes, what are the details of the plan and the estimated expenditure involved; if not, the reasons for that?

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 41)

Reply:

(I)

The Hospital Authority (HA) plans and develops public healthcare services on a cluster basis, taking into account a number of factors, including the increase of service demand as a result of population growth and demographic changes, rising prevalence of chronic diseases, technology advancement, manpower availability as well as the arrangement of services of the clusters. While monitoring the healthcare service utilisation, the HA will also conduct cluster planning and adjust service provision of clusters according to the latest population projection parameters of each district in Hong Kong and development plans of the Government, with a view to addressing the healthcare needs of its patients.

The tables below set out the population and the population aged 65 or above in each cluster of the HA in 2022, 2023 and 2024.

Population Estimates in 2022 (as at mid-2022)

District	Corresponding Hospital Cluster	Population	Population aged 65 or above
Eastern, Wan Chai, Islands (excluding Lantau Island)	HKEC	707 200	171 400
Central & Western, Southern	HKWC	480 600	105 500
Kowloon City, Yau Tsim Mong, Wong Tai Sin	KCC	1 104 200	240 800
Kwun Tong, Sai Kung	KEC	1 161 900	235 600
Sham Shui Po, Kwai Tsing, Tsuen Wan, Lantau Island	KWC	1 386 000	288 900
Sha Tin, Tai Po, North	NTEC	1 338 000	272 900
Tuen Mun, Yuen Long	NTWC	1 167 000	213 700
Overall Hong Kong		7 346 100	1 528 900

Population Estimates in 2023 (as at mid-2023)

District	Corresponding Hospital Cluster	Population	Population aged 65 or above
Eastern, Wan Chai, Islands (excluding Lantau Island)	HKEC	722 600	181 300
Central & Western, Southern	HKWC	498 700	111 800
Kowloon City, Yau Tsim Mong, Wong Tai Sin	KCC	1 133 900	255 300
Kwun Tong, Sai Kung	KEC	1 177 700	249 600
Sham Shui Po, Kwai Tsing, Tsuen Wan, Lantau Island	KWC	1 420 200	309 700
Sha Tin, Tai Po, North	NTEC	1 365 900	297 000
Tuen Mun, Yuen Long	NTWC	1 216 200	237 200
Overall Hong Kong		7 536 100	1 641 900

Population Estimates in 2024 (as at mid-2024)

District	Corresponding Hospital Cluster	Population	Population aged 65 or above
Eastern, Wan Chai, Islands (excluding Lantau Island)	HKEC	710 400	182 700
Central & Western, Southern	HKWC	494 100	113 800
Kowloon City, Yau Tsim Mong, Wong Tai Sin	KCC	1 135 500	263 400
Kwun Tong, Sai Kung	KEC	1 171 600	258 200
Sham Shui Po, Kwai Tsing, Tsuen Wan, Lantau Island	KWC	1 415 800	318 900
Sha Tin, Tai Po, North	NTEC	1 379 500	314 200
Tuen Mun, Yuen Long	NTWC	1 218 900	250 400
Overall Hong Kong		7 526 800	1 702 000

(II)

The tables below set out the number of general beds in the HA and its ratio per 1 000 population by hospital clusters in 2022-23, 2023-24 and 2024-25.

2022-23

Hospital Cluster	Number of general beds [#]	Number of general beds per 1 000 geographical population of catchment districts	Number of general beds per 1 000 geographical population aged 65 or above of catchment districts	Catchment districts
HKEC	2 283	3.2	13.3	Eastern, Wan Chai, Islands (excluding Lantau Island)
HKWC	2 797	5.8	26.5	Central & Western, Southern
KCC	5 353	4.6	21.1	Kowloon City, Yau Tsim Mong, Wong Tai Sin
KEC	2 844	2.4	12.1	Kwun Tong, Sai Kung
KWC	3 753	2.7	13.0	Sham Shui Po, Kwai Tsing, Tsuen Wan, Lantau Island
NTEC	4 167	3.1	15.3	Sha Tin, Tai Po, North
NTWC	3 060	2.6	14.3	Tuen Mun, Yuen Long
Overall HA	24 257	3.3	15.9	

Hospital beds as at 31 March 2023

2023-24

Hospital Cluster	Number of general beds [#]	Number of general beds per 1 000 geographical population of catchment districts	Number of general beds per 1 000 geographical population aged 65 or above of catchment districts	Catchment districts
HKEC	2 309	3.2	12.7	Eastern, Wan Chai, Islands (excluding Lantau Island)
HKWC	2 797	5.6	25.0	Central & Western, Southern
KCC	5 361	4.5	19.9	Kowloon City, Yau Tsim Mong, Wong Tai Sin
KEC	2 854	2.4	11.4	Kwun Tong, Sai Kung
KWC	3 753	2.6	12.1	Sham Shui Po, Kwai Tsing, Tsuen Wan, Lantau Island
NTEC	4 183	3.1	14.1	Sha Tin, Tai Po, North
NTWC	3 068	2.5	12.9	Tuen Mun, Yuen Long
Overall HA	24 325	3.2	14.8	

Hospital beds as at 31 March 2024

2024-25

Hospital Cluster	Number of general beds [^]	Number of general beds per 1 000 geographical population of catchment districts	Number of general beds per 1 000 geographical population aged 65 or above of catchment districts	Catchment districts
HKEC	2 309	3.3	12.6	Eastern, Wan Chai, Islands (excluding Lantau Island)
HKWC	2 797	5.7	24.6	Central & Western, Southern
KCC	5 378	4.5	19.4	Kowloon City, Yau Tsim Mong, Wong Tai Sin
KEC	2 876	2.5	11.1	Kwun Tong, Sai Kung
KWC	3 776	2.7	11.8	Sham Shui Po, Kwai Tsing, Tsuen Wan, Lantau Island
NTEC	4 237	3.1	13.5	Sha Tin, Tai Po, North
NTWC	3 097	2.5	12.4	Tuen Mun, Yuen Long
Overall HA	24 470	3.3	14.4	

[^] Hospital beds as at 31 December 2024

Note:

- (1) The above population figures are based on the latest revised mid-year population estimates by the Census and Statistics Department (C&SD) and the latest projection by the Planning Department (PlanD), and hence are not directly comparable. Individual figures may not add up to the total due to rounding and inclusion of marine population.
- (2) The general bed-to-population ratio involves the use of the latest revised mid-year population estimates by the C&SD and the latest projection by the PlanD.
- (3) The ratios of general beds per 1 000 population vary among clusters and such a ratio is not a suitable metric for comparison of the level of service provision directly among the clusters because:
 - (i) in planning services, the HA takes into account an array of factors, including the increase of service demand as a result of population growth and demographic changes, advancement of medical technology, manpower availability, organisation of services of the clusters and hospitals, as well as the service demand of local community. Population is only one of the many considerations;
 - (ii) patients may choose to receive treatment in hospitals other than those in their own residential districts; and
 - (iii) certain clusters and their beds provide services for patients throughout the territory as some specialised services are only available in certain hospitals in some clusters.

The above bed information includes only the general beds in the HA, while those of infirmary, mentally ill and mentally handicapped beds are not included given their specific nature.
- (4) The Hong Kong Children's Hospital (HKCH) in the KCC is a specialty hospital providing territory-wide paediatric services. It also serves as a tertiary referral centre for complex cases. Hospital beds of the HKCH are therefore excluded when calculating the bed-to-population ratio (i.e. number of beds per 1 000 population) in the

KCC. However, hospital beds of the HKCH are included when calculating the HA's overall figures.

(III)

The HA plans and develops public healthcare services with clusters as the key basis. According to experience, the desirable catchment population of a cluster is in the range of about one million to one and a half million to facilitate more effective service coordination and to ensure an adequate service capacity to achieve economies of scale. As the allocation of healthcare resources is based on service demand, the demand for healthcare facilities and staff will drop when the population in a cluster's catchment area decreases considerably, leading to misalignment of resource allocation and impact on its sustainability in the long term. Service experience and training opportunities for clinical staff will also be reduced. If a cluster serves too large a population and the corresponding healthcare service demand is too high, it may lead to uneven resource allocation and inefficient service coordination with other clusters. Therefore, rational cluster planning according to the catchment population and its demographics can enhance cluster management efficiency and is indispensable to ensuring sufficient manpower to meet the healthcare needs of the public.

During the planning of services with varying complexity, the HA has all along adopted the principle of "localising where possible, centralising where necessary" in devising the systems and service network(s) within/among the clusters. The primary healthcare services (including general out-patient services) are normally provided in the regional acute hospitals with accident and emergency services, while the provision of specialty services is concentrated in the appropriate hospitals in the clusters. As for services which are extremely specialised (such as liver transplantation), given the facilities, equipment and specialised personnel so required, they will be provided at specified service points by pooling resources together, so as to address the needs of patients from a larger area or even the entire territory.

As some specialised services are available only in certain hospitals, hospitals and beds in each cluster that provide such services will therefore have to serve patients throughout the territory. Patients may also choose to receive treatment in hospitals other than those in their own residential districts despite availability of such services therein. Service demand is thus generated as a result of such cross-cluster treatment. Hence, all these factors should be taken into account in analysing the bed-to-population ratio of catchment districts in the clusters and planning the hospital services in each cluster. It may not be appropriate to formulate fixed indicators for the bed-to-population ratio of catchment districts in the clusters.

Abbreviations

HKEC – Hong Kong East Cluster
HKWC – Hong Kong West Cluster
KCC – Kowloon Central Cluster
KEC – Kowloon East Cluster
KWC – Kowloon West Cluster
NTEC – New Territories East Cluster
NTWC – New Territories West Cluster

- End -

CONTROLLING OFFICER'S REPLY

HHB016

(Question Serial No. 1839)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Hospital Authority (HA) and the Department of Health (DH) have been actively recruiting non-locally trained medical practitioners to work in Hong Kong in recent years. In this regard, please inform this Committee of the following:

1. the number of applications for special registration received and approved each year since the passage of the Medical Registration (Amendment) Bill 2021, and, among the approved applications, the number of applicants who were medical practitioners with limited registration before approval; and
2. the respective number of medical practitioners employed by the HA and the DH through special registration since the passage of the Medical Registration (Amendment) Bill 2021, broken down by the specialist qualifications and the ranks held by the medical practitioners employed.

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 56)

Reply:

The Government has adopted a multipronged strategy to tackle the shortage of doctors in the public healthcare system. On the admission of qualified non-locally trained doctors, the Government created a new pathway (i.e. special registration (SR)) under the existing Medical Registration Ordinance (MRO) (Cap. 161) in 2021 to allow more qualified non-locally trained doctors to practise in our public healthcare system of Hong Kong so as to increase the supply of doctors in Hong Kong.

1.

According to the information provided by the Medical Council of Hong Kong (MCHK), the figures of SR and limited registration (LR) in relation to the number of applications, employing institutions and the number of applicants who have acquired specialist qualifications as at 31 December 2024 are as follows:

	SR			LR
	Holding recognised medical qualifications	Bridging from LR	Total	
Number of applications				
- Number of applicants ^{Note(1)}	108	13	121	436
- Number of approved applicants	106	13	119 ^{Note(2)}	436
- Number of applicants with registration in effect	93 ^{Note(3)}	13	106	315 ^{Note(4)}
Employing institutions				
- The University of Hong Kong	4	5	9	27
- The Chinese University of Hong Kong	2	7	9	51
- Hospital Authority (HA)	79	1	80	200
- Department of Health (DH)	8	0	8	16
- Clinics exempted from the provisions of section 7 of the Medical Clinics Ordinance	N.A.			7
- Public or private hospitals/medical institutions which are registered with the health administrative departments of the local people’s governments in the Mainland/the Health Bureau of the Macao Special Administrative Region (SAR)	N.A.			14 ^{Note(5)}
Specialist qualifications acquired ^{Note(6)}				
- Anaesthesiology	4	0	4	1
- Clinical Oncology	1	0	1	0
- Emergency Medicine	0	1	1	0
- Family Medicine	1	0	1	0
- Gastroenterology and Hepatology	1	2	3	0
- General Surgery	0	0	0	1
- Geriatrics Medicine	0	1	1	0
- Intensive Care	0	0	0	1
- Medical Oncology	0	1	1	0
- Neurosurgery	1	0	1	0
- Obstetrics and Gynaecology	0	0	0	1
- Ophthalmology	0	1	1	2
- Otorhinolaryngology	0	1	1	0
- Paediatrics	0	1	1	2
- Pathology	0	0	0	1
- Public Health Medicine	0	2	2	0
- Radiology	1	3	4	1
- Rheumatology	0	0	0	1
- Urology	1	0	1	0
Total	10	13	23	11

Note:

- (1) The numbers of applicants and approved applicants include the numbers from 1 January 2022 to 31 December 2024, excluding renewal applications.
- (2) Among the 121 SR applications, 1 application was not approved, and 1 application was approved in January 2025.
- (3) Among the 106 approved SR doctors holding recognised medical qualifications, the SR of 9 applicants came into effect only after 31 December 2024; 3 applicants had their SR terminated before 31 December 2024; and 1 applicant passed the MCHK's licensing examination and became a doctor with full registration in February 2024. The number of applicants with SR in effect includes renewed applications.
- (4) Among the 436 doctors approved for LR, 20 had their LR came into effect only after 31 December 2024; 101 had their LR terminated on or before 31 December 2024 due to expiry of registration or resignation. The number of doctors with LR in effect includes those who have submitted renewed applications.
- (5) It refers to doctors attending to the medical needs of patients(s) during the direct point-to-point cross-boundary ambulance transfer service between Hong Kong SAR and the Mainland/Macao SAR according to Promulgation No. 13 on LR under the MRO (Cap. 161).
- (6) It refers to the number of specialists whose names are included in the Specialist Register of the MCHK as at 31 December, 2024 and their relevant specialties.

2.

For the 8 SR doctors and 16 LR doctors employed by the DH mentioned in (1) above, all their ranks are at Medical and Health Officer or equivalent, and are not registered specialists of the MCHK.

Among the SR doctors employed by the HA mentioned in (1) above, 2 are Consultants, 7 are Associate Consultants, and the rest are Residents; as for the LR doctors, 20 are Associate Consultants, and the rest are Residents. Among the non-locally trained doctors employed by the HA, 13 were on the Specialist Register of the MCHK as at 31 December 2024. Their relevant specialties are set out as follows:

Specialty	Number of doctors ^{Note (1)}	
	LR	SR
Anaesthesiology	0	3
Paediatrics	2	0
Radiology	1	1
Gastroenterology and Hepatology	0	1
Neurosurgery	0	1
Surgery	1	0
Ophthalmology	1	0
Family Medicine	1	0
Endocrinology, Diabetes and Metabolism	1	0
Total	7	6

Note:

- (1) Including 2 non-locally trained doctors whose registration changed from LR to FR in December 2024.

Apart from the 13 doctors mentioned above, some non-locally trained doctors are holding specialist qualifications acquired from other places. The HA will assist them to apply to the Hong Kong Academy of Medicine for certification of specialist qualification if necessary and provide them with appropriate specialist training opportunities.

- End -

CONTROLLING OFFICER'S REPLY**HHB017****(Question Serial No. 3173)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (2) HealthControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

Regarding the continued implementation of the Voluntary Health Insurance Scheme (VHIS):

1. What were the manpower and expenditure involved in the implementation and management of the VHIS in each of the past 3 years?
2. Has the Government estimated how much medical expenses the VHIS can save on average each year?
3. What were the numbers of new VHIS policies in each of the past 3 years (with a breakdown by the gender and age group of the insured person), and the percentages of those where additional Flexi Plans had been purchased?
4. How many claims applications have been made each year since the implementation of the VHIS, and how many of them were successful?

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 6)Reply:

1. The manpower and expenditures of the Voluntary Health Insurance Scheme (VHIS) Office in the past 3 years are tabulated by financial year as follows:

Financial year	No. of staff (year-end figure)	Annual expenditure
2022-23	17	about \$31.4 million
2023-24	16	about \$27.4 million
2024-25	16 (as at 1 March 2025)	about \$30.2 million (estimated)

2. The VHIS has been fully implemented since April 2019, aiming to provide the general public with a choice of individual indemnity hospital insurance products (IHIPs) which are subject to specific regulation and of high market transparency. It offers consumers with greater confidence in purchasing health insurance and using private healthcare services when in need, thereby alleviating pressure on public healthcare system in the long run.

Since the full implementation of the VHIS, the number of policies under the scheme has been increasing. That said, the period is still relatively short and affected by the 3-year long COVID-19 epidemic, during which the use of private healthcare services by Hong Kong citizens was significantly impacted. More time is thus needed to objectively review and assess the effectiveness of the scheme. The Government believes that the VHIS will become the mainstream standard for the individual IHIP market in the long run and boost citizens' confidence in purchasing VHIS products and choosing private healthcare services when in need, thereby reducing the burden on the public healthcare system.

3. The cumulative total numbers of in-force VHIS policies collected from insurance companies and maintained by the Health Bureau (HHB) with breakdown by gender and age of insured persons are tabulated by financial year as follows:

Age of insured persons	As at 31 March 2022		As at 31 March 2023		As at 31 March 2024	
	Male	Female	Male	Female	Male	Female
0-9	54 000	50 000	60 000	56 000	67 000	62 000
10-19	49 000	44 000	58 000	53 000	64 000	58 000
20-29	69 000	78 000	79 000	89 000	84 000	95 000
30-39	96 000	117 000	114 000	137 000	126 000	152 000
40-49	89 000	117 000	105 000	136 000	114 000	149 000
50-59	71 000	97 000	81 000	113 000	88 000	124 000
60 or above	48 000	64 000	59 000	80 000	67 000	91 000
Total no. of policies	477 000	568 000	556 000	665 000	611 000	730 000

Note: Breakdown figures may not add up to the total due to rounding.

In the past 3 years, VHIS Flexi Plans accounted for about 97% of the total number of policies.

4. Since the implementation of the VHIS, over 90% claims have been successful each year. The relevant figures are tabulated as follows:

Year	No. of claims	Success rate
2019 (April to December)	26 000	96%
2020	114 000	94%
2021	195 000	93%
2022	248 000	92%
2023	349 000	93%

Note: Insurance companies provide the figures on claims by calendar year (as at 31 December of each year), and thus the HHB does not have the relevant statistics by financial year. Successful claims include cases receiving full reimbursement and those receiving partial reimbursement.

- End -

CONTROLLING OFFICER'S REPLY**HHB018****(Question Serial No. 3285)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (2) HealthControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

Regarding the Voluntary Health Insurance Scheme:

1. what is the average standard premium of Standard Plans by age group (aged 15-17, 18-24, 25-34, 35-44, 45-64, and 65 or above) of insured persons (including smokers and non-smokers) since the implementation of the Scheme?
2. given that statistics show an annual increase of premiums under the Scheme of up to nearly 10%, does the Government need to review whether such rise is reasonable, and will it consider setting a limit on the increase to avoid excessive premiums that may affect the effectiveness of the Scheme?

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 11)Reply:

1. As at 31 March 2024, the average standard premium of the Standard Plan under the Voluntary Health Insurance Scheme (VHIS), broken down by age group of insured persons, is as follows:

Age group	Average standard premium
15-17	\$1,600
18-24	\$1,800
25-34	\$2,200
35-44	\$3,000
45-64	\$5,700
65 or above	\$11,800

2. At present, all insurance companies participating in the VHIS must disclose information and premium schedules of the Certified Plans. A one-stop platform is also available on the official website of the VHIS Office to facilitate the public in comparing the features and premiums of different plans, thereby enabling them to select the one that suits their needs. The medical insurance market in Hong Kong is highly diversified, and insurance companies have to compete among themselves in terms of product types

and pricing. It is thus not appropriate for the Government to set the premium levels. The Government will strive to enhance the transparency of the VHIS market, promote healthy market competition and provide more choices for the public.

- End -

CONTROLLING OFFICER'S REPLY

HHB019

(Question Serial No. 0492)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (700) General non-recurrent

Programme: Not Specified

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the implementation of the Primary Healthcare Blueprint (Blueprint) and the enhanced development of District Health Centres (DHCs) and District Health Centre Expresses (DHCEs), will the Government advise of the following:

- 1) Given the Government plans to set up the DHCs in 18 districts across Hong Kong, 7 of which, namely in Kwai Chung, Sham Shui Po, Wong Tai Sin, Tuen Mun, Yuen Long, Southern District and Tsuen Wan, have already been established, is there a timetable for implementing such a plan in the remaining 11 districts? Please set out the current/anticipated funding for each of the centres;
- 2) For those 11 districts where no DHCs have yet been established, will the Government directly convert the transitional DHCEs into the DHCs? If not, what will be the locations of the remaining 11 DHCs, and their anticipated commissioning time and operating expenses?
- 3) What are the utilisation rates of the current DHCs and DHCEs? Has the Government assessed if the objectives of taking forward the Blueprint and popularising primary healthcare are met?
- 4) Has the Government used artificial intelligence and big data models to more accurately and effectively evaluate the health of the public at the DHCs and DHCEs for reduction of diagnostic costs? If not, has the Government assessed the costs of such a move?

Asked by: Hon CHAN Hok-fung (LegCo internal reference no.: 28)

Reply:

(1) and (2)

The Government set up 7 DHCs and 11 smaller interim District Health Centre Expresses (DHCEs) in rented properties across the territory by 2022, thereby attaining the interim goal of covering all 18 districts of Hong Kong. The Government will upgrade the three DHCEs in the Central and Western District, Eastern District, and Yau Tsim Mong District to DHCs within 2025. In April 2024, the Health Bureau launched a tender exercise for the operation of the Central and Western DHC and three women's health service points named Women Wellness Satellites located in Chai Wan, Lam Tin and Tuen Mun. A three-year operation

service contract with a total value of approximately \$531.7 million was subsequently awarded in January 2025. The Central and Western DHC, with its core centre located at 308 Des Voeux Road Central, is expected to commence service in the third quarter of this year. In July 2024, the Health Bureau conducted tender exercises for the operation of the Eastern and Yau Tsim Mong DHCs. The operation service contracts for these two DHCs are expected to be awarded this year. The Yau Tsim Mong DHC will be set up at the Ex-Mong Kok Market site and the Eastern DHC will be located at the junction of Siu Sai Wan Road and Harmony Road. Both works projects are expected to be completed in the second quarter of 2025 and commence service in the same year.

In addition, Wan Chai, Kwun Tong, Sai Kung and North DHCs will be set up at Caroline Hill Road Site, Kwun Tong Composite Development Project, Area 67 of Tseung Kwan O and Public Housing Development at Areas 4 and 30 Site 1 of Sheung Shui respectively. The funding proposals for these construction projects were approved by the Finance Committee of the Legislative Council (LegCo) in January and October 2021, and in April and July 2024 respectively. These projects will be completed gradually in the next few years. To achieve the long-term development goal of having DHCs in all 18 districts as early as possible, the Government is actively taking forward the plan to establish DHCs in the remaining four districts and will seek LegCo's funding approval in due course. Before the remaining DHCs are set up, the Government will continue to subsidise non-governmental organisations to operate DHCEs in those districts. The services provided by DHCEs will be migrated as appropriate to DHCs in respective districts at a later stage. The PHCC will, together with the operators of DHCEs, draw up and implement transition plans for upgrading DHCEs to DHCs to ensure a smooth transition of services.

The 2024-25 revised estimates (including provisions for service contracts, site maintenance and rental cost) of DHCs and DHCEs are set out in the table below:

DHC/DHCE Service Commencement Date	2024-25 Revised Estimates (\$ million)
<i>DHC</i>	
Kwai Tsing 24 September 2019	62
Sham Shui Po 30 June 2021	63
Tuen Mun 31 May 2022	80
Wong Tai Sin 30 June 2022	69
Southern 17 October 2022	58
Yuen Long 24 October 2022	73
Tsuen Wan 30 December 2022	78
<i>DHCE</i>	
Sai Kung 1 September 2021	14
Kowloon City	14

DHC/DHCE Service Commencement Date	2024-25 Revised Estimates (\$ million)
1 October 2021	
Yau Tsim Mong 1 October 2021	14
Wan Chai 4 October 2021	15
North 18 October 2021	14
Islands 18 October 2021	13
Kwun Tong 21 October 2021	14
Tai Po 22 October 2021	14
Sha Tin 30 October 2021	14
Central and Western 30 October 2021	15
Eastern 30 October 2021	14
Total	638

Upon the upgrading of the three DHCEs to DHCs this year, the 11 existing DHCEs will gradually reduce to 8, while the number of DHCs will increase to 10. The estimated expenditure for DHCs and DHCEs (including provisions for service contracts, site maintenance and rental cost) for 2025-26 are \$1.083 billion and \$213 million respectively.

(3)

The cumulative numbers of attendances of each DHC/ DHCE are set out in the table below:

DHC/DHCE Service Commencement Date	Cumulative Number of Attendances ^{Notes 1, 2, 3, 4} (As at 31 December 2024) [Provisional Figures]
<i>DHC</i>	
Kwai Tsing 24 September 2019	498 300
Sham Shui Po 30 June 2021	296 600
Tuen Mun 31 May 2022	344 100
Wong Tai Sin 30 June 2022	200 900
Southern 17 October 2022	175 300

DHC/DHCE Service Commencement Date	Cumulative Number of Attendances ^{Notes 1, 2, 3, 4} (As at 31 December 2024) [Provisional Figures]
Yuen Long 24 October 2022	255 000
Tsuen Wan 30 December 2022	175 700
DHCE	
Sai Kung 1 September 2021	84 900
Kowloon City 1 October 2021	57 300
Yau Tsim Mong 1 October 2021	48 500
Wan Chai 4 October 2021	53 000
North 18 October 2021	53 700
Islands 18 October 2021	35 900
Kwun Tong 21 October 2021	49 300
Tai Po 22 October 2021	45 000
Sha Tin 30 October 2021	71 400
Central and Western 30 October 2021	50 200
Eastern 30 October 2021	54 700
Total	2 549 900

Note:

1. Figures are rounded to the nearest hundred.
2. The figures only include service figures captured from the DHC information system, and do not include those relating to medical laboratory tests.
3. As different services are provided by the 11 DHCEs, the attendance figures are not directly comparable.
4. The service figures above have included services provided by DHCs/DHCEs for participants of the Chronic Disease Co-care Pilot Scheme which was launched on 13 November 2023.

(4)

The Government is implementing a five-year development plan of eHealth+ to transform eHealth from a health record sharing system into a comprehensive healthcare information infrastructure that integrates multiple functions of data sharing, service delivery and care journey management, with a view to supporting healthcare reforms and implementation of various healthcare measures including primary healthcare. In July 2024, the Finance Committee of the Legislative Council approved a capital funding of \$1,395.8 million to support the eHealth+ development.

Under the eHealth+ development, eHealth will become an important platform supporting the primary healthcare development by progressively integrating the primary healthcare services provided by the Department of Health, the Hospital Authority and PHCC, particularly in areas such as data sharing, process management, service delivery, and monitoring of health outcomes. At present, all citizens and healthcare providers (HCPs) participating in DHCs are required to register with eHealth. Citizens can use the eHealth mobile application to manage their family doctor pairing at DHCs, arrange allied health and laboratory services and access relevant health records. Healthcare professionals can share relevant medical records of citizens with their consent through the eHealth+ platform so as to provide coherent healthcare services catered to their needs. To further enhance the quality of healthcare services, we will consider introducing artificial intelligence-powered tools in the future to more effectively utilise relevant data for assessing and analysing citizens' health conditions so as to formulate suitable treatment plans and assist citizens and healthcare professionals in monitoring relevant health conditions.

- End -

CONTROLLING OFFICER'S REPLY

HHB020

(Question Serial No. 0399)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

On promoting the development of Chinese medicine (CM) in Hong Kong, please advise this Committee on the following:

- (1) the number of CM practitioners registered in Hong Kong;
- (2) the numbers of CM practitioners trained in Hong Kong and in places other than Hong Kong in each of the past 3 years;
- (3) the types of programmes for nurturing talents in CM and conducting research and studies implemented in each of the past 3 years and the expenditure incurred; and
- (4) the manpower and expenditure involved in administering the Chinese Medicine Development Fund (CMDF) and details of work done since its establishment; the number of projects financed by the CMDF, and the names and scopes of such funded projects, amount of funding granted, implementation timetables and results.

Asked by: Hon CHAN Kapui, Judy (LegCo internal reference no.: 25)

Reply:

(1) and (2)

As at 28 February 2025, there was a total of 10 690 Chinese medicine practitioners (CMPs) in the territory. Among them, 8 574 were registered CMPs, 39 were CMPs with limited registration and 2 077 were listed CMPs.

At present, there are 3 local universities, namely the Hong Kong Baptist University, the Chinese University of Hong Kong, and the University of Hong Kong offering full-time Chinese medicine (CM) undergraduate programmes recognised by the Chinese Medicine Practitioners Board (CMPB) of the Chinese Medicine Council of Hong Kong. Those who have successfully completed the above undergraduate programmes are eligible to sit for the Chinese Medicine Practitioners Licensing Examination (CMPLE) organised by the CMPB. In the academic years between 2021/22 and 2023/24, the numbers of local graduates of University Grants Committee-funded full-time bachelor of CM programmes were as follows:

Academic year	Number of local graduates
2021/22	81
2022/23	70
2023/24	74

There are 31 universities in the Mainland offering full-time CM degree courses recognised by the CMPB. Those who have successfully completed the above courses in the Mainland are eligible to sit for the CMPLE. Candidates who have passed the CMPLE are qualified to apply for registration as registered CMPs for practicing CM in Hong Kong. There have been no other applications for registration of CMPs trained in places other than Hong Kong and the Mainland. In the past 3 years, the numbers of undergraduates of local universities and non-locally trained graduates who passed the CMPLE and got registered were as follows:

Year	Number of undergraduates from the 3 local universities who passed the CMPLE and got registered	Number of non-locally trained graduates who passed the CMPLE and got registered
2022	82	181
2023	58	159
2024	60	202

(3) and (4)

The Government has been committed to promoting the high-quality development of CM on all fronts in Hong Kong and will continue to take forward various initiatives conducive to the nurturing of talents, scientific research and innovation and the overall development of CM sector, including taking forward training and research work on CM through the Hospital Authority (HA); promoting scientific research and standard-setting for CM testing through the Government Chinese Medicines Testing Institute (GCMTI); and taking forward various capacity building initiatives for the sector through the Chinese Medicine Development Fund (CMDF).

Training and scientific research undertaken by the HA

The HA, non-governmental organisations and local universities operate the Chinese Medicine Clinics cum Training and Research Centres (CMCTRs) in 18 districts under a tripartite collaboration model, aiming to promote the development of CM by providing services, training and conducting research. The HA has all along been providing various types of CM training for CM professionals of various ranks in the 18 CMCTRs, including CMP trainees, CMPs, senior CMPs and CM pharmacists, with a view to nurturing more local CM talents. For instance, the HA launched the CMP trainee programme in March 2020 by adopting “evidence-based” medicine as an approach to comprehensively enhance the clinical ability and professional standard of CMP trainees and to help them develop solid clinical capability. At present, the 18 CMCTRs provide a total of 216 training places for CMP trainees, of which 72 are to be allocated to graduates of local full-time CM undergraduate programmes with less than a year’s experience in clinical practice.

The HA has also enhanced various types of on-the-job training for CMPs at other levels. These include scholarships at junior and advanced levels, training on the knowledge and practice of scientific research, commissioned training in Western medicine, etc. Meanwhile, the HA also offers related training for CM drug professionals, including programmes on CM drug professional training and fundamental knowledge on Western medicine, as well as online training platforms, so as to enhance their expertise.

To foster the cultivation of local CM talents, the HA launched the Greater Bay Area (GBA) CM Visiting Scholars Programme and the CM Enhanced In-patient Training Programme with GBA in November 2022 and April 2024 respectively, with the aim to enhance the clinical competency of local CMPs in providing CM in-patient services on all fronts. The GBA CM Visiting Scholars Programme is Hong Kong’s first CM in-patient training programme adopting “mentoring and shadowing” model, inviting CM experts from Tier III Class A CM hospitals in GBA to provide in-patient clinical training for local CMPs in public hospitals in Hong Kong. Since the launch of the programme, around 20 experienced CM experts have joined the CM expert pool, with around 130 local CMPs trained. For CM Enhanced In-patient Training Programme with GBA, it is the first-of-its-kind training programme. It is a breakthrough in arranging CMPs selected from the 18 CMCTRs to obtain Mainland practicing qualifications, enabling them to practice in the clinical teams of CM hospitals in GBA and receive advanced in-patient clinical training. The Guangdong Provincial Hospital of Traditional Chinese Medicine is the collaborating training partner for the first phase of the programme. At present, a total of 16 local CMPs have joined the programme, and the training scope has been expanded to three areas (neurology, acupuncture and oncology).

On the front of scientific research, the HA actively collaborates with the CMCTRs and local universities to conduct systematic research programmes on CM and diseases. Since 2006, a total of 70 CM research projects have been completed and more than 80 scholar articles published in academic journals.

Regarding the expenditure, the Government has earmarked funding for the HA to take forward initiatives for promoting CM development, which include operating the CMCTRs to provide Government-subsidised outpatient services and CMP trainee programme, providing integrated Chinese-Western medicine services, providing “evidence-based” CM training, operating the Toxicology Reference Laboratory, conducting quality assurance and central procurement of CM drugs, and enhancing and maintaining the CM Information System.

The relevant financial provisions in the past 3 years are tabulated below:

Financial Year	2022-23	2023-24	2024-25
Provision (\$ million)	229	348	427

Scientific research undertaken by the GCMTI

Established by the Department of Health (DH) in 2017, the GCMTI specialises in scientific research on CM drugs, with a view to setting internationally recognised reference standards for the safety, quality and testing methods of CM drugs.

One of the key activities of the GCMTI is to take forward the project on the Hong Kong Chinese Materia Medica Standards (HKCMMS). So far, reference standards for a total of 344 Chinese Materia Medica (CMM) have been established and released. The actual expenditures involved in the HKCMMS in the past 3 years are tabulated below:

Financial Year	2022-23	2023-24	2024-25 (Revised Estimate)
Expenditure (\$ million)	6.3	7.9	9.8

Moreover, the DH set up the GCMTI Advisory Committee in 2017 as a platform for stakeholders to advise on the long-term development strategies, measures and specific research proposals of the GCMTI. With the support of the Committee, the GCMTI has embarked on 12 research and thematic projects in the past 3 years, details of which are set out in the **Annex**. As most research projects are maintained by internal resources allocation, the expenditures on manpower and outsourcing of services are subsumed under the overall expenditure of the Chinese Medicine Regulatory Office of the DH. Therefore, the total expenditure on research projects cannot be set out in full.

Holistic support rendered by the CMDF to the CM sector

As the first dedicated fund set up to support Chinese medicine (CM) development, the Chinese Medicine Development Fund (CMDF) has been injected with a total of \$1 billion since its official launch in June 2019. The CMDF aims to enhance the overall standards of the CM sector to promote the high-quality development of CM in Hong Kong on all fronts. Having regard to the diverse needs of stakeholders, the CMDF has launched various support programmes covering different areas to benefit CM personnel and organisations of different segments of the sector. As of end of February 2025, the CMDF has approved an accumulative total of about 8 900 funding applications, involving a total funding of about \$403 million (provisional figure) for the approved projects and benefiting more than 3 million members of the sector and the general public, with major achievements listed below:

- (a) **Talent nurturing:** Close to 3 500 Chinese medicine practitioners (CMPs) and CMs personnel have received subsidies to attend CM professional training programmes for continuously upskilling their professional knowledge and ability. The CMDF has supported programme providers to design and organise innovative training projects, benefitting over 41 300 practitioners. The CMDF has supported 85 CMPs and CMs personnel to participate in the Hong Kong Chinese Medicine Talent Training Programme co-organised by the National Administration of Traditional Chinese Medicine and Health Bureau (HHB) to cater for the need of establishing a talent pool;
- (b) **Quality enhancement:** The CMDF has supported more than 560 CM clinics and 220 Chinese herbal medicine retailers/wholesalers to upgrade their facilities and equipment with a view to enhancing service quality and the safety and quality control of CMs. The CMDF has also supported nearly 180 proprietary Chinese medicines (pCm) manufacturers/wholesalers to engage consultancy services or technical support for over 760 pCm products, thereby levelling up the quality of Hong Kong-registered pCm products;

- (c) Market development: The CMDF has provided subsidies for 12 Hong Kong-registered pCm products for external use to be registered and sold on the Mainland through streamlined approval procedures to promote industry development;
- (d) Research and applied studies: The CMDF has supported the commencement of 72 CM research and applied studies projects which are instrumental in driving academic and clinical research as well as the professional and industry development of CM in Hong Kong; and
- (e) Publicity and promotion: The CMDF has supported more than 1 100 CM publicity and public education activities of various forms, targeting audiences such as kindergarten, primary and secondary school students, and elderly persons.

Following an additional injection of funds in the 2023-24 Budget, the CMDF has rolled out various new and enhanced initiatives to cater for the needs of the CM sector and align with its latest development. For example:

- (a) To facilitate Hong Kong pCms to explore the Mainland market and promote industry development, the CMDF launched the Greater Bay Area pCm Industry Development Support Scheme in February 2024 to provide subsidies for Hong Kong-registered pCms for external use to apply for registration in the Mainland through the streamlined approval procedures;
- (b) To dovetail with the phased service commencement of The Chinese Medicine Hospital of Hong Kong at the end of 2025, the CMDF invited organisations to submit applications for 6 talent training programmes relating to cross-disciplinary collaboration, healthcare administration and management under the Strategic Theme Commissioned Project Funding Programme from mid-2024. The approval process for the relevant commissioned training programmes was completed and the programmes are expected to commence in phases starting from mid-2025; and
- (c) To further fostering cultural inheritance and promotion of CM, the CMDF raised the funding ceiling of CM public promotion projects to \$2 million from April 2024 to enhance the scale and effectiveness of public education and promotion projects designed and implemented by the CM sector. The CMDF also invited organisations to submit applications under the Strategic Theme Commissioned Project Funding Programme for the development of CM teaching and learning resource kits for secondary and primary schools in mid-2024. The approval process for the relevant commissioned projects was completed and the projects is expected to commence in phases starting from mid-2025.

The HHB will continue to closely monitor the implementation of the CMDF in consultation with the Advisory Committee on CMDF, work with the CMDF's implementation agent (the Hong Kong Productivity Council) to maintain close liaison with the CM sector and relevant stakeholders, and introduce more enhancement measures as and when necessary.

The details and vetting criteria of the funding schemes as well as the amount of subsidy, progress and achievements of the approved projects have been uploaded to the CMDf website (www.cmdevfund.hk).

As the work on overseeing the CMDf's operation is part of the overall duties of the Chinese Medicine Unit under the HHB, separate breakdown of manpower and expenditures involved is not available.

**Research and Thematic Projects Conducted by the GCMTI of the DH
from 2022-23 to 2024-25**

Research/Thematic Project	Commencement Date	Completion Date
Identification of tiny seed and fruit types of CMM	April 2022	May 2024
Consolidation of the Preliminary Index of CMM Resources in Hong Kong under the Fourth National Survey of CMM Resources	June 2022	December 2022
Building of 3D CMM Images for the Digital Herbarium for Chinese Medicines	March 2023	In progress
Survey of CMM Resources under the Fourth National Survey of CMM Resources (Phase II) – Survey on Hong Kong’s CMM market and traditional knowledge	May 2023	March 2025
Study on the identification of Ziziphi Spinosae Semen and its commonly confused species by DNA method	June 2023	December 2024
Analysis of chemical markers in pCms containing Psoraleae and Ginseng	July 2023	December 2024
Collection of specimens of Western herbal medicines and Lingnan herbal medicines for the Chinese Medicines Herbarium of the GCMTI	September 2023	In progress
Pilot Study on Analysis of Chemical Markers in Compound Chinese Medicine Granules	January 2024	September 2024
Macroscopic and Microscopic Identification of Cortex type of Decoction Pieces Commonly Found in Hong Kong	June 2024	In progress
Survey of CMM Resources under the Fourth National Survey of CMM Resources (Phase II) – Collection of medicinal plant specimens of Hong Kong (Winter and Spring)	August 2024	In progress
Study on the Identification of Radix or Rhizoma Podophylli emodis and its Confused Species by DNA method	January 2025	In progress
Analysis of Chemical Markers in Compound Chinese Medicine Granules	January 2025	In progress

- End -

CONTROLLING OFFICER'S REPLY**HHB021****(Question Serial No. 0400)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (2) HealthControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

Please inform this Committee of the following in each of the past 3 years:

- (1) the number of new registrations and the total number of registrations with the Centralised Organ Donation Register;
- (2) the numbers of donors and recipients in respect of the transplant operations, performed in public hospitals on human organs/tissues, including the transplants of kidney (living, cadaveric), liver (living, cadaveric), heart, lung (single, double), cornea, skin and bone, as well as the numbers of persons waiting for such transplants; and
- (3) the details of promoting organ donation among the public and the expenditure involved; and the percentage of such expenditure in the overall expenditure of the Bureau.

Asked by: Hon CHAN Ka-pui, Judy (LegCo internal reference no.: 26)Reply:

(1)

The numbers of registrations recorded in the Centralised Organ Donation Register (CODR) in the past 3 years are as follows:

	2022	2023	2024
Number of new registrations ¹	13 418	25 968	24 809
Cumulative total number of registrations (as at 31 December of the year)	356 093	367 199	391 187

Note:

1. Number of new registrations refers to:
 - (i) In or before April 2022 – the number of new registrations verified by the Department of Health (DH) minus the number of effective withdrawals during the same period (i.e. net increase in the cumulative number of registrations in the period); and

- (ii) In or after May 2022 (after enhancement of the CODR System) – the number of new registrations verified by the DH (the number of effective withdrawals during the same period is not deducted in order to indicate more clearly the number of new registrations).

(2)

The number of patients waiting for organ/tissue transplant, the number of organ donors and the number of organ/tissue donation cases handled by the Hospital Authority (HA) in the past 3 years are as follows:

Year (as at December 31)	Organ/ Tissue	Number of Patients Waiting for Transplant	Number of Organ Donors		Number of Donation Cases
			Number of Cadaveric Donors ²	Number of Living Donors ³	
2022	Kidney	2 451	29	23	56 (Cadaveric donation: 45 Living donation: 11)
	Liver	66			29 (Cadaveric donation: 17 Living donation: 12)
	Heart	81			11
	Lung	13			7
	Cornea (piece)	357			244
	Skin	N/A ⁴			5
	Bone				0
2023	Kidney	2 429	24	24	52 (Cadaveric donation: 41 Living donation: 11)
	Liver	81			30 (Cadaveric donation: 17 Living donation: 13)
	Heart	76			8
	Lung	21			2
	Cornea (piece)	474			253
	Skin	N/A ⁴			2
	Bone				0
2024	Kidney	2 476	30	32	59 (Cadaveric donation: 41 Living donation: 18)
	Liver	79			37 (Cadaveric donation: 23 Living donation: 14)
	Heart	77			4
	Lung	21			2
	Cornea (piece)	532			306
	Skin	N/A ⁴			7
	Bone				1

Note:

2. The number refers to any one or more solid organ donations which include kidney(s), liver, heart and lung(s) from cadaveric donors.
3. Living donation applies to liver/kidney transplant only.
4. Cases of skin and bone transplant are sudden and emergency in nature. Substitutes will be used if no suitable skin or bone is identified for transplant.

(3)

The Health Bureau (HHB), together with the DH and the HA, have been making continuous efforts to collaborate with community partners in promoting organ donation through different channels and on various fronts.

Since 2023, the DH has stepped up its publicity efforts by (1) setting up organ donation promotion booths and deploying the organ donation promotion vehicle to organise promotion activities, with a view to encouraging public registration in the CODR; (2) using various channels, e.g. television, radio, newspapers and the internet for publicity; (3) promoting e-engagement of the public through a dedicated social media page “Organ Donation at HK”; (4) educating the public through health talks; (5) producing publicity materials for distribution in various events and activities; (6) developing an institution-based network by working with signatories of the Organ Donation Promotion Charter and supporters to promote organ donation; and (7) staging large-scale publicity events to support the Organ Donation Day on the second Saturday of November every year.

In line with the Government’s strategies and initiatives of promoting organ donation, the HA has organised various promotion activities, including (1) setting up a designated webpage, with publicity and education videos as well as an e-poster hyperlinked to the CODR, in the HA’s internet and intranet websites; (2) promoting organ donation on the HA’s social media platform and disseminating publicity articles on various media platforms; (3) setting up promotion booths in various HA hospitals; and (4) recruiting summer volunteers to participate in organ donation promotion activities.

The Government will continue its multi-pronged publicity strategies and strengthen collaboration with different sectors through various channels to jointly promote organ donation.

The expenditure and manpower deployed for work in relation to publicity for organ donation cannot be separately identified as they are absorbed by the HHB’s overall expenditure, the DH’s overall provision for health promotion and the HA’s overall expenditure on provision of healthcare services respectively.

- End -

CONTROLLING OFFICER'S REPLY

HHB022

(Question Serial No. 0402)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the 2 COVID-19 oral antiviral drugs introduced by the Hospital Authority (HA) in 2022, please inform this Committee of the following:

- (1) the respective quantities of the 2 COVID-19 oral drugs purchased by the HA and the related expenditure in 2024-25, along with the estimated quantities to be purchased and the projected expenditure for 2025-26;
- (2) the annual figures for the prescriptions of the COVID-19 oral drugs at the HA, private doctors and clinics under the Department of Health (including Families Clinics and Elderly Health Centres, etc.) over the past 3 years; and
- (3) the reasons for the delay in granting full registration to the other COVID-19 oral antiviral drugs, given that only Paxlovid was granted full registration in February 2024.

Asked by: Hon CHAN Kapui, Judy (LegCo internal reference no.: 28)

Reply:

With the ever evolvement of the SARS-CoV-2 virus, the prevention and treatment capacities of the local healthcare system and the handling capacity of the society as a whole have been enhanced significantly. COVID-19 has been managed as an upper respiratory tract illness by the Government since early 2023. Despite this, the World Health Organization still highlights the importance of ensuring access to appropriate treatments for patients with COVID-19, which includes providing oral antiviral drugs to high-risk patients on a need basis taking local situation into account. High-risk persons concerned include the elderly, immunocompromised individuals or persons with chronic illnesses.

The Health Bureau, together with the Department of Health (DH) and the Hospital Authority (HA), have been keeping abreast of the latest development of clinical treatment and scientific evidence-based research relating to SARS-CoV-2 virus, while making reference to the latest data from drug regulatory authorities and drug manufacturers globally so as to provide appropriate treatment for the COVID-19 patients.

(1)

In 2024-25 (as at 31 December 2024), the quantities of the 2 COVID-19 oral antiviral drugs purchased by the HA, namely Paxlovid and Molnupiravir, were about 91 000 treatment courses, and the total expenditure was about \$540 million.

Apart from providing antiviral drugs for treating COVID-19 at public hospitals/clinics under the HA, the Government has been providing private doctors with the 2 aforementioned COVID-19 oral drugs procured by the HA for free prescription to eligible COVID-19 confirmed patients since April 2022. Private doctors who have registered under the Electronic Health Record Sharing System (eHRSS) can make requests for provision of the 2 COVID-19 oral drugs via the dedicated online platform. Private doctors must follow the treatment guidelines set out by the HA. Besides, the DH's clinic dispensaries also distributed a small amount of treatment courses.

The DH and the HA will continue to closely monitor the supply and utilisation of the relevant drugs and keep in view the latest data from drug regulatory authorities and drug manufacturers globally. Drugs suitable for treating COVID-19 will be purchased and stockpiled in a timely manner based on the scientific evidence available. The aforementioned arrangement of prescribing COVID-19 oral drugs to patients will also be reviewed.

(2)

From 2022 to 2024, the HA had prescribed the 2 COVID-19 oral drugs to about 471 300 HA patients (a single patient may be prescribed with COVID-19 oral antivirals for more than once), including about 314 600 patients prescribed with Paxlovid and about 156 700 with Molnupiravir. Separately, about 181 700 treatment courses were prescribed by private doctors to eligible COVID-19 confirmed patients for free, in which about 104 000 Paxlovid treatment courses and about 77 700 Molnupiravir treatment courses were prescribed. About 1 500 treatment courses were prescribed by clinics under the DH (including Families Clinics and Elderly Health Centres).

(3)

According to the Pharmacy and Poisons Ordinance (Cap. 138), pharmaceutical products must satisfy the criteria of safety, efficacy and quality for registration with the Pharmacy and Poisons Board of Hong Kong (the Board) before they can be sold or supplied in Hong Kong.

During the COVID-19 pandemic, the then Pharmacy and Poisons (Registration of Pharmaceutical Products and Substances: Certification of Clinical Trial/Medicinal Test) Committee (the Committee) established under the Board considered that, in view of the public health emergency and the local medical need at the time, together with the relevant scientific evidence, the benefits of the use of antiviral drugs, namely Paxlovid and Molnupiravir in the treatment of mild-to-moderate COVID-19 outweighed the risks and hence conditionally approved the applications of the relevant drugs for registration in February and March 2022 respectively. As part of the conditional approval of registration, the corresponding drug registration certificate holders were required to submit additional data through clinical studies and post-marketing report to the Board according to the conditions imposed by the Committee (including that the concerned products can only be supplied to doctors and medical

institutions). The certificate holders of the drugs have been continuously providing relevant reports and data to substantiate their products' safety, efficacy and quality. In this connection, Paxlovid was granted full registration in February 2024. As for Molnupiravir, its certificate holder is expected to provide the relevant reports and data required for full registration for the Committee's approval.

- End -

CONTROLLING OFFICER'S REPLY

HHB023

(Question Serial No. 0403)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Government is enhancing the support for local couples to receive assisted reproductive services. In this connection, please inform this Committee of the following:

- (1) the annual number of assisted reproductive service quotas for in-vitro fertilisation (IVF) treatment provided by the Hospital Authority (HA) and the actual utilisation rate over the past 3 years;
- (2) the annual number of assisted reproductive service quotas for IVF treatment to be provided by the HA, and the estimated expenditure involved to provide additional quotas, over the next 4 years;
- (3) the details of the Government's plan to enhance the professional training in assisted reproduction in future and the estimated expenditure involved; and
- (4) whether the Government plans to enhance the assisted reproductive services provided by Chinese medicine given its strengths in infertility treatment and prenatal and postpartum care. If so, what are the details? If not, what are the reasons?

Asked by: Hon CHAN Kapui, Judy (LegCo internal reference no.: 29)

Reply:

(1)

The Government encourages families wishing to have children to grasp the optimal childbearing age and give birth as early as possible, so as to increase the chances of success while reducing the risks to the pregnant woman and the foetus, and provides appropriate support to couples with medical needs for use of assisted reproduction technology.

There are 9 public hospitals with Gynaecology specialist services under the Hospital Authority (HA) where assisted reproductive (AR) services are provided for those in need. Among these hospitals, Queen Mary Hospital (QMH), Prince of Wales Hospital (PWH) and Kwong Wah Hospital (KWH) provide in-vitro fertilisation (IVF) treatment services. For the 3 financial years starting from 2021-22, the HA provided a total of about 1 100 publicly-funded IVF treatment cycles annually, and the respective numbers of such treatments provided by QMH, PWH and KWH were about 600, 200 and 300.

(2)

To further support couples with fertility difficulties, it was announced in the Chief Executive's 2023 Policy Address that the HA would increase the relevant public service quota on AR services for IVF. In 2024-25, the HA provided an additional 100 such service quotas and in 2025-26 it will further increase the quota by 300. The estimated expenditure for 2025-26 is about \$12.6 million. In 2026-27, 2027-28 and 2028-29, an additional 100 quotas will be provided each year. The number of the relevant service quotas will reach 1 800 in 2028-29.

(3)

Reproductive Medicine (RM) is a subspecialty of Obstetrics and Gynaecology (O&G). Upon completion of specialist training in O&G, doctors are required to undergo subspecialty training in the training hospitals (i.e. Queen Mary Hospital – Kwong Wah Hospital Joint Training Centre and Prince of Wales Hospital) for 2 to 3 years, during which they need to complete a specified number of procedures and assessments before they can apply for certification as a specialist in RM under the Specialist Register. Based on the current caseload, the HA can train 4 doctors to obtain specialist qualifications in RM every 2 to 3 years. This structured training programme can ensure that the trainees are equipped with necessary skills and experience, so that patients will benefit from the higher-quality and evidence-based care.

The subspecialty training of RM specialists is conducted during their daily services in hospitals and is part of their on-going clinical duties. Also, as the training process is tailored to the specific conditions of each trainee and hinges on the applicability of the cases, relevant training costs cannot be separately quantified.

(4)

Chinese medicine (CM) enjoys a competitive edge in regulating body functions and assisting reproduction. At present, the HA, non-governmental organisations and local universities operate the Chinese Medicine Clinics cum Training and Research Centres (CMCTRs) in 18 districts under a tripartite collaboration model to provide the public with Government-subsidised and non-Government-subsidised CM out-patient services at the district level. Members of the public who need treatment of infertility and subfertility or prenatal and postnatal care may make appointments for out-patient services at the 18 CMCTRs. In addition, The Chinese Medicine Hospital of Hong Kong (CMHHK), which is expected to commence services in phases by the end of 2025, will provide a range of CM clinical services including Gynecology in CM as one of the 6 specialised CM services. The main treatment scope includes diseases related to menstruation, leucorrhoea, pregnancy, postnatal and other gynecological disorders (including infertility). A special disease programme named "Infertility, prenatal and postnatal care" under Gynecology in CM will also be launched. Talents and experts of Gynecology in CM in Hong Kong will provide CM treatment options to women having plans or difficulties in pregnancy. This will further promote the development of CM services related to AR.

- End -

CONTROLLING OFFICER'S REPLY

HHB024

(Question Serial No. 0404)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Hospital Authority (HA) plans to merge the Hong Kong East Cluster (HKEC) and the Hong Kong West Cluster (HKWC) into one cluster, citing a decline in population size and overall service demand as the rationale for the decision. In this connection, please advise this Committee on the following:

- (1) the estimated expenditure to be involved in the merger of the HKEC and HKWC for 2025-26 and 2026-27 respectively;
- (2) the specialty services expected to be affected by the merger of the HKEC and HKWC, and details of such impact; and
- (3) given that the Steering Committee on Review of Hospital Authority stated in its report in 2015 that the allocation of resources based solely on a simple population-based model was too crude, what other considerations and criteria, apart from population figures, have been taken into account by the Government regarding the merger of the HKEC and HKWC?

Asked by: Hon CHAN Kapui, Judy (LegCo internal reference no.: 30)

Reply:

(1)

The Hospital Authority (HA) has commenced the preparation and engagement work for the service consolidation of the Hong Kong Island clusters since early this year, with the objectives of enhancing the existing service quality, refining treatment procedures as well as enhancing the cost-effectiveness of the utilisation of resources within the clusters. The relevant work is still under planning and discussion and there is for the time being no specified estimated expenditure for the HA on the merging of the Hong Kong Island clusters.

(2)

In carrying out the cluster consolidation, the HA will take into full consideration the need of the patients to seek medical consultation in nearby hospitals. During the further planning of clinical services with varying complexity on the Hong Kong Island, the HA will, as in the past, follow the principle of "localising where possible, centralising where necessary". The primary healthcare services including general out-patient services and some general specialty services with high volume and relatively stable complexity, such as medicine, general surgery

and orthopaedics & traumatology services etc, will be made available in the vicinity for the patients. These services are normally being provided in the regional acute hospitals with accident and emergency services. Currently, most clusters have a few acute hospitals located in different districts to share out the said functions, meaning that the majority of patients can receive treatments in nearby hospitals. For some specialty services that have a relatively lower volume but involve operation by personnel with the specialised qualifications and clinical expertise, as well as application of sophisticated equipment and advanced technology, consideration will be given for such services to be provided in a relatively more concentrated manner in hospitals with the appropriate personnel and equipment according to the actual circumstances among districts within a cluster, so as to enable the patients to receive the most appropriate care from hospitals in the cluster according to different types of healthcare need.

In addition, with the rapid development of the treatment model of certain acute illnesses in recent years, it is noted that there is an improvement in treatment outcome by arranging a medical team with good teamwork and sophisticated skills for timely treatment of acute patients with cardiovascular or cerebrovascular diseases. In forming the medical teams progressively in providing these services, the HA will plan the relevant service points having regard to the needs arising from the new treatment models and arrange visits by the relevant medical teams to multiple hospitals for provision of support.

As for those services which are extremely specialised, given the facilities needed and the uniqueness of the equipment, consideration will be given to pooling of resources for such services to be provided at designated service points for addressing the needs of patients from the cluster after consolidation or even the entire territory. For instance, the Hong Kong West Cluster offers major organ transplant services for patients across Hong Kong, while the Hong Kong East Cluster provides such services as high-pressure oxygen treatment and compulsory hospitalisation for psychiatric treatment.

(3)

When reviewing the cluster planning and service provision of the Hong Kong Island clusters, the HA considers not only the population of catchment areas, but also anticipated changes in service demand arising from future population distribution and demographic changes. On such a basis, the HA reviews and plans the service provision of clusters and the catchment areas under the following principles –

- General healthcare services and facilities should be provided to local residents within a reasonable geographical distance to ensure accessibility and convenience; the coverage of each cluster should also be of a reasonable scale; and
- Following the consolidation of their existing facilities and functions of hospitals within a cluster, each hospital will continue to perform its current key functions and deliver specialty services, while complementing the strengths of the other hospitals within the cluster, with a view to providing comprehensive care services more effectively and ensuring that patients can receive a continuum of treatment under the same geographical setting.

In addition, to ensure the sustainability and effectiveness of service delivery, the HA, similar to the planning work of other clusters, will also take a holistic consideration of the following factors –

- To review and plan the service provision in the light of the development of primary healthcare and ambulatory care services, with a view to enhancing the management of the public hospital system and the overall efficiency of healthcare services of the cluster.
- The roles, positioning and service delivery models of hospitals will be defined during cluster consolidation to integrate clinical services at different levels, improve treatment procedures and allocation of healthcare resources, and consideration will be given to centralise the provision of healthcare services requiring professional skills and sophisticated equipment at suitable healthcare units, with a view to optimising the use of limited public resources, ensuring the timely and appropriate treatment for patients at critical moments, and facilitating the training of healthcare professionals.
- Drawing from past experiences, it was recognised that maintaining the catchment population of a cluster at about 1 million would facilitate service co-ordination more effectively and ensure an adequate service capacity for economies of scale.

In conclusion, the consolidation of the Hong Kong Island clusters will help stabilise the manpower supply, rationalise allocation of resources and minimise duplication. In the long run, such an arrangement will reduce administrative costs and enhance the overall efficiency and quality of healthcare services. By effectively allocating resources and ensuring inter-departmental cooperation, patients' treatment and experience will be enhanced.

- End -

CONTROLLING OFFICER'S REPLY**HHB025****(Question Serial No. 0644)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (2) HealthControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

The Voluntary Health Insurance Scheme (VHIS) has been fully implemented since April 2019, aiming to provide the general public with a choice of individual indemnity hospital insurance products which are subject to specific regulation and of high market transparency. It enables them to use private healthcare services when in need, thereby alleviating pressure on the public healthcare system in the long run. It is stated in Programme (2) that the Government will continue to implement the VHIS. In this connection, please inform this Committee:

1. of the number of policies and average premiums by the age of the insured person in the past 3 years;
2. of the number of taxpayers who claimed tax deduction and the total amount of qualifying premiums allowed under the VHIS in the past 3 years; and
3. given that the VHIS has been launched for nearly 6 years, whether the Government will review its effectiveness and possible areas of refinement, such as benefit items, service charges, claim limits and tax deduction arrangements; if so, of the details; if not, the reasons for that.

Asked by: Hon CHAN Kin-por (LegCo internal reference no.: 6)Reply:

1. According to the latest statistics, the number of policies of the Voluntary Health Insurance Scheme (VHIS) Certified Plans reached 1 341 000 as at 31 March 2024. The breakdown by the age of insured persons in the past 3 years is as follows:

Age of insured persons	As at 31 March 2022*	As at 31 March 2023*	As at 31 March 2024*
0-9	104 000	116 000	129 000
10-19	93 000	111 000	122 000
20-29	147 000	168 000	179 000
30-39	213 000	251 000	278 000

40-49	207 000	241 000	263 000
50-59	168 000	194 000	212 000
60 or above	113 000	140 000	157 000
Total	1 045 000	1 220 000	1 341 000

* Breakdown figures may not add up to the total due to rounding.

The average annual premium for the Standard Plan under the VHIS is approximately \$4,800. As the product design of the Flexi Plans under the VHIS offered by different insurance companies varies greatly with different benefit coverage, the Health Bureau (HHB) cannot provide the average premium for the Flexi Plans.

- According to the latest information provided by the Inland Revenue Department, the data on tax deduction in the past 3 years (based on year of assessment) is as follows:

	No. of taxpayers claimed tax deduction	Total amount of VHIS qualifying premiums allowed (HK\$ billion)
Year of assessment 2021-22	329 000	2.355
Year of assessment 2022-23	404 000	2.987
Year of assessment 2023-24 (preliminary figures)	456 000	3.480

- The VHIS has been fully implemented since April 2019, aiming to provide the general public with a choice of individual indemnity hospital insurance products which are subject to specific regulation and of high market transparency. It offers consumers with greater confidence in purchasing health insurance and using private healthcare services when in need, thereby alleviating pressure on public healthcare system in the long run.

Since the full implementation of the VHIS, the number of policies under the scheme has been increasing. That said, the period is still relatively short and affected by the 3-year long COVID-19 epidemic. The HHB will closely monitor the implementation of the VHIS and the market response, collect market data and listen to the views of various stakeholders. We will review the effectiveness of the VHIS and possible areas for refinement in due course, so as to respond to the latest trends in the healthcare market and dovetail with the various public health policies of the Government.

- End -

CONTROLLING OFFICER'S REPLY

HHB026

(Question Serial No. 0645)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Under this Programme, the Health Bureau states that it will take forward and implement policy initiatives to promote the development of primary healthcare having regard to the Primary Healthcare Blueprint, including developing a community drug formulary and a community pharmacy programme. In this connection, will the Government inform this Committee of:

1. the number of community pharmacies at present and the target number for the next 3 years, broken down by 18 districts;
2. the drug selection criteria of the community drug formulary and the way to ensure that the formulary covers most medications commonly used by the public; and
3. the expected impact, in terms of expenditure, staffing establishment, waiting time, etc., on the public healthcare system after the regularisation of community pharmacies?

Asked by: Hon CHAN Kin-por (LegCo internal reference no.: 7)

Reply:

1. The Government will launch the community pharmacy programme (the Programme) by phases starting from the fourth quarter of 2026. Currently, the Government is developing the service model, drug supply methods and related information systems. To solicit feedback from the industry and assess the market's acceptance level, the Government conducted a market consultation in November 2024. The Government plans to extend the services of the Programme across all 18 districts of Hong Kong, with at least 4 to 5 community pharmacies in each district.
2. The community drug formulary (the Formulary) will be expanded in phases according to patient needs starting from the end of 2025, with the number of drugs covered to exceed 100 at the commencement stage. The Formulary will include various designated drugs (primarily generic drugs) and specified patented drugs. To address

the clinical needs of primary healthcare patients, we will establish an expert panel to advise on the listing of drugs in the Formulary.

3. Compared with the Hospital Authority, which usually prescribes medication to its outpatients for a longer duration, community pharmacies under the Programme will arrange more frequent drug dispensing to reduce medication waste and ensure accurate drug dispensing meeting the clinical needs of patients, thereby improving their use of medication. Meanwhile, citizens participating in various primary healthcare programmes (such as the Chronic Disease Co-Care Pilot Scheme) can more conveniently obtain affordable primary healthcare drugs, and therefore reduce their overreliance on the public healthcare system.

- End -

CONTROLLING OFFICER'S REPLY

HHB027

(Question Serial No. 0646)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in paragraph 128 of the Budget Speech that the Task Group on New Medical School has invited local universities interested in setting up the third medical school to submit proposals. It expects to complete assessment and formulate recommendations to the Government this year. In this connection, please advise this Committee of:

1. the assessment criteria and procedure timetable adopted by the Task Group on New Medical School; and
2. whether a budget has been set to meet the preparation and operation costs of the New Medical School. If yes, what are the details? If no, what are the reasons?

Asked by: Hon CHAN Kin-por (LegCo internal reference no.: 8)

Reply:

(1)

Established in October 2024, the Task Group on New Medical School (the Task Group) is responsible for devising the direction and parameters for a new medical school and selecting a suitable university for setting up the new medical school. In November 2024, the Task Group set out 10 key parameters for consideration of proposals on the establishment of the new medical school, namely innovative strategic positioning, staffing, campus and teaching facilities, clinical exposure and learning resources, curriculum structure and assessment methodologies, student admission arrangements, funding arrangements, implementation plans, teaching and learning quality, as well as research excellence. In December 2024, the Task Group issued a letter of invitation to local universities interested in establishing the new medical school for submission of proposals by 17 March 2025. The Task Group has received a total of 3 proposals for the establishment of the third medical school before the submission deadline, which are submitted by Hong Kong Baptist University, the Hong Kong Polytechnic University, and the Hong Kong University of Science and Technology respectively.

Moreover, the Task Group discussed the next steps for evaluating proposals at the meeting in February 2025. The Task Group agreed to adopt a holistic and comprehensive approach, in accordance with the 10 key parameters (including the financial sustainability of the new medical school), for evaluating the proposals submitted by universities from various perspectives and will conduct interviews within the second quarter of 2025 with the universities which have submitted proposals. The Task Group expects to complete the evaluation and make recommendations to the Government within this year.

(2)

The Task Group will review the proposed funding sources and financial management plans in the proposals. Depending on the recommendations of the Task Group and the implementation timetable of the recommended proposal, the Government will set aside resources on a matching basis as announced in the 2025-26 Budget to support universities in developing a new medical school.

- End -

CONTROLLING OFFICER'S REPLY

HHB028

(Question Serial No. 0405)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in paragraph 206 of the Budget Speech that the Government will upgrade the District Health Centre Expresses in Central and Western District, Eastern District and Yau Tsim Mong District into District Health Centres this year. In this connection, will the Government inform this Committee of:

- (1) the operational expenses, number of members, and number of attendances of each District Health Centre and District Health Centre Express over the past 3 years, with a breakdown by District Council district;
- (2) the measures the Government has put in place to encourage the public to use the services provided by the District Health Centres or District Health Centre Expresses and participate in the activities they organise;
- (3) the respective expenditures incurred for upgrading the District Health Centre Expresses in Central and Western District, Eastern District and Yau Tsim Mong District into District Health Centres; and the expected commencement dates of the District Health Centres in the 3 districts;
- (4) whether the Government has drawn up a timetable for upgrading the remaining District Health Centre Expresses into District Health Centres; if so, the details; if not, the reasons for that.

Asked by: Hon CHAN Kapui, Judy (LegCo internal reference no.: 31)

Reply:

(1)

The expenditures of District Health Centres (DHCs) and District Health Centre Expresses (DHCEs) in 2022-23 and 2023-24, and the 2024-25 revised estimates (including provisions for service contracts, site maintenance and rental cost) are set out in the table below:

District	2022-23 Expenditure (\$ million)	2023-24 Expenditure (\$ million)	2024-25 Revised Estimates (\$ million)
DHC			
Kwai Tsing	62	63	62
Sham Shui Po	34	64	63
Tuen Mun	69	80	80
Wong Tai Sin	60	77	69
Southern	52	73	58
Yuen Long	49	69	73
Tsuen Wan	38	65	78
DHCE			
Sai Kung	11	14	14
Kowloon City	10	14	14
Yau Tsim Mong	11	14	14
Wan Chai	11	15	15
North	10	14	14
Islands	10	13	13
Kwun Tong	10	14	14
Tai Po	11	14	14
Sha Tin	10	14	14
Central and Western	11	15	15
Eastern	11	14	14

The cumulative numbers of members and attendances of DHCs and DHCEs are set out in the table below:

DHC/DHCE Service Commencement Date	Cumulative Number of Members ^{Note 1} (as at 31 December 2024) [Provisional Figures]	Cumulative Number of Attendances ^{Notes 1, 2, 3, 4} (as at 31 December 2024) [Provisional Figures]
DHC		
Kwai Tsing 24 September 2019	46 100	498 300
Sham Shui Po 30 June 2021	34 300	296 600
Tuen Mun 31 May 2022	38 100	344 100
Wong Tai Sin 30 June 2022	34 700	200 900
Southern 17 October 2022	23 900	175 300
Yuen Long 24 October 2022	42 500	255 000
Tsuen Wan 30 December 2022	26 000	175 700
DHCE		

DHC/DHCE Service Commencement Date	Cumulative Number of Members^{Note 1} (as at 31 December 2024) [Provisional Figures]	Cumulative Number of Attendances^{Notes 1, 2, 3, 4} (as at 31 December 2024) [Provisional Figures]
Sai Kung 1 September 2021	10 600	84 900
Kowloon City 1 October 2021	11 300	57 300
Yau Tsim Mong 1 October 2021	9 600	48 500
Wan Chai 4 October 2021	6 800	53 000
North 18 October 2021	8 700	53 700
Islands 18 October 2021	6 400	35 900
Kwun Tong 21 October 2021	10 800	49 300
Tai Po 22 October 2021	7 800	45 000
Sha Tin 30 October 2021	13 300	71 400
Central and Western 30 October 2021	7 900	50 200
Eastern 30 October 2021	10 900	54 700
Total	349 900	2 549 900

Note:

1. Figures are rounded to the nearest hundred.
2. The figures only include service figures captured from the DHC/DHCE information system, and do not include those relating to medical laboratory tests.
3. As different services are provided by the 11 DHCEs, the attendance figures are not directly comparable.
4. The service figures above have included services provided by DHCs/DHCEs for participants of the Chronic Disease Co-care Pilot Scheme which was launched on 13 November 2023.

(2)

The Government promotes primary healthcare services of DHCs/DHCEs through various channels and media, including territory-wide publicity and local outreach activities. DHCs/DHCEs strengthen connection with the local community, especially the hard-to-reach groups, through outreach activities, telephone and other communication technology support, telecare platform, etc. Also, outdoor health exhibitions, health mobile vans and community programmes are regularly organised.

(3) and (4)

The Government set up 7 DHCs and 11 smaller interim DHCEs in rented properties across the territory by 2022, thereby attaining the interim goal of covering all 18 districts of Hong Kong. The Government will upgrade the 3 DHCEs in the Central and Western District, Eastern District, and Yau Tsim Mong District to DHCs within 2025. In April 2024, the Health Bureau (HHB) launched a tender exercise for the operation of the Central and Western DHC and 3 women's health service points named Women Wellness Satellites located in Chai Wan, Lam Tin and Tuen Mun. A three-year operation service contract with a total value of approximately \$531.7 million was subsequently awarded in January 2025. The Central and Western DHC is expected to commence operation in the third quarter of this year. In July 2024, the HHB conducted tender exercises for the operation of the Eastern and Yau Tsim Mong DHCs. The operation service contracts for these 2 DHCs are expected to be awarded this year.

Upon the upgrading of the 3 DHCEs to DHCs this year, the 11 existing DHCEs will gradually reduce to 8, while the number of DHCs will increase to 10. The estimated expenditure for DHCs and DHCEs (including provisions for service contracts, site maintenance and rental cost) for 2025-26 are \$1.083 billion and \$213 million respectively.

In addition, the funding proposals for the construction projects of Wan Chai, Kwun Tong, Sai Kung and North District DHCs were approved by the Finance Committee of the Legislative Council (LegCo) in January and October 2021, and in April and July 2024 respectively. These projects will be completed gradually in the next few years. To achieve the long-term development goal of having DHCs in all 18 districts as early as possible, the Government is actively taking forward the plan to establish DHCs in the remaining 4 districts and will seek LegCo's funding approval in due course. Before the remaining DHCs are set up, the Government will continue to subsidise non-governmental organisations to operate DHCEs in those districts. The services provided by DHCEs will be migrated as appropriate to DHCs in respective districts at a later stage. The Primary Healthcare Commission will, together with the operators of DHCEs, draw up and implement transition plans for upgrading DHCEs to DHCs to ensure a smooth transition of services.

- End -

CONTROLLING OFFICER'S REPLY

HHB029

(Question Serial No. 0545)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Since 24 March of this year, the Hospital Authority (HA) only dispenses a maximum of 24-weeks supply of medication per visit to general and specialist outpatients and for discharged inpatients. In this connection, would the authorities please advise this Committee on the following:

1. the annual expenditure on dispensing medication to patients by the HA in the past 5 years, and the staff establishment and expenditure on emoluments for handling related matters;
2. specific guidelines on this new arrangement for dispensing medication to patients, and the estimated savings resulted from it for the next 5 years; and
3. Dr Tony KO, the Chief Executive of the HA, stated earlier that the HA has introduced such measures as procuring drugs from the Mainland to reduce costs. What were the relevant costs spent in the past 5 years, and what were the cost-saving results?

Asked by: Hon CHAN Pui-leung (LegCo internal reference no.: 7)

Reply:

1.

In line with the Government's public healthcare policy to ensure that citizens are not denied adequate medical care due to lack of means, the Hospital Authority (HA) provides healthcare services and drugs as well as medical items, which are heavily subsidised by the Government, to patients based on their clinical needs and in accordance with the HA's treatment guidelines. Currently, the HA Drug Formulary (HADF) includes about 1 500 types of drugs, encompassing approximately 2 700 items, to meet treatment needs. The table below sets out the HA's expenditure on the procurement of drugs (including the expenditure on drugs charged at standard fees and self-financed items) over the past 5 years:

	2020-21	2021-22	2022-23	2023-24	2024-25 (Projection)
Drug Expenditure^ (\$ billion)	8.685	9.642	12.451	13.127	12.951

^ Excluding other expenditures (such as storage and repackaging)

Regarding manpower deployment and salary expenditure, the HA flexibly deploys and arranges for rotation of pharmacy professionals among hospitals within each cluster in a timely manner having regard to the service needs and operational requirements. These professionals may have to deliver different services within the pharmacy departments, including drug dispensing and clinical pharmacy services, etc. Therefore, the manpower supporting drug dispensing cannot be separately quantified. As at December 2024, there were about 2 400 pharmacists and dispensers working in various clusters of the HA, and the total salary expenditure involved in 2024-25 (full-year projection) is \$1.984 billion.

Note: Total salary expenditure includes basic salary, allowance, gratuity and other on-costs (such as provision of housing benefit and death & disability benefit).

2.

The HA has been monitoring drug utilisation and expenditure in accordance with the established mechanism to ensure prudent and effective use of limited public healthcare resources and provide appropriate treatment to patients. To further optimise the current drug dispensing mechanism in public hospitals and reduce drug wastage, the HA has introduced a new measure starting from 24 March 2025. Under the new measure, the target dispensing period for drugs prescribed to patients attending specialist out-patient clinics and general out-patient clinics, as well as discharged in-patients, will not exceed 24 weeks per visit. If a patient is prescribed with medications for more than 24 weeks, arrangement will be made for the patient to collect the medication by batches through medication refills. In addition, the HA will adjust the dispensing quantity of “As Needed” medications as necessary and enhance the services of pharmacist clinics, so as to improve the treatment outcomes and drug compliance of patients. Meanwhile, the HA will also boost efforts in patient empowerment to prevent patients from accumulating excess drugs, thereby lowering the risk of misuse of drugs and reduce wastage due to excessive drugs. It is expected that upon the implementation of the aforementioned measures, patients will collect “As Needed” medications from public hospitals based on their clinical needs, while some patients will no longer need to refill their long-term drugs due to changes in their medical conditions. It is estimated that these measures can reduce drug wastage by about \$70 million to \$80 million each year.

The HA will continue to engage and exchange views with relevant departments, patient groups, healthcare professional bodies and different stakeholders to continuously optimise the drug dispensing system and reduce drug wastage by patients through education, publicity and administrative measures.

Besides, the Government and the HA will press ahead with the implementation of the fees and charges reform for public healthcare announced recently, which aims to guide the public

to make optimal use of healthcare resources through 3 aspects, namely reforming the subsidisation structure, reducing wastage and abuse, and enhancing healthcare protection. It also seeks to strengthen the healthcare protection on all fronts for patients who are “poor, acute, serious or critical”, with a view to ensuring that the limited healthcare resources can be directed in a more targeted manner to assist those patients most in need, thereby enhancing the sustainability of the healthcare system so as to cope with the challenges posed by an ageing population, inflation of healthcare cost, etc., and serve as a safety net for all.

3.

The HA has all along been exploring new sources of drug supply through various measures. Regardless of whether the drugs registered in Hong Kong are manufactured locally, in the Mainland or elsewhere, the HA aims to introduce more cost-effective drugs to increase choices and promote market competition while ensuring that the drugs meet the quality and safety requirements. The HA established a “Cost Assessment Panel” in 2024 to conduct price negotiation with pharmaceutical companies with a view to reducing the costs and prices of introducing new drugs as far as possible. For example, not only has the procurement cost of 2 new drugs for treating metastatic colorectal cancer been reduced by nearly 30% after successful price negotiation, but they have also been listed in the “Special Drug” category of the HADF. Patients are only required to pay the standard fee if they are prescribed these two drugs under specific clinical indications, significantly alleviating their financial burden. It is expected that nearly 300 cancer patients will benefit each year. For another new drug for treating paroxysmal nocturnal haemoglobinuria, price negotiation has not only reduced the procurement cost by 30%, but also triggered a voluntary price reduction of 37% for a similar drug. In addition, the HA will continue to optimise the centralised procurement model for pharmaceutical products and explore the introduction of market competition so as to achieve better procurement efficiency and economies of scale for further cost reduction. The HA will continue to closely monitor market developments and maintain communication with different stakeholders to promote diversification of drug supply so as to provide patients with safe, efficacious and cost-effective drugs. The work of the “Cost Assessment Panel” is undertaken by the department responsible for drug procurement in the HA and the HA does not have a breakdown of the operating costs of the relevant work.

- End -

CONTROLLING OFFICER'S REPLY

HHB030

(Question Serial No. 0578)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The provision for 2025-26 is \$849.7 million higher than the revised estimate for 2024-25, mainly due to the increased provision for primary healthcare development and The Chinese Medicine Hospital of Hong Kong (CMHHK), and the increased cash flow requirement for the general non-recurrent item on the Health and Medical Research Fund (HMRF). In this connection, would the Government inform this Committee of the following:

1. Of the increased provision of \$849.7 million in the Estimates, what are the respective budgets for primary healthcare development, the CMHHK and the HMRF? What is the latest progress of the HMRF's invitation of applications for investigator-initiated research projects and health promotion projects? What are the details of the projects and funding amounts involved?
2. The Government indicates that there will be a net increase of 3 posts in 2025-26. What are the detailed staffing provision and estimated expenditures of the posts?

Asked by: Hon CHAN Pui-leung (LegCo internal reference no.: 22)

Reply:

1. The provision for 2025-26 under Programme (2) of Head 140 is \$849.7 million higher than the revised estimate for 2024-25. This is mainly due to the increased provision for primary healthcare development and the Chinese Medicine Hospital of Hong Kong (CMHHK) as well as the increased cash flow requirement for the general non-recurrent item on Health and Medical Research Fund (HMRF). The comparisons between the provisions for 2025-26 and the revised estimates for 2024-25 of these items are tabulated below:

Item	Estimated expenditure for 2025-26 (\$ million)	Increase over the revised estimate for 2024-25 (\$ million)
Expenses related to primary healthcare development	2,028.5	+568.1
Expenses on supporting the CMHHK project	203.0	+171.9
Cash flow requirement for the general non-recurrent item on HMRF	330.0	+75.0

From the establishment of the HMRF in 2011 to end 2024, the HMRF has provided funding support to about 2 200 investigator-initiated projects with a total commitment of over \$2,250 million. Among them, about half are on-going. These funded projects cover the following research areas:

- (a) public health, human health and health services (e.g. primary healthcare, non-communicable diseases and Chinese medicine, etc.);
- (b) prevention, treatment and control of infectious diseases with public health implications;
- (c) advanced medical research which applies advanced technologies to facilitate the translation of knowledge generated from health and health services or infectious diseases studies into clinical practice and to inform health policy; and
- (d) health promotion that facilitates mobilisation of local resources to promote good health and prevention of illness in the community.

Details of the funded projects and reports of closed projects are available at the Research Fund Secretariat website (<https://rfs.healthbureau.gov.hk>).

2. There will be a net increase of 3 posts in the Health Bureau in 2025-26. Details are as follows:

Rank	Number	Notional Annual Mid-point Salary (\$)	Purpose/Reason
Creation of 5 posts			
Senior Administrative Officer (Time-limited post)	+1	1,645,020	To provide policy support for matters on manpower planning for healthcare professionals, including the establishment of a new medical school
Senior Executive Officer (Time-limited post)	+1	1,221,300	To provide administrative support to the Clinical Trial Development Team
Senior Executive Officer (Time-limited post)	+1	1,221,300	To assist in monitoring the Hong Kong Genome Institute (HKGI) and provide administrative support for genomic medicine-related policies

Rank	Number	Notional Annual Mid-point Salary (\$)	Purpose/Reason
Senior Executive Officer (Time-limited post)	+1	1,221,300	To provide administrative support for the implementation of primary healthcare-related policies
Executive Officer I	+1	892,140	To provide administrative support for policies related to end-of-life care
Deletion of 2 posts			
Nursing Officer	-1	852,120	Upon several years of operation, the HKGI has established its publicity and genetic counselling teams. The time-limited post thus does not need to be extended and will lapse accordingly
Assistant Information Officer	-1	564,120	Lapse of a time-limited post in the Secretariat Press Office
Total:	+3		

- End -

CONTROLLING OFFICER'S REPLY

HHB031

(Question Serial No. 0579)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in the Matters Requiring Special Attention in 2025-26 that the Government will oversee the establishment of the Hong Kong Centre for Medical Products Regulation (CMPR) and the roadmap towards “primary evaluation” for drugs and medical devices. In this connection, will the Government inform this Committee of the following:

1. What are the details of the staffing provision and estimated expenditure required for establishing the CMPR?
2. The Government stated earlier that it will, in the first half of this year, put forward the timetable for establishing the CMPR and the roadmap towards the adoption of “primary evaluation”. What is the progress of the relevant work at present and when, in the first half of this year, are the above be expected to be put forward?

Asked by: Hon CHAN Pui-leung (LegCo internal reference no.: 23)

Reply:

1.

As mentioned in the Chief Executive’s 2023 Policy Address and the Chief Executive’s 2024 Policy Address, the Government of the Hong Kong Special Administrative Region (HKSAR Government) would enhance the approval and registration mechanism for drugs and establish an internationally renowned regulatory authority of drugs and medical devices (medical products), i.e. the Hong Kong Centre for Medical Products Regulation (CMPR).

The Legislative Council has approved the creation of 4 permanent directorate posts/non civil-service positions (including Controller, Deputy Controller and 2 Assistant Controllers) in the CMPR of the Department of Health (DH) in 2025-26 to provide dedicated support for embarking on the various tasks, and formulating and implementing the enhanced medical products regulation and approval regime under the “primary evaluation” approach. The DH will delete 4 existing permanent Consultant posts upon the creation of the above posts.

In addition, the current functions in relation to the regulation of Western medicines, Chinese medicines and medical devices of these services will be consolidated and re-organised by the DH to be put under the purview of the CMPR, which makes fuller use of the existing highly

efficient regulatory regime to achieve greater benefits and synergies. This also centralises relevant expertise and optimises resource allocation, with the aim of supporting the approval of innovative medical products, promoting the scientific advancement of medical products and medical technologies, and expediting their clinical application, thereby driving the development of industries relating to the research and development (R&D) as well as testing of medical products. The above re-organisation will involve redeployment of 7 permanent directorate officers (including 2 Assistant Directors of Health, 3 Chief Pharmacists and 2 Principal Medical and Health Officers) and about 420 non-directorate officers.

In 2025-26, the financial provision for the CMPR is \$41.63 million. The DH will continue to review the consolidation of various functions of the CMPR as well as the manpower and resources required.

2.

The HKSAR Government has set up the Preparatory Office for the CMPR under the DH in June 2024. The Preparatory Office is proactively reviewing the regulatory functions on Chinese and Western medicines and medical devices under the DH, and studying the potential restructuring and strengthening of the current regulatory and approval regimes for medical products and medical technologies. The Preparatory Office will also put forward proposals and steps for the establishment of the CMPR which will be a step towards the transition to the “primary evaluation” approach in approving applications for registration of new medical products. This will help accelerate the clinical application of new medical products, and foster the development of emerging industries relating to the R&D and testing of medical products. The Preparatory Office is drawing up the timetable for establishing the CMPR and the roadmap towards adoption of “primary evaluation”, which will be announced in the first half of 2025 as planned.

- End -

CONTROLLING OFFICER'S REPLY

HHB032

(Question Serial No. 0580)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in the Matters Requiring Special Attention in 2025-26 that the Government will oversee the realignment of functions and responsibilities and transfer of services among the Hospital Authority (HA), the Department of Health (DH) and the Primary Healthcare Commission (PHCC). In this connection, will the Government inform this Committee of: the detailed functional differentiation upon the realignment of functions among the HA, the DH and the PHCC; what services will be involved in the transfer of services; and whether new manpower arrangements will be involved to handle the relevant matters; if so, what are the details of the relevant staffing provision and estimated expenditures; if not, what are the reasons for that?

Asked by: Hon CHAN Pui-leung (LegCo internal reference no.: 24)

Reply:

As announced in the Chief Executive's 2024 Policy Address, to enhance the health of the people of Hong Kong, improve healthcare protection and quality, and capitalise on our healthcare professions' strengths, the Government is conducting a comprehensive review on the positioning and objectives of the healthcare system. The review covers a reform of the functions and division of work among the Hospital Authority (HA), the Department of Health (DH) and the Primary Healthcare Commission (PHCC), and among which a reform of the HA's governance efficiency, with a view to improving the standards and efficiency of its specialist and in-patient services. Meanwhile, the PHCC and the DH will enhance their work on health promotion and disease prevention, continuing to shift the emphasis of the healthcare system from treatment-oriented to prevention-focused, so as to address the existing problem of system imbalance. The DH will also strengthen its roles as the Government's public health adviser and the regulatory authority by focusing on its public health functions. To this end, the DH is gradually transferring its specialist clinical and primary healthcare services to the HA and the PHCC respectively, including the following:

- (i) The transfer of the clinical genetic service to the HA was completed in early 2024;

- (ii) Woman health services will be integrated into the district health network, to be named as Women Wellness Satellites, of the PHCC under the Health Bureau within 2025, forming a network with District Health Centres/District Health Centre Expresses in all 18 districts across Hong Kong to provide eligible women with prevention-based and more personalised primary healthcare services. In addition, to further develop the multi-disciplinary primary healthcare service network, the PHCC plans to prepare for the integration of services of the Elderly Health Centres under the DH into the district health network in phases, starting from 2025/26, with a view to enhancing service synergy and minimising service duplication. Details of the transitional arrangements will be announced upon discussion with the DH; and
- (iii) In 2025-26, hospital dental services will be integrated into those under the HA and there is a plan to gradually transfer services such as child assessment service and tuberculosis and chest service to the HA.

The manpower and expenditure involved in the integration of services into those under the HA and the PHCC is subsumed under the overall provision of the DH, and hence no breakdown is available.

- End -

CONTROLLING OFFICER'S REPLY

HHB033

(Question Serial No. 0581)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (1) Director of Bureau's Office

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Office of the Secretary for Health is responsible for providing support to the Secretary for Health in undertaking political and administrative work. The provision for 2025-26 is \$100,000 lower than the revised estimate for 2024-25. This is mainly due to the decreased requirement for operating expenses. In this connection, will the Government inform this Committee of the following:

1. Please list in detail the titles, ranks, duties and payroll cost in respect of the existing posts in the Office of the Secretary for Health.
2. The revised estimate for 2024-25 is \$3.6 million higher than the actual expenditure for 2023-24. Please provide details on how the additional operating expenses will be spent. The provision for 2025-26 is \$100,000 lower than the revised estimate for 2024-25. What are the details regarding the decreased requirement for operating expenses? Against the present backdrop of fiscal deficit, will the operating expenses of the Office of the Secretary for Health continue to remain at a lower level in the coming years?

Asked by: Hon CHAN Pui-leung (LegCo internal reference no.: 25)

Reply:

The estimated financial provision for the Office of the Secretary for Health (the Office) for 2025-26 is \$24.9 million, which is mainly used to cover expenses pertaining to the remuneration and related allowances of politically appointed officials, civil servants and other non-civil service staff in the Office.

There are 18 officers in the Office, including politically appointed officials, civil service staff in the administrative, information, executive, secretarial and clerical grades, etc., as well as non-civil service staff.

The increase in the revised estimate for 2024-25 over the actual expenditure for 2023-24, and the decrease in the estimated financial provision for 2025-26 are mainly due to the changes

in the expenses pertaining to the remuneration and related allowances of civil servants and non-civil service staff.

It is proposed in the 2025-26 Budget that, on the premise of maintaining efficient public services, the Government will step up the Productivity Enhancement Programme and reduce the civil service establishment by 2% each in 2026-27 and 2027-28. The Health Bureau is reviewing the relevant expenditures and establishment to utilise resources more effectively, with a view to achieving the objective of expenditure control set out in the Budget.

- End -

CONTROLLING OFFICER'S REPLY

HHB034

(Question Serial No. 3155)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (4) Subvention: Prince Philip Dental Hospital

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is stated under Matters Requiring Special Attention in 2025-26 that the Prince Philip Dental Hospital will increase its capacity for clinical training as well as training places of dental care professionals and continue strengthening its clinic services for recruiting patients for clinical training. In this connection, will the Government inform this Committee of the following:

1. how the additional training places will be allocated among different programmes (such as diploma programmes in dental technology and dental surgery assisting); and
2. whether subsidies are provided for the recruited patients; if so, the details and expenditure; if not, the reasons.

Asked by: Hon CHAN Pui-leung (LegCo internal reference no.: 40)

Reply:

The Prince Philip Dental Hospital (PPDH) is a purpose-built teaching hospital to provide the Faculty of Dentistry of the University of Hong Kong (HKU) with facilities for training dentists. It also assists in the training of dental care professionals (DenCPs) (namely dental hygienists and dental therapists) as well as other ancillary dental workers (namely dental technicians and dental surgery assistants). The PPDH co-organises a 2-year Higher Diploma in Dental Hygiene programme with the School of Professional and Continuing Education of the University of Hong Kong (HKU SPACE), and a 1-year Advanced Diploma in Dental Therapy programme with the Department of Health (DH) and HKU SPACE. In February 2025, the Vocational Training Council (VTC) launched an 18-month programme for Professional Diploma in Dental Hygiene.

(1) Additional Training Places for DenCPs

To strengthen the training of local DenCPs, the Government announced in the 2023 Policy Address that it would gradually increase the training places of DenCPs. In the 2025/26 academic year, the total number of training places (including places offered by the PPDH's programmes for dental hygienists and dental therapists, and 60 places offered by the VTC's

new programme for Professional Diploma in Dental Hygiene) will rise to 220, representing an increase of nearly 20% compared to the 2024/25 academic year. The increase rate will reach 57% in the 2028/29 academic year.

To attract more young people to join the industry, the DH has offered full tuition fee sponsorship since the 2023/24 academic year to students studying the programmes for dental hygienists and dental therapists. Dental hygienists and dental therapists who have received the sponsorship are required to work in dental clinics of the DH or specified non-governmental organisations for 1 year after graduation.

(2) Recruitment of Teaching Patients

For teaching undergraduate students of the HKU Faculty of Dentistry, DenCP students or for other designated teaching purposes, the PPDH will recruit a wide range of dental patients and accept them as teaching patients upon initial examination. Apart from providing teaching-related treatment to general dental patients, in order to meet the curriculum and learning needs, the HKU and the PPDH have set up the Oral Diagnosis Clinic since May 2023 targeting patients with acute oral problems. Undergraduates or PPDH dentists will provide such patients with consultation and/or emergency pain relief treatment on need basis. If the dental problems of the patients are suitable for designated teaching purposes, the PPDH will recruit the patients as teaching patients and continue following up on their cases.

Teaching patients are charged nominal fees to encourage attendance by members of the public. The attendance fee for teaching patients of the PPDH is pegged to the attendance fee at general outpatient clinics of the Hospital Authority (HA), charged at HK\$50 per day visit. The fees for other treatment and dental appliances are charged on the basis of cost recovery. Details of the fees are available at the PPDH's website. Patients receiving Comprehensive Social Security Assistance or those who are assessed by the Social Welfare Department, Medical Social Services of the HA or a social service agency to be in hardship may apply for waiver of fees as appropriate. The total amount of fees waived in 2023-24 came to HK\$324,665.

- End -

CONTROLLING OFFICER'S REPLY

HHB035

(Question Serial No. 1802)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas Chan)

Director of Bureau: Secretary for Health

Question:

According to the Budget, the Health Bureau will further promote the development of Chinese medicine (CM) in Hong Kong in 2025-26. In this connection, please inform this Committee of the following:

- (1) the respective financial provisions for the Chinese Medicine Clinics cum Training and Research Centres (CMCTRs) in 18 districts allocated by the Government in the past 5 years, and their respective proportions in the annual total health expenditure;
- (2) the Government's estimated provision for the 18 CMCTRs in 2025-26, and its percentage in the year's total health expenditure; and
- (3) whether the Government knows the 18 CMCTRs' actual expenditures and their respective proportions in the total expenditures in the past 3 years on providing government-subsidised services; CM practitioner trainee programme; provision of integrated Chinese-Western medicine services; operation of the Toxicology Reference Laboratory; implementation of quality assurance and central procurement of CM drugs; development and provision of training in "evidence-based" CM; and enhancement to and maintenance of the CM Information System.

Asked by: Hon CHAN Wing-kwong (LegCo internal reference no.: 1)

Reply:

The Hospital Authority (HA), non-governmental organisations and local universities operate the Chinese Medicine Clinics cum Training and Research Centres (CMCTRs) in 18 districts under a tripartite collaboration model, aiming to promote the development of Chinese medicine (CM) by providing services, training and conducting research. Since March 2020, the 18 CMCTRs have been providing Government-subsidised CM outpatient services at the district level. The annual quota has increased from about 600 000 to 800 000 since October 2023, representing an increase of over 30%. The Government will continue to review the service capacities of the 18 CMCTRs and the public demand for Government-subsidised CM outpatient services, with a view to enhancing the service arrangements as appropriate.

Regarding the budget estimate, the Government has earmarked \$473 million in 2025-26 for the HA to take forward initiatives for promoting CM development, which include operating

the CMCTRs to provide Government-subsidised outpatient services and CM practitioner trainee programme, providing integrated Chinese-Western medicine services, providing “evidence-based” CM training, operating the Toxicology Reference Laboratory, conducting quality assurance and central procurement of CM drugs, and enhancing and maintaining the CM Information System.

The relevant financial provisions in the past 5 years are tabulated below:

Financial Year	Financial Provision (\$m)
2020-21	227
2021-22	230
2022-23	229
2023-24	348
2024-25	427

- End -

CONTROLLING OFFICER'S REPLY**HHB036****(Question Serial No. 1840)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): (001) SalariesProgramme: (2) HealthControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

It is mentioned in the Budget that the Health Bureau will further promote the development of Chinese medicine (CM) in Hong Kong in 2025-26. To promote the professional development and manpower training for CM in Hong Kong, the Government has established Chinese Medicine Clinics cum Training and Research Centres (CMCTRs) in all 18 districts across the territory. They are run by the Hospital Authority, non-governmental organisations and universities under a tripartite collaboration model. In this connection, please advise this Committee of:

- (1) the respective total numbers of attendances at the 18 CMCTRs in the past 5 years;
- (2) the respective total numbers of Chinese medicine practitioners (CMPs) employed by the 18 CMCTRs in the past 5 years;
- (3) the current salary levels of CMPs working at the CMCTRs; and
- (4) whether the Government knows if there is a wastage of CMPs at the CMCTRs; if yes, the details.

Asked by: Hon CHAN Wing-kwong (LegCo internal reference no.: 2)Reply:

The Hospital Authority (HA), non-governmental organisations (NGOs) and local universities operate the Chinese Medicine Clinics cum Training and Research Centres (CMCTRs) in 18 districts under a tripartite collaboration model, aiming to promote the development of Chinese medicine (CM) by providing services, training and conducting research. Since March 2020, the 18 CMCTRs have been providing Government-subsidised CM outpatient services at the district level. The annual quota has increased from about 600 000 to 800 000 since October 2023, representing an increase of over 30%. The Government will continue to review the service capacities of the 18 CMCTRs and the public demand for Government-subsidised CM outpatient services, with a view to enhancing the service arrangements as appropriate.

The attendances of the 18 CMCTRs in the past 5 years are set out in the table below:

District	Attendance for the Year				
	2020	2021	2022	2023	2024
Central & Western	33 527	52 385	87 186	93 358	85 873

Tsuen Wan	81 132	93 815	96 071	112 384	117 118
Tai Po	60 933	74 512	86 229	100 866	90 482
Wan Chai	52 074	66 212	76 430	94 946	89 448
Sai Kung	50 932	60 908	65 529	89 331	92 570
Yuen Long	74 952	85 267	92 070	94 257	96 807
Tuen Mun	58 732	67 669	75 719	77 887	74 609
Kwun Tong	63 010	71 948	82 556	86 916	74 523
Kwai Tsing	36 196	54 794	71 806	79 053	69 601
Eastern	61 732	83 095	104 034	114 504	104 188
North	75 723	85 988	98 671	119 156	119 404
Wong Tai Sin	50 179	61 685	74 040	72 486	70 958
Sha Tin	65 284	83 067	89 020	107 076	101 757
Sham Shui Po	54 304	63 783	76 836	78 628	72 136
Southern	52 521	61 031	87 486	98 312	85 030
Kowloon City	64 199	78 922	80 630	86 845	82 688
Yau Tsim Mong	56 585	70 978	90 694	86 288	82 504
Islands	55 282	63 928	83 629	91 978	89 092
Total	1 047 297	1 279 987	1 518 636	1 684 271	1 598 788

Note: The above attendances cover CMCTRs' regular services (both Government-subsidised and non-Government-subsidised outpatient services), Integrated Chinese-Western Medicine services, Civil Service Chinese Medicine Clinic services, as well as the time-limited Special Chinese Medicine Out-patient Programme for COVID-19 Infected Persons introduced during the COVID-19 epidemic.

The numbers of Chinese medicine practitioners (CMPs) employed by the 18 CMCTRs in the past 5 years are set out in the table below:

District	Number of CMPs as at Year End				
	2020	2021	2022	2023	2024
Central & Western	27	29	30	31	28
Tsuen Wan	26	25	26	31	32
Tai Po	32	31	30	29	26
Wan Chai	24	22	22	24	26
Sai Kung	24	20	18	24	26
Yuen Long	24	21	20	23	22
Tuen Mun	25	24	25	24	26
Kwun Tong	30	28	24	28	30
Kwai Tsing	18	19	19	21	24
Eastern	27	27	29	32	30
North	20	21	22	24	28
Wong Tai Sin	22	19	20	20	23
Sha Tin	23	21	23	25	29
Sham Shui Po	21	19	21	24	27
Southern	26	26	29	30	34
Kowloon City	23	19	21	22	22
Yau Tsim Mong	25	21	19	18	22
Islands	24	23	21	27	31
Total	441	415	419	457	486

Note: CMPs are employed by the NGOs operating the CMCTRs and their terms of employment and remuneration packages are determined by the respective NGOs. The above information is provided by the respective NGOs.

CMPs of the 18 CMCTRs are employed by the NGOs operating the CMCTRs. Their terms of employment and remuneration packages are determined by the respective NGOs which review and adjust the salary level of CMPs based on the market situation every year. According to the information submitted by these NGOs at the end of 2024, the monthly salaries of CMP trainees at the 18 CMCTRs ranged from \$25,000 to \$35,000, while the monthly salaries of other CMPs of various ranks ranged from \$35,000 to \$120,000, depending on their experience, qualifications and duties. In 2024-25, the salaries of the CMPs concerned have been increased by about 4% based on the personnel management mechanisms of individual NGOs. To dovetail with the continuous development of the services concerned, there was also an increase in the overall number of CMPs in the 18 CMCTRs in 2024.

- End -

CONTROLLING OFFICER'S REPLY

HHB037

(Question Serial No. 1870)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in the Budget that the Health Bureau will expand the Government-subsidised Integrated Chinese-Western Medicine (ICWM) services in 2025-26. In this connection, will the Government inform this Committee of the following:

(1) The number of participating patients and the cumulative number of attendances since the implementation of the ICWM Pilot Programme by the Hospital Authority in 2014 as commissioned by the Government; and the numbers of participating patients of each selected disease area, their numbers of attendances and the percentages they represent in the total number of participating patients, and the cumulative number of attendances respectively; and

(2) Under the current framework of the ICWM services, participating patients are required to pay a fee of \$120 for each attendance of ICWM inpatient services (not including general fees for public hospital services), while Comprehensive Social Security Assistance recipients are waived from the service fees. In this regard, whether the Government knows the number of patients who have been waived from the service fees and the total amount waived since the launch of the programme; and the total amount paid by patients who have not been waived from the service fees and the highest amount paid by them?

Asked by: Hon CHAN Wing-kwong (LegCo internal reference no.: 3)

Reply:

To gather experience in the operation of integrated Chinese-Western medicine (ICWM) and Chinese medicine (CM) in-patient services, the Government has earlier commissioned the Hospital Authority (HA) to launch the ICWM services through a Pilot Programme, to provide ICWM treatment to in-patients under the 3 designated disease areas (namely stroke care, musculoskeletal pain management and cancer palliative care) through the 18 Chinese Medicine Clinics cum Training and Research Centres. To dovetail with the policy direction of strengthening ICWM services, the HA regularised and further expanded the services to more hospital sites in early 2023, enabling more patients to benefit from such services.

Succeeding the implementation experience and effectiveness of the ICWM services, the HA

piloted 3 new ICWM programmes on cancer care, respiratory diseases care and knee osteoarthritis care by phases starting from the latter half of 2023. Among them, the Cancer Care Pilot Programme, which was first launched in the latter half of 2023 in Kowloon West Cluster and New Territories West Cluster, was subsequently extended to the Hong Kong West Cluster and Hong Kong East Cluster in the third quarter of 2024 and the first quarter of 2025 respectively, and will continue to be extended to the three remaining clusters.

As at end-December 2024, the number of public hospitals providing ICWM services has increased from eight to 26, with the number of designated hospital sites significantly increased to 61. The HA will continue to expand the ICWM services to cover more disease areas in which CM has an advantage, as well as hospital sites, so as to further leverage the strengths of CM and ICWM.

With Government subsidises, patients only need to pay \$120 for each attendance of the ICWM services (excluding general fees for public hospital services) while Comprehensive Social Security Assistance (CSSA) recipients are eligible for the medical fee waiver.

Cumulative numbers of patients enrolled for and attendances in the ICWM services as at 31 December 2024 are tabulated below:

Disease area	Number of patient enrollment (%)	Number of attendances (%)
Stroke care	3 774 (45.0%)	41 977 (66.1%)
Musculoskeletal pain management	2 649 (31.6%)	7 413 (11.7%)
Cancer palliative care	1 477 (17.6%)	11 682 (18.4%)
Cancer care pilot programme	172 (2.1%)	1 210 (1.9%)
Respiratory diseases care pilot programme	123 (1.5%)	297 (0.5%)
Knee osteoarthritis care pilot programme	187 (2.2%)	918 (1.4%)
Total	8 382 (100%)	63 497 (100%)

Note: Of the attendances in the ICWM services, about 14% were CSSA recipients.

- End -

CONTROLLING OFFICER'S REPLY**HHB038****(Question Serial No. 1872)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (2) HealthControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

It is mentioned in the Budget that the Government will continue to prepare for the service commencement of The Chinese Medicine Hospital of Hong Kong (CMHHK) in 2025. In this connection, please advise this Committee whether sufficient resources have been reserved to tie in with the service commencement of the CMHHK. If yes, what are the details? If not, what are the reasons?

Asked by: Hon CHAN Wing-kwong (LegCo internal reference no.: 4)Reply:

The Chinese Medicine Hospital of Hong Kong (CMHHK) is constructed by the Government and operated under a public-private-partnership model. Hong Kong Baptist University (HKBU) was selected through tendering procedures as the Contractor for the operation of the CMHHK. HKBU and the Operator (a company limited by guarantee incorporated by HKBU according to the service deed) are working together on the commissioning tasks (including the procurement of hospital furniture and equipment and the development of information technology (IT) system for the hospital) as stipulated in the service deed. The construction works of the CMHHK commenced in June 2021, with the hospital building expected to be handed over in batches to the Health Bureau (HHB) starting from mid-2025. The CMHHK is expected to commence services in phases from the end of 2025.

In 2021, the Finance Committee of the Legislative Council approved the following commitments under Capital Works Reserve Fund (CWRF) Head 703 Buildings, CWRF Head 710 Computerisation, and Subhead General non-recurrent of Head 140 respectively:

Items	Amount
The Development of Chinese Medicine Hospital (CMH) in Tseung Kwan O	\$8,620 million
IT Support for the CMH	\$383.9 million
Preparation for Service Commencement of the CMH	\$80.445 million

In tandem with the commissioning of the CMHHK, the HHB has earmarked about \$203 million in the estimate for 2025-26 to cater for the relevant expenditure on the CMHHK project.

- End -

CONTROLLING OFFICER'S REPLY

HHB039

(Question Serial No. 1976)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in the Budget that the Health Bureau will further promote the development of Chinese medicine (CM) in Hong Kong in 2024-25. Established in 2018, the Chinese Medicine Unit (CMU) is a dedicated unit responsible for co-ordinating and promoting the development of CM in Hong Kong at policy level. In this connection, please inform this Committee of the following:

- (1) The operational expenses and estimated expenditure of the CMU in the past 3 years and for 2025-26 respectively;
- (2) The staff establishment, posts and salary levels of the CMU in the past 3 years and for 2025-26 respectively; and
- (3) Given that the Government has been making dedicated efforts to promote the development of CM in recent years, are there any plans to increase the manpower of the CMU so as to meet the development needs? If yes, what are the details? If not, what are the reasons?

Asked by: Hon CHAN Wing-kwong (LegCo internal reference no.: 5)

Reply:

(1) to (3)

To implement the work on enhancing the functions of the Chinese Medicine Unit (CMU) of the Health Bureau (HHB) as set out in the Chief Executive's 2022 Policy Address, the Government has created the post of Commissioner for Chinese Medicine Development (C for CMD) since 2023-2024, and increased the number of non-directorate supporting staff of the CMU which include recruiting personnel from the market with professional background in the areas of Chinese medicine (CM) practice, CMs, public education and publicity, professional education and academic research on non-civil service contract (NCSC) terms. The Government will continue to review the scope of work and manpower requirements of the CMU to ensure that there are sufficient and appropriate manpower to support the coordination and oversight of the development of CM.

The numbers of posts and the salary expenditures of the CMU in the past 3 financial years and in 2025-26 are tabulated below.

Year	Number of establishment posts	Number of NCSC positions [Number of positions for personnel with CM professional background]	Salary Expenditure
2022-2023 (Note 1)	6	3 [1]	About \$8,537,000
2023-2024	9 (Note 2)	19 [15] (Note 3)	About \$13,355,000
2024-2025	9 (Note 4)	19 [15] (Note 5)	About \$24,887,000
2025-2026 (Estimates)	9 (Note 4)	18 [15] (Note 6)	About \$28,340,000

Note:

1. The CMU of the HHB was under Team 7/Chinese Medicine Unit in the organisational structure before 1 April 2023. The numbers of posts listed above include Principal Assistant Secretary for Health 7/Head (Chinese Medicine Unit) and other posts responsible for the work of the CMU.
2. The creation of the post of C for CMD was approved in 2023-24 and the appointee assumed office in May 2024.
3. Of the 15 NCSC positions created for personnel with CM professional background, 6 were filled in 2024-2025.
4. The figure includes 1 C for CMD, 1 Senior Administrative Officer (time-limited post until 2025-26), 1 Chief Executive Officer (CEO), 2 Senior Executive Officers (SEO), 1 Executive Officer I (EO I), 1 Executive Officer II (EO II), 1 Personal Secretary I and 1 Assistant Clerical Officer.
5. The figure includes 15 positions created for personnel with CM professional background, namely 1 Consultant Chinese Medicine Practitioner (CEO-equivalent), 1 Consultant Chinese Medicine Officer (CEO-equivalent), 5 Senior Chinese Medicine Officers (SEO-equivalent), 5 Chinese Medicine Officers (EO I-equivalent) and 3 Assistant Chinese Medicine Officers (EO II-equivalent); and 4 executive positions, namely 1 Senior Executive Manager (SEO-equivalent), 2 Executive Managers (EO I-equivalent) and 1 Assistant Executive Manager (EO II-equivalent).
6. The figure includes 15 positions created for personnel with CM professional background (see Note 5) and 3 executive positions (namely 2 Executive Managers (EO I-equivalent) and 1 Assistant Executive Manager (EO II-equivalent)).

- End -

CONTROLLING OFFICER'S REPLY

HHB040

(Question Serial No. 2700)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in the Estimates that the Health Bureau will enhance funding support to the Chinese medicine (CM) sector through the Chinese Medicine Development Fund and take forward more training programmes for nurturing CM talents in 2025-26. In this connection, will the Government inform this Committee of the following:

- (1) the latest situation regarding the usage of the Chinese Medicine Development Fund (CMDF) and its balance (including the implementation schedule of various support programmes of the CMDF, the cumulative number of applications received, the cumulative number of applications approved and the amount of funding approved); and
- (2) the measures to be taken by the authorities to extend the coverage and depth of the support programmes of the CMDF to better support the development of CM.

Asked by: Hon CHAN Wing-kwong (LegCo internal reference no.: 6)

Reply:

(1)- (2)

As the first dedicated fund set up to support Chinese medicine (CM) development, the Chinese Medicine Development Fund (CMDF) has been injected with a total of \$1 billion since its official launch in June 2019. The CMDF aims to enhance the overall standards of the CM sector to promote the high-quality development of CM in Hong Kong on all fronts. Having regard to the diverse needs of stakeholders, the CMDF has launched various support programmes covering different areas to benefit CM personnel and organisations of different segments of the sector. As of end of February 2025, the CMDF has approved an accumulative total of about 8 900 funding applications, involving a total funding of about \$403 million (provisional figure) for the approved projects and benefiting more than 3 million members of the sector and the general public, with major achievements listed below:

- (a) Talent nurturing: Close to 3 500 Chinese medicine practitioners (CMPs) and CMs personnel have received subsidies to attend CM professional training programmes for continuously upskilling their professional knowledge and ability. The CMDF has supported programme providers to design and organise innovative training

projects, benefitting over 41 300 practitioners. The CMDF has supported 85 CMPs and CMs personnel to participate in the Hong Kong Chinese Medicine Talent Training Programme co-organised by the National Administration of Traditional Chinese Medicine and the Health Bureau (HHB) to cater for the need of establishing a talent pool;

- (b) Quality enhancement: The CMDF has supported more than 560 CM clinics and 220 Chinese herbal medicine retailers/wholesalers to upgrade their facilities and equipment with a view to enhancing service quality and the safety and quality control of CMs. The CMDF has also supported nearly 180 proprietary Chinese medicines (pCm) manufacturers/wholesalers to engage consultancy services or technical support for over 760 pCm products, thereby levelling up the quality of Hong Kong-registered pCm products;
- (c) Market development: The CMDF has provided subsidies for 12 Hong Kong-registered pCm products for external use to be registered and sold on the Mainland through streamlined approval procedures to promote industry development;
- (d) Research and applied studies: The CMDF has supported the commencement of 72 CM research and applied studies projects which are instrumental in driving academic and clinical research as well as the professional and industry development of CM in Hong Kong; and
- (e) Publicity and promotion: The CMDF has supported more than 1 100 CM publicity and public education activities of various forms, targeting audiences such as kindergarten, primary and secondary school students, and elderly persons.

Following an additional injection of funds in the 2023-24 Budget, the CMDF has rolled out various new and enhanced initiatives to cater for the needs of the CM sector and align with its latest development. For example:

- (a) To facilitate Hong Kong pCms to explore the Mainland market and promote industry development, the CMDF launched the Greater Bay Area pCm Industry Development Support Scheme in February 2024 to provide subsidies for Hong Kong-registered pCms for external use to apply for registration in the Mainland through the streamlined approval procedures;
- (b) To dovetail with the phased service commencement of The Chinese Medicine Hospital of Hong Kong at the end of 2025, the CMDF invited organisations to submit applications for six talent training programmes relating to cross-disciplinary collaboration, healthcare administration and management under the Strategic Theme Commissioned Project Funding Programme from mid-2024. The approval process for the relevant commissioned training programmes was completed and the programmes are expected to commence in phases starting from mid-2025; and
- (c) To further fostering cultural inheritance and promotion of CM, the CMDF raised the funding ceiling of CM public promotion projects to \$2 million from April 2024 to enhance the scale and effectiveness of public education and promotion projects

designed and implemented by the CM sector. The CMDF also invited organisations to submit applications under the Strategic Theme Commissioned Project Funding Programme for the development of CM teaching and learning resource kits for secondary and primary schools in mid-2024. The approval process for the relevant commissioned projects was completed and the projects is expected to commence in phases starting from mid-2025.

The HHB will continue to closely monitor the implementation of the CMDF in consultation with the Advisory Committee on CMDF, work with the CMDF's implementation agent (the Hong Kong Productivity Council) to maintain close liaison with the CM sector and relevant stakeholders, and introduce more enhancement measures as and when necessary.

The details and vetting criteria of the funding schemes as well as the amount of subsidy, progress and achievements of the approved projects have been uploaded to the CMDF website (www.cmdevfund.hk).

- End -

CONTROLLING OFFICER'S REPLY

HHB041

(Question Serial No. 2702)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in the Budget Speech that the Government will set aside resources to support universities in the development of the new medical school on a matching basis. In this connection, will the Government inform this Committee of:

- (1) the details of the resources set aside;
- (2) the staff establishment involved in supporting the Task Group on New Medical School; and
- (3) the latest progress of the establishment of the third medical school?

Asked by: Hon CHAN Wing-kwong (LegCo internal reference no.: 8)

Reply:

(1) and (3)

Established in October 2024, the Task Group on New Medical School (the Task Group) is responsible for devising the direction and parameters for a new medical school and selecting a suitable university for setting up the new medical school. In November 2024, the Task Group set out 10 key parameters for consideration of proposals on the establishment of the new medical school, namely innovative strategic positioning, staffing, campus and teaching facilities, clinical exposure and learning resources, curriculum structure and assessment methodologies, student admission arrangements, funding arrangements, implementation plans, teaching and learning quality, as well as research excellence. In December 2024, the Task Group issued a letter of invitation to local universities interested in establishing the new medical school for submission of proposals by 17 March 2025. The Task Group has received a total of 3 proposals for the establishment of the third medical school before the submission deadline, which are submitted by Hong Kong Baptist University, the Hong Kong Polytechnic University, and the Hong Kong University of Science and Technology respectively.

Moreover, the Task Group discussed the next steps for evaluating proposals at the meeting in February 2025. The Task Group agreed to adopt a holistic and comprehensive approach, in accordance with the 10 key parameters (including the financial sustainability of the new

medical school), for evaluating the proposals submitted by universities from various perspectives and will conduct interviews within the second quarter of 2025 with the universities which have submitted proposals. The Task Group expects to complete the evaluation and make recommendations to the Government within this year.

The Task Group will review the proposed funding sources and financial management plans in the proposals. Depending on the recommendations of the Task Group and the implementation timetable of the recommended proposal, the Government will set aside resources on a matching basis as announced in the 2025-26 Budget to support universities in developing a new medical school.

(2)

The Health Bureau (HHB) is responsible for handling work related to the establishment of the third medical school, including policies on healthcare manpower and training, coordination on cross-bureaux/departments issues, and provision of secretarial support to the Task Group. The manpower responsible for handling the above work is provided through internal resources allocation by the HHB, the Hospital Authority and the Department of Health.

- End -

CONTROLLING OFFICER'S REPLY

HHB042

(Question Serial No. 2863)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

According to the Estimates, the Health Bureau (HHB) will continue to take forward and enhance the development of District Health Centres (DHCs) and DHC Expresses (DHCEs) across the territory, and integrate the services of Woman Health Centres and Elderly Health Centres into DHC Network during 2025-26. In this connection, will the Government inform this Committee of:

- (1) the specific measures to be taken by the HHB to take forward and enhance the development of DHCs and DHCEs in 2025-26, and the estimated expenditure involved;
- (2) the respective staff establishment (including medical professionals and other supporting staff) and expenditure of the DHCs/DHCEs since the provision of services; and
- (3) the respective service volume and total number of attendances of the DHCs/DHCEs since the commencement of services?

Asked by: Hon CHAN Wing-kwong (LegCo internal reference no.: 27)

Reply:

(1)

The Government set up District Health Centres (DHCs) and smaller interim District Health Centre Expresses (DHCEs) across the territory by the end of 2022, thereby attaining the interim goal of covering all 18 districts. The Primary Healthcare Commission (PHCC) continues to take forward the plan of establishing DHCs in all districts across the city, including the preparation for upgrading the three DHCEs in the Central and Western District, Yau Tsim Mong District and Eastern District to DHCs within 2025. By then, 10 out of the 18 Districts in Hong Kong will have DHCs in place to serve members of the public. Each DHC will set up several satellite centres/service points and DHCEs will set up service points to expand public reach.

The Government carries out various territory-wide promotion of the primary healthcare services of DHCs and DHCEs through various means and media. For district-level promotion, DHCs and DHCEs strengthen connection with the local community, especially

the hard-to-reach groups, through outreach activities, telephone and other communication technology support, telecare platform, etc. Also, outdoor health exhibitions, health mobile vans and community programmes are regularly organised.

As the DHC operators are required under their service contracts to launch targeted promotional activities in their districts, the estimated expenditure has been included in the total price of the contract of each DHC, and a breakdown of the relevant expenditure is thus unavailable. Besides, the PHCC has also arranged territory-wide activities to promote DHCs. The relevant expenditure is included in the operating expenditure of the PHCC, and a breakdown is not available.

(2)

The staff establishment (including healthcare professionals and other supporting staff) and revised estimate (including the provisions for service contracts, site maintenance and rental cost) of DHCs in Kwai Tsing, Sham Shui Po, Tuen Mun, Wong Tai Sin, Southern, Yuen Long and Tsuen Wan in 2024-25 are set out in the table below:

	DHC						
	Kwai Tsing	Sham Shui Po	Tuen Mun	Wong Tai Sin	Southern	Yuen Long	Tsuen Wan
Staff establishment Note 1							
Executive Director	1	1	1	1	1	1	1
Medical Consultant Note 2	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Chief Care Coordinator	1	1	1	1	1	1	1
Care Coordinator/ Nurse	21	18.5	26	25	16	29	21
Physiotherapist	3.5	2	3	3	3	3	2
Occupational Therapist	1.5	2	2	2	3	3	2
Dietitian	1	1	1	2	1	2	2
Pharmacist	1	1	1	1	1	1	1
Social Worker, Administrative Staff and Supporting Staff	55	69	62	62	59	50	48
Total	85.5	96	97.5	97.5	85.5	90.5	78.5
2024-25 Revised Estimate (\$ million)	62	63	80	69	58	73	78

Note:

1. The staff establishment is proposed by DHC operators through tendering procedures according to the service demand in the community and manpower estimation, and is approved by the Government. The 0.5 staff establishment refers to a part-time position

with half of the working hours of a full-time position. The actual number of staff may vary from time to time, depending on factors such as service demand and short-term manpower turnover, etc. The Government will continue to monitor the situation to ensure that services are not affected.

2. Medical Consultants are part-time or outsourced positions.

The staff establishment (including healthcare professionals and other supporting staff) and revised estimate (including the provisions for service contracts, site maintenance and rental cost) of all DHCEs in 2024-25 are set out in the table below:

	DHCE										
	Central and Western	Eastern	Islands	Kowloon City	Kwun Tong	North	Sai Kung	Sha Tin	Tai Po	Wan Chai	Yau Tsim Mong
Staff establishment Notes 3,4											
Project Coordinator	1	1	1	1	1	1	1	1	1	1	1
Medical Consultant Note 5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Care Coordinator	3	3	3	1	2	1	2	5	5	5	1
Nurse	1	3		5	4	3	4				4
Physiotherapist	1	1	1	1	1	1	1	1	1	1	1
Occupational Therapist					1		1		0.5	1	
Pharmacist	0.5	0.5					1	1		1	
Dietitian				1	1	0.5	1		1		1
Social Worker, Administrative Staff and Supporting Staff	14	15	12	13	15.5	14.5	12	18	14	7.5	14
Total	21	24	17.5	22.5	26	21.5	23.5	26.5	23	17	22.5
2024-25 Revised Estimate (\$ million)	15	14	13	14	14	14	14	14	14	15	14

Note:

3. The staff establishment is proposed by DHCEs according to the service demand in the community and manpower estimation, and is reviewed and approved by the Government before entering into contracts with operators. The 0.5 staff establishment refers to a part-time position with half of the working hours of a full-time position. The actual number of staff may vary from time to time, depending on factors such as service demand and

short-term manpower turnover, etc. The Government will continue to monitor the situation to ensure that services are not affected.

4. The staff establishment of each DHCE is dependent on the service demand and service delivery model of the district concerned, and so the figures are not directly comparable.
5. Medical Consultants are part-time or outsourced positions.

Upon the upgrading of the 3 DHCEs to DHCs this year, the existing DHCEs will gradually reduce from 11 to 8, while the number of DHCs will increase to 10. The estimated expenditure for DHCs and DHCEs (including provisions for service contracts, site maintenance and rental cost) for 2025-26 are \$1.083 billion and \$213 million respectively.

(3)

The cumulative numbers of members and attendances of DHCs/DHCEs are set out in the table below:

DHC/DHCE Service Commencement Date	Cumulative Number of Members^{Note 6} (as at 31 December 2024) [Provisional Figures]	Cumulative Number of Attendances^{Notes 6, 7, 8, 9} (as at 31 December 2024) [Provisional Figures]
DHC		
Kwai Tsing 24 September 2019	46 100	498 300
Sham Shui Po 30 June 2021	34 300	296 600
Tuen Mun 31 May 2022	38 100	344 100
Wong Tai Sin 30 June 2022	34 700	200 900
Southern 17 October 2022	23 900	175 300
Yuen Long 24 October 2022	42 500	255 000
Tsuen Wan 30 December 2022	26 000	175 700
DHCE		
Sai Kung 1 September 2021	10 600	84 900
Kowloon City 1 October 2021	11 300	57 300
Yau Tsim Mong 1 October 2021	9 600	48 500
Wan Chai 4 October 2021	6 800	53 000
North 18 October 2021	8 700	53 700
Islands	6 400	35 900

DHC/DHCE Service Commencement Date	Cumulative Number of Members^{Note 6} (as at 31 December 2024) [Provisional Figures]	Cumulative Number of Attendances^{Notes 6, 7, 8, 9} (as at 31 December 2024) [Provisional Figures]
18 October 2021		
Kwun Tong 21 October 2021	10 800	49 300
Tai Po 22 October 2021	7 800	45 000
Sha Tin 30 October 2021	13 300	71 400
Central and Western 30 October 2021	7 900	50 200
Eastern 30 October 2021	10 900	54 700
Total	349 900	2 549 900

Note:

6. Figures are rounded to the nearest hundred.
7. The figures only include service figures captured from the DHC/DHCE information system, and do not include those relating to medical laboratory tests.
8. As different services are provided by the 11 DHCEs, the attendance figures are not directly comparable.
9. The service figures above have included services provided by DHCs/DHCEs for participants of the Chronic Disease Co-care Pilot Scheme which was launched on 13 November 2023.

- End -

CONTROLLING OFFICER'S REPLY

HHB043

(Question Serial No. 2868)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the psychiatric services provided by the Hospital Authority (HA), will the Government inform this Committee of:

- (1) the major initiatives taken by the HA to enhance mental health services over the past 3 years, as well as the manpower and expenditure involved;
- (2) the manpower and estimated expenditure involved for enhancing mental health services by the HA in 2025-26, and whether there are new initiatives to enhance mental health services; if so, the details and estimated expenditure involved;
- (3) the number and utilisation rate of psychiatric beds in each hospital cluster under the HA in the past 3 years;
- (4) the total number of psychiatric patients treated and the number of patients diagnosed with schizophrenia spectrum disorder in each hospital cluster under the HA in the past 3 years;
- (5) the specific actions to be taken by the Health Bureau (HHB) in 2025-26 to continue to enhance community psychiatric services; and
- (6) whether the HHB has reviewed the effectiveness of its community psychiatric services; if so, the details.

Asked by: Hon CHAN Wing-kwong (LegCo internal reference no.: 28)

Reply:

(1)

The Hospital Authority (HA) takes an integrated and multi-professional approach in delivering mental health services. Teams comprising professionals such as psychiatric doctors, psychiatric nurses, clinical psychologists, occupational therapists and medical social workers provide comprehensive medical services, including inpatient services, outpatient services, day rehabilitation training and community support services, to patients with mental health needs according to their medical conditions and clinical needs. The HA also collaborates with other stakeholders including the Social Welfare Department (SWD), schools and non-governmental organisations to offer appropriate mental health services and support on different fronts to patients and carers in need.

The HA's initiatives to enhance mental health services in the past 3 years (from 2022-23 to 2024-25) are tabulated below:

Year	Initiative	Additional funding
2022-23	(a) Enhancing mental health services for children and adolescents (C&As), including developing specialised C&A psychiatric service in HKEC and KCC in phases; (b) Stepping up community psychiatric services by recruiting additional case managers and providing the "Mental Health Direct" call centre service; and (c) Strengthening psychiatric inpatient, specialist outpatient and consultation liaison services.	Around \$70.5 million
2023-24	(a) Enhancing community psychiatric services by recruiting additional case managers; (b) Strengthening nursing manpower as well as allied health support for psychiatric inpatient and day hospital services; and (c) Stepping up psychiatric consultation liaison service.	Around \$18.9 million
2024-25	(a) Enhancing community psychiatric services by further recruiting additional case managers; (b) Strengthening nursing manpower as well as allied health and peer support for psychiatric inpatient and outpatient services; and (c) Enhancing the use of long-acting injectable antipsychotics in the treatment of mental illness.	Around \$127 million

(2)

The HA has earmarked an additional funding of around \$25 million in 2025-26 to enhance mental health services. The relevant measures include:

- (a) optimising the nursing manpower and allied health support for psychiatric inpatient and outpatient services;
- (b) enhancing psychiatric services for C&As; and
- (c) strengthening the "Mental Health Direct" hotline service.

(3)

The numbers of hospital beds and inpatient bed occupancy rates for psychiatric services in each hospital cluster under the HA from 2022-23 to 2024-25 (as of 31 December 2024) are tabulated below:

2022-23

2011-12								
	Hospital Cluster							Overall
	HKEC	HKWC	KCC	KEC	KWC	NTEC	NTWC	
Psychiatry								
Number of hospital beds*	400	82	456	80	920	552	1 176	3 675
Inpatient bed occupancy rate	55%	76%	74%	63%	76%	69%	59%	66%

*Number of beds as of 31 March 2023

2023-24

		Hospital Cluster							Overall
		HKEC	HKWC	KCC	KEC	KWC	NTEC	NTWC	
Psychiatry									
Number of hospital beds*	400	82	465	80	955	552	1 176	3 710	
Inpatient bed occupancy rate	65%	84%	85%	70%	88%	81%	64%	76%	

*Number of beds as of 31 March 2024

2024-25 (as of 31 December 2024)

2017-18 (as of 31 December 2017)								
		Hospital Cluster						Overall
		HKEC	HKWC	KCC	KEC	KWC	NTEC	
Psychiatry								
Number of hospital beds*	400	82	465	80	955	552	1 176	3 710
Inpatient bed occupancy rate	65%	81%	84%	79%	88%	89%	63%	77%

*Number of beds as of 31 December 2024

As far as the HA is concerned, day inpatients refer to those who are admitted to hospitals for non-emergency treatment and discharged on the same day. Inpatients are those who are admitted to hospitals via Accident & Emergency departments or those who have been hospitalised for more than one day. The numbers of both inpatients and day inpatients are included in the calculation of the number of hospital beds. The number of day inpatients, however, is not included in the calculation of inpatient bed occupancy rate.

(4)

The total numbers of psychiatric patients receiving treatment and the numbers of patients diagnosed with schizophrenia spectrum disorder in each hospital cluster under the HA from 2022-23 to 2024-25 (the projections as of 31 December 2024) are tabulated below:

Hospital Cluster	2022-23		2023-24		2024-25 (the projections as of 31 December 2024)	
	Total Number of Psychiatric Patients Receiving Treatment ^{1,2}	Number of Patients Diagnosed With Schizophrenia Spectrum Disorder ^{1,2}	Total Number of Psychiatric Patients Receiving Treatment ^{1,2}	Number of Patients Diagnosed With Schizophrenia Spectrum Disorder ^{1,2}	Total Number of Psychiatric Patients Receiving Treatment ^{1,2}	Number of Patients Diagnosed With Schizophrenia Spectrum Disorder ^{1,2}
HKEC	25 800	3 400	27 200	3 400	28 300	3 400
HKWC	25 800	3 100	25 900	3 100	26 300	3 000
KCC	22 000	5 000	23 400	5 100	24 400	5 000
KEC	43 000	7 600	45 200	7 600	46 800	7 700
KWC	82 000	16 500	85 000	16 600	88 000	16 600
NTEC	55 800	8 400	57 700	8 400	60 100	8 500
NTWC	48 000	8 600	50 800	8 700	53 000	8 900
Overall³	296 900	51 100	309 400	51 200	320 600	51 300

Note:

1. Including inpatients, patients at specialist outpatient clinics and day hospitals.
2. Figures are rounded to the nearest hundred.
3. The figures for each hospital cluster may not add up to the total as patients may be treated in more than one hospital cluster.

Remark:

In view of the COVID-19 epidemic in Hong Kong in early 2020, the HA adjusted its services in response to the epidemic. This should be taken into account when comparing the throughput of services provided by the HA across the years. With the subsiding of local COVID-19 epidemic situation and cessation of anti-epidemic measures in early 2023, the HA has been gradually resuming provision of all of its public healthcare services to tie in with the Government's normalcy measures.

(5)

The multi-professional teams of the HA's community psychiatric services offer appropriate community support to persons in mental recovery in the community, having regard to their medical conditions as well as clinical needs and risks. Community psychiatric services of the HA cover 3 levels of services, namely the Intensive Care Team, Case Management Programme and Standard Community Psychiatric Service. Taking into account patients' medical conditions as well as clinical needs and risks, the multi-professional teams provide them with community support as appropriate. Through regular outreach or home visits, as well as close collaboration with community partners, case managers help persons in mental recovery set goals and draw up recovery plans for their re-integration into the community, and also offer support and advice as appropriate to their carers and families while endeavouring to promote mental health in the community. Meanwhile, the HA further recruited additional case managers to step up its community psychiatric services in 2024-25, with the aim to further optimise the ratio of case manager to patients to no higher than 1:40. Patients in need of community psychiatric support services may be referred through various channels such as Integrated Community Centres for Mental Wellness (ICCMWs) subvented

by the SWD or social workers. Moreover, the HA and the SWD's medical social workers provide appropriate assistance for patients and their families in need, including financial/in-kind assistance, counselling services and connection with community resources, to facilitate their recovery and re-integration into society. On another front, the HA will strengthen its "Mental Health Direct" service. Operated around the clock by professional psychiatric nurses, "Mental Health Direct" answers calls from psychiatric patients, carers, relevant stakeholders and the public to provide professional advice on mental health issues and arrange timely referrals for them, in a bid to enhance support for persons in mental recovery and their carers.

Through cross-departmental collaboration of the Education Bureau, Health Bureau and SWD, the Three-Tier School-based Emergency Mechanism (the Emergency Mechanism) has been implemented since December 2023 for early identification of and early support to students with higher risks. The Government announced in the Chief Executive's 2024 Policy Address that the Emergency Mechanism would be enhanced and extended to 31 December 2025. Under the third tier of the Emergency Mechanism, school principals may refer students of higher risks to the psychiatric specialist out-patient clinics of the HA. Upon triage and screening, students in urgent cases requiring early treatment will be accorded priority.

(6)

The HA actively reviews its various psychiatric services including community psychiatric services. To offer more complete and sustained support for patients through closer collaboration between the medical and welfare sectors, the HA further strengthens communication in case management with the SWD, including exploring enhanced exchanges of information on cases jointly handled by the HA and the SWD, so as to provide a more comprehensive assessment on medical, emotional and family conditions, etc. of the persons concerned. The HA will continue to refine the patients' information exchange mechanism to ensure closer communication between the medical service providers and welfare services organisations, with a view to more fully addressing the needs and risks of patients.

Abbreviations:

HKEC – Hong Kong East Cluster

HKWC – Hong Kong West Cluster

KCC – Kowloon Central Cluster

KEC – Kowloon East Cluster

KWC – Kowloon West Cluster

NTEC – New Territories East Cluster

NTWC – New Territories West Cluster

- End -

CONTROLLING OFFICER'S REPLY

HHB044

(Question Serial No. 2870)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It was mentioned in the Budget that the Hospital Authority (HA) would continue to implement the Public-Private Partnership (PPP) programmes in 2025-26. In this connection, please advise this Committee of:

- (1) the services throughput and number of beneficiaries of the PPP programmes over the past 3 years;
- (2) the staffing number and expenditure for the HA's implementation of the PPP programmes over the past 3 years; and
- (3) the factors that will be taken into account by the HA when including a new medical service into the PPP programmes, and whether the HA has considered including any new medical services in the PPP programme in the coming year; if yes, of the details and the estimated expenditure so involved.

Asked by: Hon CHAN Wing-kwong (LegCo internal reference no.: 29)

Reply:

(1)

In the past 3 years, the Hospital Authority (HA) continued to operate a series of Public-Private Partnership (PPP) programmes, including the Cataract Surgeries Programme (CSP), Haemodialysis PPP Programme (HD PPP), Project on Enhancing Radiological Investigation Services through Collaboration with the Private Sector (Radi Collaboration), General Outpatient Clinic PPP Programme (GOPC PPP)/Co-care Service Model (Co-care), Colon Assessment PPP Programme (Colon PPP) and Glaucoma PPP Programme (Glaucoma PPP).

To cope with the COVID-19 epidemic since early 2020, the HA has expanded the service scope of some of the initial PPP Programmes, including expanding the service group of the Radi Collaboration to cover all eligible cancer patients, increasing the service quota of the HD PPP, as well as extending the Colon PPP to cover the colonoscopy cases that were delayed due to the epidemic (Colon PPP Surge Special). Furthermore, the HA has also launched new PPP initiatives as contingency COVID-19 PPPs to divert suitable patients from public hospitals to the private sector for treatment. These initiatives include the Trauma Operative

Service Collaboration Programme (Trauma Collaboration), Breast Cancer Operative Service Collaboration Programme (Breast Cancer Collaboration), Radiation Therapy Service PPP Programme (RT PPP) and Oesophago-Gastro-Duodenoscopy Collaboration Programme (OGD Collaboration). The HA will make timely adjustments to the arrangements of the PPP programmes in the light of actual need and effectiveness of the programmes. Among the above 4 contingency PPP programmes, Trauma Collaboration, Breast Cancer Collaboration and RT PPP are still being run by the HA whereas OGD Collaboration has ceased operation. On another front, the HA launched the Investigation PPP Programme (Investigation PPP) in March 2024, under which laboratory services, including testing of blood, urine and sputum and electrocardiogram, are provided to GOPC PPP patients by designated private laboratories.

Service provisions by PPP programme in the past 3 years are tabulated below:

Programme	2022-23 Actual Provision	2023-24 Actual Provision	2024-25 Planned Provision
CSP (surgeries)	2 914	4 850	5 000
HD PPP ¹ (places)	376	426	441
Radi Collaboration ² (scans)	56 148	70 629	56 000
GOPC PPP/Co-care (participating patients)	49 384	54 716	56 280
Colon PPP & Surge Special ³ (colonoscopies)	2 924	1 780	2 200
Glaucoma PPP (participating patients)	2 686	2 673	2 700
Trauma Collaboration ⁴ (patients)	586	647	700
Breast Cancer Collaboration ⁵ (patients)	379	356	430
RT PPP ⁶ (patients)	98	155	100
OGD Collaboration ⁷ (patients)	1 151	N/A	N/A
Investigation PPP ⁸ (investigations)	N/A	4	112 560

Note:

1. HD PPP benefited 416 patients and 500 patients in 2022-23 and 2023-24 (on a full-year basis) respectively.
2. The HA, in the light of service demand, increased the actual service provision under the Radi Collaboration in 2023-24, with adjustments made to such service provision based on demand in 2024-25.
3. In view of the development of the COVID-19 epidemic, the Surge Special was introduced for Colon PPP between April and August 2022 to cope with the colonoscopy cases that were delayed or cancelled due to the epidemic.

4. Launched in April 2020 as a PPP programme in response to the COVID-19 epidemic, Trauma Collaboration continued as a PPP programme.
5. Launched in June 2020 as a COVID-19 PPP, Breast Cancer Collaboration continued as a PPP programme.
6. First launched in February 2020 and ended in February 2021, RT PPP was then re-activated in July 2022 as a PPP programme.
7. First launched in June 2020 and ended in April 2021, OGD Collaboration was then re-activated in March 2022 and ended in August 2022.
8. Launched in late March 2024, Investigation PPP is applicable to GOPC PPP/Co-care.

(2)

The number of staff deployed for supporting the PPP programmes in the past 3 years is as follows:

Year	2022-23	2023-24	2024-25
Number of Staff	113	113	113

The expenditures involved in implementing the PPP programmes, including payments to service providers, spending on service and administrative support, and clinical and information technology, in the past 3 years are as follows:

Year	2022-23 Actual	2023-24 Actual	2024-25 Projected
Expenditure (\$ million)	530.4	656.2	718.9

(3)

In 2016, the Government allocated to the HA \$10 billion for setting up the HA PPP Fund to generate investment returns for implementing clinical PPP initiatives so as to alleviate pressure on the public healthcare system. To dovetail with the Government's healthcare policies, enhance healthcare system operational efficiency and address service demands more effectively, the Health Bureau established the Strategic Purchasing Office in 2022 to develop and roll out a common platform for strategic purchasing, facilitating integrated purchasing of healthcare services, including consolidation of existing HA's and the Department of Health's PPP programmes. With the development of the healthcare reform, the Government is reviewing various PPP programmes, integrating those programmes aimed at relieving short-term pressure back into HA's routine services, and the Strategic Purchasing Office will refine and consolidate those PPP programmes with long-term development needs so that such programmes can be managed and developed under the model of strategic purchasing.

The 2025-26 Budget puts forward bringing back the unspent balance of six seed capital funds, including the HA PPP Fund, to the Government's accounts after setting aside resources to meet the necessary expenditure of these funds for the next 5 years so that their sustainable

operation will not be affected. This will provide a more comprehensive picture of the Government's fiscal position and enable better use of its financial resources. To this end, the HA has reviewed the latest financial position of the HA PPP Fund and projected the cash flow requirements for the next 5 years having regard to the past expenditure, needs of relevant programmes and the related development strategies, and set aside resources to meet the necessary expenditure for the next 5 years.

- End -

CONTROLLING OFFICER'S REPLY**HHB045****(Question Serial No. 2871)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (3) Subvention: Hospital AuthorityControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

It is stated in the Estimates that one of the objectives of the Hospital Authority (HA) is to attract, motivate and retain staff. In this connection, will the authorities inform this Committee of the following:

- (1) the numbers of doctors, nurses and allied health professionals of the HA, calculated on a full-time equivalent basis, in the past 5 years in tabular form;
- (2) the attrition rates of nurses and allied health professionals, and that of full-time doctors broken down by department and rank in the past 5 years in tabular form; and
- (3) the measures to be implemented by the authorities in 2025-26 to attract, motivate and retain staff; and the estimated expenditure for and assessment of effectiveness of such measures.

Asked by: Hon CHAN Wing-kwong (LegCo internal reference no.: 30)Reply:

(1)

The full-time equivalent (FTE) strength⁽¹⁾ of doctors, nurses and allied health professionals of the Hospital Authority (HA) in the past 5 years is tabulated as follows:

Staff category	2020-21 (as at 31 March 2021)	2021-22 (as at 31 March 2022)	2022-23 (as at 31 March 2023)	2023-24 (as at 31 March 2024)⁽²⁾	2024-25 (as at 31 December 2024)⁽²⁾
Doctors ⁽³⁾	6 457	6 484	6 541	6 807	7 184
Nurses ⁽⁴⁾	29 736	29 793	29 599	28 865	29 538
Allied health professionals ⁽⁵⁾	8 886	8 941	9 131	9 497	9 886

Note:

- (1) The manpower figures above are calculated on full-time equivalent basis including permanent, contract and temporary staff in the HA.
- (2) Since January 2024, the FTE for temporary part-time staff has been calculated based on their actual working hours. The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.
- (3) Doctors exclude Interns and Dental Officers.
- (4) The strength of nurses includes senior nursing officers, department operations managers, nurse consultants, associate nurse consultants, ward managers, nursing officers, advanced practice nurses, registered nurses, enrolled nurses, nursing trainees, etc.
- (5) Allied health professionals include radiographers, medical technologists/medical laboratory technicians, occupational therapists, physiotherapists, pharmacists and medical social workers.

(2)

The attrition (wastage) rates⁽¹⁾⁽²⁾ of full-time nurses and allied health professionals of the HA in the past 5 years are tabulated below:

Staff category	2020-21	2021-22	2022-23	2023-24⁽³⁾	2024-25 (rolling 12 months from January to December 2024)⁽³⁾
Nurses	5.8%	9.4%	10.9%	8.1%	7.5%
Allied health professionals ⁽⁴⁾	4.4%	8.7%	8.6%	6.7%	5.8%

Note:

- (1) Attrition (wastage) includes all types of cessation of service (including retirement) from the HA for permanent and contract staff on headcount basis.
- (2) Rolling attrition (wastage) rate = (Total number of staff who left the HA in the past 12 months / Average strength in the past 12 months) x 100%
- (3) Since January 2024, the HA has excluded those staff under the Extending Employment Beyond Retirement (EER) arrangement when compiling the statistics of Attrition (Wastage). The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.
- (4) Allied health professionals include radiographers, medical technologists/medical laboratory technicians, occupational therapists, physiotherapists, pharmacists and medical social workers.

A breakdown of the attrition (wastage) rates⁽¹⁾⁽²⁾⁽³⁾ of full-time doctors of the HA by major specialty and rank in the past 5 years is tabulated below:

2020-21

Major specialty	Consultant	Senior Medical Officer / Associate Consultant	Medical Officer / Resident	Total
Accident & Emergency	6.8%	3.6%	4.0%	4.1%
Anaesthesia	9.4%	6.4%	2.9%	5.2%
Cardiothoracic Surgery	0.0%	0.0%	0.0%	0.0%
Family Medicine	0.0%	2.5%	5.7%	4.6%
Intensive Care Unit	5.0%	3.6%	1.3%	2.6%
Internal Medicine	7.8%	2.7%	2.6%	3.3%
Neurosurgery	5.5%	8.6%	1.8%	4.1%
Obstetrics & Gynaecology	11.6%	7.7%	3.6%	6.4%
Ophthalmology	4.8%	5.3%	6.6%	6.0%
Orthopaedics & Traumatology	5.1%	6.6%	0.0%	2.7%
Paediatrics	12.0%	2.9%	2.4%	4.1%
Pathology	5.3%	7.9%	1.9%	4.5%
Psychiatry	9.2%	4.7%	2.5%	4.1%
Radiology	6.3%	13.0%	2.0%	6.0%
Surgery	4.1%	6.0%	1.8%	3.4%
Others	11.0%	3.3%	3.5%	4.9%
Total	7.2%	4.7%	2.9%	4.1%

2021-22

Major specialty	Consultant	Senior Medical Officer / Associate Consultant	Medical Officer / Resident	Total
Accident & Emergency	12.7%	10.4%	5.6%	8.0%
Anaesthesia	8.9%	19.2%	6.7%	11.8%
Cardiothoracic Surgery	0.0%	0.0%	5.6%	2.1%
Family Medicine	3.8%	6.6%	9.7%	8.6%
Intensive Care Unit	18.5%	15.0%	6.4%	11.1%
Internal Medicine	5.3%	7.3%	4.3%	5.4%

Major specialty	Consultant	Senior Medical Officer / Associate Consultant	Medical Officer / Resident	Total
Neurosurgery	4.6%	4.3%	3.4%	3.9%
Obstetrics & Gynaecology	6.8%	14.7%	4.5%	7.9%
Ophthalmology	3.9%	29.7%	3.2%	11.2%
Orthopaedics & Traumatology	11.3%	10.6%	1.4%	5.5%
Paediatrics	14.1%	2.9%	4.2%	5.4%
Pathology	16.4%	12.9%	5.8%	11.0%
Psychiatry	13.8%	11.9%	7.3%	9.7%
Radiology	16.7%	37.5%	1.8%	13.6%
Surgery	16.7%	11.0%	3.4%	7.9%
Others	11.4%	20.1%	5.5%	10.8%
Total	11.0%	11.7%	5.1%	8.1%

2022-23

Major specialty	Consultant	Senior Medical Officer / Associate Consultant	Medical Officer / Resident	Total
Accident & Emergency	5.5%	11.7%	8.9%	9.5%
Anaesthesia	9.2%	11.3%	4.2%	7.5%
Cardiothoracic Surgery	29.4%	0.0%	5.8%	10.4%
Family Medicine	3.4%	6.7%	8.4%	7.7%
Intensive Care Unit	7.9%	7.9%	3.9%	5.9%
Internal Medicine	6.4%	9.1%	4.1%	6.0%
Neurosurgery	12.9%	0.0%	3.7%	4.9%
Obstetrics & Gynaecology	10.6%	16.8%	4.7%	9.4%
Ophthalmology	6.9%	21.7%	1.0%	7.6%
Orthopaedics & Traumatology	1.5%	6.8%	1.8%	3.1%
Paediatrics	12.7%	3.6%	4.6%	5.6%
Pathology	10.9%	13.8%	1.8%	7.5%
Psychiatry	0.0%	7.3%	7.3%	6.4%
Radiology	15.5%	15.8%	0.6%	7.2%
Surgery	8.2%	10.1%	3.9%	6.5%
Others	6.1%	20.3%	6.1%	9.9%
Total	8.2%	9.8%	4.8%	6.9%

2023-24⁽⁴⁾

Major specialty	Consultant	Senior Medical Officer / Associate Consultant	Medical Officer / Resident	Total
Accident & Emergency	5.2%	4.5%	8.2%	6.6%
Anaesthesia	7.3%	14.8%	5.5%	8.9%
Cardiothoracic Surgery	13.0%	14.0%	5.4%	10.3%
Family Medicine	0.0%	6.1%	8.0%	7.0%
Intensive Care Unit	7.9%	1.9%	2.5%	3.2%
Internal Medicine	4.8%	4.1%	4.9%	4.6%
Neurosurgery	0.0%	8.1%	0.0%	1.9%
Obstetrics & Gynaecology	4.1%	8.0%	2.6%	4.4%
Ophthalmology	17.6%	11.6%	2.0%	7.3%
Orthopaedics & Traumatology	4.2%	5.8%	1.8%	3.3%
Paediatrics	1.4%	7.3%	6.0%	5.7%
Pathology	5.8%	3.3%	2.6%	3.8%
Psychiatry	0.0%	11.2%	1.1%	4.6%
Radiology	3.2%	4.9%	1.1%	2.4%
Surgery	7.7%	8.9%	2.5%	5.2%
Others	2.9%	6.4%	4.3%	4.5%
Total	4.9%	6.9%	4.4%	5.2%

2024-25 (rolling 12 months from January to December 2024)⁽⁴⁾⁽⁵⁾

Major specialty	Consultant	Senior Medical Officer / Associate Consultant	Medical Officer / Resident	Total
Accident & Emergency	0.0%	5.6%	8.3%	6.4%
Anaesthesia	8.3%	10.1%	3.4%	6.4%
Cardiothoracic Surgery	0.0%	0.0%	0.0%	0.0%
Clinical Oncology	0.0%	2.8%	0.0%	0.6%
Ear, Nose & Throat/Otorhinolaryngology	0.0%	13.8%	1.7%	4.5%
Family Medicine	0.0%	3.6%	6.6%	5.4%
Intensive Care Unit	7.0%	1.8%	3.5%	3.6%

Major specialty	Consultant	Senior Medical Officer / Associate Consultant	Medical Officer / Resident	Total
Internal Medicine	4.2%	3.8%	5.5%	4.7%
Neurosurgery	0.0%	0.0%	0.0%	0.0%
Obstetrics & Gynaecology	11.7%	13.4%	4.2%	8.3%
Ophthalmology	10.7%	20.1%	0.0%	7.0%
Orthopaedics & Traumatology	6.5%	6.8%	2.3%	4.2%
Paediatrics	2.6%	6.7%	10.0%	7.6%
Pathology	5.7%	14.6%	4.3%	7.2%
Psychiatry	0.0%	6.0%	2.5%	3.4%
Radiology	9.5%	19.3%	0.0%	5.9%
Surgery	7.3%	8.5%	2.0%	4.7%
Others	0.0%	9.6%	8.5%	5.6%
Total	5.0%	7.0%	4.4%	5.2%

Note:

- (1) Attrition (wastage) includes all types of cessation of service (including retirement) from the HA for permanent and contract staff on headcount basis.
- (2) Rolling attrition (wastage) rate = (Total number of staff who left the HA in the past 12 months / Average strength in the past 12 months) x 100%
- (3) Doctors exclude Interns and Dental Officers.
- (4) Since January 2024, the HA has excluded those staff under the EER arrangement when compiling the statistics of Attrition (Wastage). The related figures before January 2024 are for reference only and direct comparison with figures derived from the revised calculation method is not appropriate.
- (5) Since 2024-25, Ear, Nose & Throat/Otorhinolaryngology and Clinical Oncology has no longer been classified in the category of “Others”. The related figures of this category before 2024-25 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.

(3)

Over the years, the HA has been closely monitoring its manpower situation and introduced a series of measures to attract, develop and retain talents. The HA has implemented ongoing measures within its overall budget, such as increasing the number of Resident Trainee posts to recruit local medical graduates, recruiting non-locally trained doctors to supplement local recruitment, improving promotion prospects to retain staff, hiring part-time healthcare staff by, for example, recruitment of locum staff, offering flexible full-time work arrangements, offering further employment to suitable staff beyond retirement, enhancing the Home Loan Interest Subsidy Scheme (HLISS) and providing better training opportunities for various grades by establishment of the HA Academy. The above measures have begun to bear fruits,

as evidenced by an increase in the number of the HA's healthcare staff in the past year and a fall from the peak attrition rate over the past 2 years.

The HA established the Task Group (TG) on Sustainability to review in December 2019 strategies for retaining staff. In line with the key directions recommended by the Task Group, the HA gradually rolled out further staff retention measures in 2023-24 and will continue with the relevant work in 2025-26, including:

- (a) creating opportunities for Associate Consultants to be promoted to Consultant rank, so as to retain experienced medical personnel to address the service, manpower and training needs in the HA. As at December 2024, there has been an increase of 400 additional posts for Associate Consultants to be promoted to Consultants;
- (b) providing Specialty Nurse Allowance to eligible registered nurses, with over 4 800 nurses receiving the allowance as at December 2024, so as to retain manpower and encourage professional development of nurses through recognising their specialty qualifications;
- (c) providing more career advancement opportunities for its allied health professionals and providing Specialist Allied Health Professionals Allowance for eligible resident physiotherapists, occupational therapists and radiographers, so as to retain manpower and support the demand for and development of specialist services. As at December 2024, around 66 applications have been received; and
- (d) continuing efforts in implementing EER to attract more retired staff who are willing to stay after retirement. As at December 2024, there were 181 doctors, 565 nurses, 113 allied health professionals and 3 020 supporting/other grades staff working in the HA after retirement. Among all doctors/nurses/allied health professionals retiring during 2024-25 to 2028-29, at least 338 doctors, 880 nurses and 200 allied health professionals had indicated interest/agreed to take up full-time or part-time employment after retirement.

The additional financial provision for the above 4 measures is around \$161 million in 2025-26. The HA will continue to closely monitor the manpower situation and actively adopt measures to attract, develop and retain talents for supporting the overall service needs and development in the HA.

- End -

CONTROLLING OFFICER'S REPLY

HHB046

(Question Serial No. 2873)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

According to the Budget, the Health Bureau will continue its efforts to promote organ donation in 2025-26. In this connection, please advise this Committee on the following:

- (1) the details of the work of the Bureau in promoting organ donation, and the manpower and actual expenditure involved;
- (2) the details of the continued efforts of the Bureau in promoting organ donation, and the estimated manpower and expenditure involved in 2025-26;
- (3) the respective numbers of new registrations, withdrawal of registrations and total registrations recorded in the Centralised Organ Donation Register in each of the past 5 years; and
- (4) the numbers of organ donors, the numbers of patients waiting for transplant, the average and the longest waiting times for transplant in each of the past 5 years, with a breakdown by the type of organ in tabular form.

Asked by: Hon CHAN Wing-kwong (LegCo internal reference no.: 31)

Reply:

(1) and (2)

The Health Bureau (HHB), together with the Department of Health (DH) and the Hospital Authority (HA), has been making continuous efforts to collaborate with community partners in promoting organ donation through different channels and on various fronts.

Since 2023, the DH has stepped up its publicity efforts by (1) setting up organ donation promotion booths and deploying the organ donation promotion vehicle to organise promotion activities with a view to encouraging public registration in the Centralised Organ Donation Register (CODR); (2) using various channels such as television, radio, newspapers and the internet for publicity; (3) promoting e-engagement of the public through a dedicated social media page “Organ Donation at HK”; (4) educating the public through health talks; (5) producing publicity materials for distribution in various events and activities; (6) developing an institution-based network by working with signatories of the Organ Donation Promotion

Charter and supporters to promote organ donation; and (7) staging large-scale publicity events to support the Organ Donation Day on the second Saturday of every November.

In line with the Government's strategies and initiatives of promoting organ donation, the HA has organised various promotion activities, including (1) setting up a designated webpage, with publicity and education videos as well as an e-poster hyperlinked to the CODR, in the HA's internet and intranet websites; (2) promoting organ donation on the HA's social media platform and disseminating publicity articles on various media platforms; (3) setting up promotion booths in various HA hospitals; and (4) recruiting summer volunteers to participate in organ donation promotion activities.

The Government will continue its multi-pronged publicity strategies and strengthen collaboration with different sectors through various channels to jointly promote organ donation.

The expenditure and manpower deployed for work in relation to publicity for organ donation cannot be separately identified as they are absorbed by the HHB's overall expenditure, DH's overall provision for health promotion and the HA's overall expenditure on provision of healthcare services.

(3)

The numbers of registrations at the CODR in the past 5 years are as follows:

	2020	2021	2022	2023	2024
Number of new registrations ¹	13 317	12 829	13 418	25 968	24 809
Cumulative total number of registrations (as at 31 December of the year)	330 764	343 593	356 093	367 199	391 187
Number of withdrawals of registration ²	730	748	1 068	14 862 ³	821

Note:

1. Number of new registrations refers to:
 - (a) in or before April 2022, the number of new registrations verified by the DH minus the number of effective withdrawals during the same period (i.e. net increase in the cumulative number of registrations in the period); and
 - (b) in or after May 2022 (after enhancement of the CODR System), the number of new registrations verified by the DH (the number of effective withdrawals during the same period is not deducted in order to indicate more clearly the number of new registrations).
2. Number of withdrawals of registration refers to:
 - (a) in or before April 2022, the number of applications for withdrawal handled by the DH (without deducting the invalid applications); and
 - (b) in or after May 2022 (after enhancement of the CODR System), the number of effective withdrawals only as verified by the DH.

3. During the period of May and June 2023, the spreading of quite a number of malicious remarks intending to mislead the public had led to an unusual surge in the number of withdrawals of registration from the CODR. Subsequently, with the Government's strengthened publicity efforts, the number of withdrawals of registration has returned to normal, with less than 100 cases per month.

(4)

The number of patients waiting for organ/tissue transplant handled by the HA, the average waiting time for transplant and the number of organ donors in the past 5 years are as follows:

Year (as at 31 December)	Organ/ Tissue	Number of Patients Waiting for Transplant	Average Waiting Time (months) ⁴	Number of Organ Donors ⁵	
				Number of Cadaveric Donors ⁶	Number of Living Donors ⁷
2020	Kidney	2 302	55	N/A	N/A
	Liver	72	37.1		
	Heart	78	24.4		
	Lung	29	18.1		
	Cornea (piece)	280	14.5		
	Skin	N/A ⁸			
	Bone				
2021	Kidney	2 360	56	36	35
	Liver	69	38.2		
	Heart	78	27.7		
	Lung	19	22.9		
	Cornea (piece)	263	15.1		
	Skin	N/A ⁸			
	Bone				
2022	Kidney	2 451	56.8	29	23
	Liver	66	38.2		
	Heart	81	23.5		
	Lung	13	27.6		
	Cornea (piece)	357	21.2		
	Skin	N/A ⁸			
	Bone				
2023	Kidney	2 429	60	24	24
	Liver	81	33.4		
	Heart	76	36.8		
	Lung	21	28.2		
	Cornea (piece)	474	31.3		
	Skin	N/A ⁸			
	Bone				

Year (as at 31 December)	Organ/ Tissue	Number of Patients Waiting for Transplant	Average Waiting Time (months) ⁴	Number of Organ Donors ⁵	
				Number of Cadaveric Donors ⁶	Number of Living Donors ⁷
2024	Kidney	2 476	61	30	32
	Liver	79	33.4		
	Heart	77	37.7		
	Lung	21	32.3		
	Cornea (piece)	532	31.6		
	Skin	N/A ⁸			
	Bone				

Note:

4. “Average waiting time” is the average of the waiting time for patients on the organ/tissue transplant waiting list as at the end of that year.
5. Figures are available from 2021 onwards.
6. Number refers to any one or more solid organ donations which include kidney(s), liver, heart and lung(s) from cadaveric donors.
7. Living donation applies to liver/kidney transplant only.
8. Cases of skin and bone transplant are sudden and emergency in nature. Substitutes will be used if no suitable skin or bone is identified for transplant.

- End -

CONTROLLING OFFICER'S REPLY

HHB047

(Question Serial No. 2883)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

As mentioned in the Budget, during 2025-26, the Health Bureau will continue to take forward and implement the five-year plan of eHealth+ to transform eHealth from a health record sharing system into a comprehensive healthcare information infrastructure that integrates multiple functions of healthcare data sharing, service delivery and care journey management. In this connection, please inform this Committee:

- (1) of the operational expenses and manpower involved in overseeing and operating eHealth in the past 3 years;
- (2) of the staffing establishment and estimated expenditure involved in taking forward the development and implementation of eHealth+ in 2025-26;
- (3) of the respective usage of eHealth by public hospitals, public clinics, private hospitals and private healthcare institutions (including clinics, residential care homes for the elderly and social welfare organisations providing medical services) since its launch by the Government;
- (4) of the respective number of various types of healthcare professionals registered to use eHealth and their proportion to the total number of the relevant healthcare professionals since its launch by the Government;
- (5) of the downloads and usage of the eHealth App since its launch; and the measures to be taken to encourage the public to register for the use of eHealth; and
- (6) whether the Government will take measures to facilitate the sharing of medical records in eHealth between Chinese and Western medicine practitioners; if yes, of the details; if not, the reasons for that.

Asked by: Hon CHAN Wing-kwong (LegCo internal reference no.: 33)

Reply:

eHealth is a territory-wide electronic health record sharing system launched by the Government in 2016 that enables citizens to authorise healthcare providers (HCPs) in the public and private sectors to view and share their electronic health records (eHRs) for healthcare purposes. Building on the strengths of the existing infrastructure of eHealth, the Government announced in the 2023 Policy Address the initiative to roll out a five-year

development plan of eHealth+ to transform eHealth into a comprehensive healthcare information infrastructure that integrates multiple functions of data sharing, service delivery and care journey management. eHealth+ aims to facilitate care coordination, cross-sector collaboration, as well as active health management and surveillance, thereby better serving our citizens in obtaining optimal healthcare services, and supporting the healthcare reform and various healthcare policies more effectively, such as primary healthcare and cross-boundary healthcare services. The Government is taking forward the eHealth+ development in phases in accordance with the patient-centric principle and four strategic directions, namely, “One Health Record”, “One Care Journey”, “One Digital Front Door to Empowering Tool” and “One Health Data Repository”.

The reply to the question raised by the Hon CHAN Wing-kwong is as follows:

(1) The Hospital Authority (HA) is the technical agency for the development and operation of eHealth. The operational expenditure and the manpower incurred by the HA’s dedicated team (including health informatics staff, information technology (IT) staff and project management staff involved for overseeing and operating) in the past 3 years are as follows:

Financial Year	Operational Expenditure (\$ million)	Manpower (number of posts in HA)
2022-23 (Actual)	243.2	223
2023-24 (Actual)	265.8	223
2024-25 (Revised Estimate)	312.6	223

As for the Health Bureau, eHealth-related work is only part of the relevant staff’s duties. We do not maintain a breakdown on the relevant expenditure and manpower.

(2) In July 2024, the Finance Committee of the Legislative Council approved a commitment of \$1,395.8 million for the eHealth+ development from 2024-25 to 2028-29. eHealth+ is a highly complex and large-scale comprehensive healthcare information infrastructure programme and its development work requires extensive clinical expertise and experience in operating clinical management systems. Therefore, the HA will engage specialists with relevant qualifications to co-ordinate the five-year plan for eHealth+, particularly for developing and implementing the core projects. The estimated expenditure on the development team for 2025-26 is \$86 million. The team comprises 58 HA staff members, which include health informatics staff, IT staff and project management staff, covering different professions.

(3) and (4) As of end-February 2025, eHealth has covered over 80% of the Hong Kong population and the majority of public and private HCPs. The number of HCPs registered with eHealth by the type of organisation is tabulated as follows:

Type of HCPs	Number of HCPs Registered with eHealth (on an Organisational Basis)	Number of Healthcare Service Locations Registered with eHealth

Public hospitals (i.e. hospitals under the HA)	1	43
Public clinics (e.g. clinics under the HA and the Department of Health (DH))	11	390
Other public HCPs (e.g. District Health Centres)	20	217
Private hospitals	13	43
Other private HCPs (e.g. clinics, residential care homes for the elderly, and social welfare organisations providing healthcare services)	3 681	6 018
Total	3 726	6 711

Besides, as of end-February 2025, about 58 800 healthcare professionals (HCProfs) have registered with eHealth. The number and percentage of each type of HCProfs registered with eHealth are tabulated as follows:

Type of HCProfs	Number of HCProfs Registered with eHealth	Percentage of Registered HCProfs
Doctor	13 190	82%
Nurse	35 578	52%
Dentist	1 731	60%
Physiotherapist	2 260	49%
Radiographer	1 721	59%
Occupational Therapist	1 472	46%
Pharmacist	1 349	41%
Optometrist	330	14%
Medical Laboratory Technologist	230	5%
Chinese Medicine Practitioner	966	9%
Total	58 827	49%

(5) The Government has been actively promoting and facilitating eHealth registration to bring every citizen on board, including providing more registration channels. At present, all Hong Kong residents can register with eHealth online and use “iAM Smart” for identity verification to instantly create their eHealth accounts. Citizens can also register with eHealth in person at over 60 registration centres under the HA and DH or create their eHealth accounts at designated post offices in 18 districts across Hong Kong. Starting from February 2025, registered citizens can use the “My Family” function of the eHealth mobile application (eHealth App) for one-stop creation of eHealth accounts and identity verification for their children aged below 16. Besides, we have integrated the eHealth registration into certain health services provided by the DH (e.g. Maternal and Child Health Centres and the Human

Papillomavirus Vaccination Catch-up Programme) and required mandatory eHealth registration for citizens participating in the Public-Private Partnership (PPP) programmes (e.g. the Chronic Disease Co-Care Pilot Scheme). We will gradually expand this requirement to all government-funded programmes and all public healthcare services provided by the DH and HA.

Under the strategic development direction of “One Digital Front Door to Empowering Tool”, the eHealth App is positioned as a patient-centric integrated health tool for citizens to gain access to medical services at different locations, manage their health service processes, take control of their health information, monitor their health condition, prevent diseases and build a healthier lifestyle. At present, through the eHealth App, users are able to access 9 types of eHRs^{Note}, and may self-input health data (such as blood pressure, blood sugar and body mass index) to facilitate the monitoring of health condition. The eHealth App also provides functions on healthcare programme management (e.g. Elderly Health Care Voucher balance enquiry, test result of the Colorectal Cancer Screening Programme and membership card of District Health Centres), “Cross-boundary Health Record” and “Personal Folder” to facilitate citizen’s participation in government-subsidised or PPP programmes and their use of eHRs outside Hong Kong. The new “e+Life” health challenge platform under eHealth was also launched in September 2024 to complement the DH’s health promotion efforts, encouraging the general public to adopt a healthier lifestyle. As of end-February 2025, the application has recorded more than 3.7 million downloads and an average monthly login frequency of about 800 000.

Note: Including personal identification and demographic data, allergies and adverse drug reactions, encounters/appointments, immunisation records, medication, laboratory and radiology reports, healthcare referrals, observation and lifestyle records, and medical certificates.

The Government will continue to add and improve functions of the eHealth App. Among other things, we have developed the basic function of “eBooking” and will gradually extend the function to cover more primary healthcare services provided by the HA, the DH and other private healthcare organisations. To enable citizens to take control of their eHRs and those of their family members, we will gradually expand the scope of personalised eHRs accessible on the eHealth App, such as radiology images, Chinese medicine (CM) prescription records, dental check-up records and tooth conditions, etc. In addition, through the eHealth App, citizens will be able to manage records of more government-subsidised healthcare programmes, such as those under the “Primary Dental Co-care Pilot Scheme for Adolescents” launched in March 2025. We will continue to leverage various online and offline publicity channels (including social media, online communication platforms, promotional activities and posters) to encourage citizens to use the eHealth App in managing the health condition of their own and their family members.

(6) Since March 2022, eHealth has been supporting the deposit and sharing of CM information. At present, the CM information which can be shared includes CM diagnosis, procedures, prescriptions, dispensing, attendance and appointments as well as records of allergies and adverse drug reactions. Chinese medicine practitioners (CMPs) can join eHealth and, with patients’ sharing consent, view all their eHRs shared by other CMPs, as well as records of encounters and appointments, immunisation, allergies and adverse drug reactions that are shared by Western medicine (WM) practitioners on eHealth. As of end-February 2025, about 970 CMPs and about 500 CM service locations have registered with eHealth.

To facilitate the sharing of CM information on eHealth, the Government has developed EC Connect, a clinical management system for CM clinics, after taking into consideration the views of the CM sector and the actual operation of CM clinics. Apart from essential functions of a typical clinical management system such as patient registration and appointment, clinical documentation, prescriptions, dispensary and billing, EC Connect can record consultations on non-drug treatments such as acupuncture and bone-setting by CMPs. Officially launched in July 2022, EC Connect primarily supports the computerisation of the daily administration and clinical management of CM clinics in need, while providing a software choice for CM clinics in the sector to connect with eHealth to promote the sharing of CM clinical data. As of end-February 2025, about 160 CM clinics are using EC Connect. On the other hand, for CM clinics which are already using other clinical management systems in the market, we are working with the system solution vendors to co-fund system enhancements in achieving seamless sharing between these healthcare systems and eHealth, thereby enabling the CM sector to deposit citizens' CM clinical data into their eHealth accounts.

The Government is open to further expanding the sharable scope of eHRs on eHealth between CM and WM practitioners. Generally, healthcare institutions can only access the health data of patients under their care and with the patients' prior consent. eHRs are accessed in accordance with the respective clinical needs and roles of authorised users on a need-to-know basis. We have been discussing with the relevant CM and WM professional bodies on relevant issues, such as the types of eHRs on eHealth that need to be accessed by different HCProfs and the forms of access, including the relevance of different types of eHRs to the practice of different HCProfs, as well as the sector's stance about the professional and legal liabilities arising from accessing such records, etc. We will expand the scope of information sharable between CM and WM practitioners on eHealth as appropriate, after taking into account the relevant developments within the sector and the views of relevant CM and WM HCProfs, so as to better complement the relevant clinical services (e.g. integrated Chinese-Western medicine services), and to facilitate diagnosis and treatment, thereby enhancing healthcare quality and efficiency. We expect to progressively enable the sharing of CM and WM information on eHealth, when the first CM Hospital in Hong Kong commences services in phases from end-2025.

- End -

CONTROLLING OFFICER'S REPLY

HHB048

(Question Serial No. 2888)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

According to the Estimates, the Health Bureau (HHB) will continue efforts to promote breastfeeding during 2025-26. In this regard, will the Government please inform this Committee of:

- (1) the details of the promotion of breastfeeding by the HHB in the past 3 years, including the manpower and expenditure involved;
- (2) the details of the HHB's continuous efforts to promote breastfeeding in 2025-26, including the manpower and provision involved; and
- (3) whether the HHB has reviewed its promotion work regularly; if so, the details; if not, the reasons?

Asked by: Hon CHAN Wing-kwong (LegCo internal reference no.: 34)

Reply:

(1)

The Health Bureau (HHB) and the Department of Health (DH) have been promoting, protecting and supporting breastfeeding through a multi-pronged approach, including strengthening publicity and education on breastfeeding; implementing the Baby-Friendly Health Facilities accreditation programme in Maternal and Child Health Centres (MCHCs) to enhance the professional support to breastfeeding mothers after discharge from hospitals; encouraging the implementation of Breastfeeding Friendly Workplace policy to support working mothers to continue breastfeeding after returning to work; fostering the establishment of Breastfeeding Friendly Premises in public places so that the breastfeeding mothers can breastfeed their children or express milk anytime; imposing a mandatory requirement for the provision of babycare rooms and lactation rooms in the sale conditions of government land sale sites for new commercial premises; mandating the provision of babycare rooms and lactation rooms in some newly completed government premises; implementing the voluntary "Hong Kong Code of Marketing of Formula Milk and Related Products and Food Products for Infant and Young Children"; implementing the Breastfeeding Peer Support Scheme and train women with breastfeeding experience to support mothers in

breastfeeding as peers; and continuing the surveillance on local breastfeeding situation. In addition, the HHB and the DH also set up a working group under the Committee on Promotion of Breastfeeding to enhance and reinforce breastfeeding-friendly measures at public and private hospitals with obstetrics departments.

From 2022-23 to 2024-25, a breakdown of the expenditure incurred by the DH for promotion of breastfeeding is as follows:

Item	Expenditure		
	2022-23 (actual) (\$ million)	2023-24 (actual) (\$ million)	2024-25 (revised estimate) (\$ million)
Publicity or advocacy events for promoting breastfeeding (e.g. publicising or advocating through exhibitions, seminars, public transport, mass media and social media, etc.)	2.0	2.0	4.9 [^]
Production of promotional videos*	1.0	1.0	0.6
Production and dissemination of health education resources and guidelines [#]	1.0	1.0	0.9
Research and studies on breastfeeding-related promotion and services	0.9	1.0	0.8
Implementation of Breastfeeding Peer Support Scheme	1.1	1.0	1.4

* The videos are broadcast on television, radio and public transport.

[#] The health education materials and guidelines are distributed to MCHCs, public and private healthcare institutions, commercial institutions, non-government organisations etc., and are uploaded to the DH's website.

[^] In view of the drop in the local breastfeeding rate during the COVID-19 epidemic, the DH has allocated more resources in 2024-25 to publicise and advocate breastfeeding, including organising breastfeeding seminars, territory-wide publicity and promotional efforts through the mass media, etc.

(2)

In 2025-26, the Government will continue to work closely with different sectors of the society to promote, protect and support breastfeeding through different strategies. The key areas of work include:

- Of the 29 MCHCs under the DH, 8 of them have been accredited as Baby-Friendly Health Facilities. Except the North District MCHC which was newly opened in January 2025, accreditation procedures have commenced for the remaining 20 MCHCs. The MCHCs will formulate infant feeding policies and action plans, provide training for staff members, continue monitoring the implementation of breastfeeding support measures, etc. The DH will continue to expedite the accreditation of Baby-Friendly Health Facilities for MCHCs to strengthen the professional support offered by the healthcare institutions and staff members to breastfeeding mothers;

- Continuing to follow up on the relevant work with the working group under the Committee on Promotion of Breastfeeding to enhance and reinforce the breastfeeding-friendly measures at hospitals with obstetrics departments; and
- Stepping up publicity for breastfeeding through mass media and social media platforms with a view to cultivating a stronger supportive culture to breastfeeding in the community and create a breastfeeding-friendly environment.

For 2025-26, the Family Health Service (FHS) of the DH will receive a provision of \$6 million for promoting breastfeeding. The breastfeeding-related workload generated will be absorbed within the existing manpower resources of the FHS under the DH and therefore cannot be separately identified.

(3)

The DH has been regularly conducting surveys of the trend of local breastfeeding rates. According to the data in the past few years, there is a decline in the local breastfeeding rate, presumably due to the constraints imposed on the support services and promotion in hospitals, MCHCs and the community by various anti-epidemic measures implemented amid the COVID-19 epidemic. Notwithstanding, the breastfeeding rate on hospital discharge still reached 84% in 2023, marking a significant increase when compared to the 55% recorded in 2000. The rate of exclusive breastfeeding till 4 months of age also rose from 8% in 2000 to 22% in 2022. These reflected that the community is, in general, supportive of breastfeeding by virtue of the proactive and close collaboration between the Government and different sectors. As mentioned above, the Government will continue to work closely with various sectors of the community to promote, protect and support breastfeeding through a holistic strategy. In 2024-25, more resources have been allocated to publicise and advocate breastfeeding with a view to increasing the local breastfeeding rate.

- End -

CONTROLLING OFFICER'S REPLY

HHB049

(Question Serial No. 3266)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

According to the Estimates, one of the objectives of the Hospital Authority (HA) is to use hospital beds and clinics, staff, equipment and other resources efficiently to provide medical services of the highest standard within the resources available. In this connection, will the Government advise this Committee on the following:

- (1) the average waiting time for Accident & Emergency services, elective surgeries, and specialist outpatient services at all public hospitals under the HA in 2024-25; and
- (2) specific measures to be implemented in 2025-26 to shorten the waiting time of patients and enhance the service quality of public hospitals.

Asked by: Hon CHAN Wing-kwong (LegCo internal reference no.: 37)

Reply:

(1)

Accident and emergency (A&E) services

At present, there are 18 public hospitals under the Hospital Authority (HA) providing A&E services for the critically ill or seriously injured people and victims of disasters. To ensure that citizens with urgent needs can receive timely services, A&E departments implement a patient triage system under which patients are classified into 5 categories, namely Critical, Emergency, Urgent, Semi-urgent and Non-urgent based on their clinical conditions, and will receive treatment as prioritised by their urgency category. The HA's service target specifies that Critical patients (i.e. 100 percent) will receive immediate treatment while those categorised as Emergency and Urgent will also be given priority for receiving treatment upon arrival at A&E departments. The target is that most of the Emergency (95 percent) and Urgent (90 percent) patients will be treated within 15 and 30 minutes respectively. The HA has met its service targets for both Critical and Emergency patients, but the target achievement rate for Emergency cases is 76.6%, indicating that some emergency patients could not be treated within 30 minutes.

At present, patients triaged as critical, emergency and urgent are handled immediately and with priority according to the HA's performance targets. If the conditions of patients triaged as semi-urgent and non-urgent worsen while waiting, healthcare staff on site will assess whether the patients' triage category needs to be adjusted depending on the situation. In fact, since A&E departments aim to provide emergency medical services for patients with more urgent conditions, if A&E departments receive patients with more critical conditions, they will have to deploy healthcare staff to treat the more critical patients and patients triaged as semi-urgent or non-urgent will need to wait for a longer period of time.

The tables below set out the attendances and average waiting time for A&E services in various triage categories at the HA in 2024-25 (up to 31 December 2024).

	No. of A&E attendances				
	Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
2024-25 (up to 31 December 2024)	19 070	41 588	597 240	795 561	32 358

Note: The attendances for A&E services under various triage categories at the HA exclude (i) first-time visits without triage categories, and (ii) follow-up visits to the A&E departments.

	Average waiting time (minutes) for A&E services				
	Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
2024-25 (up to 31 December 2024)	0	8	25	164	190

Elective surgeries

The HA has not surveyed the waiting list and average waiting time for common elective surgeries performed in different specialty departments of its hospitals, given the wide range of surgeries performed and that patients' surgeries are accordingly scheduled depending on the urgency of the surgeries. The table below sets out the estimated waiting time range for some common elective surgeries performed at public hospitals in 2024-25 (up to 31 December 2024).

2024-25 (up to 31 December 2024)

Surgery	Range of estimated waiting time (month)
Herniorrhaphy	3 to 36
Cholecystectomy	3 to 34
Total Joint Replacement	59 to 80
Transurethral Resection of Prostate	3 to 22
Myomectomy	6 to 24

Surgery	Range of estimated waiting time (month)
Total Abdominal Hysterectomy +/- Bilateral Salpingectomy	8 to 24
Thyroidectomy	4 to 29
Haemorrhoidectomy	4 to 37
Anterior Cruciate Ligament Reconstruction	2 to 6
Tonsillectomy	4 to 20

Note:

1. The waiting time for the above common elective surgeries, except total joint replacement, refers to the estimated waiting time collected manually. There is no information available on fixed surgical appointments for estimating the waiting time for elective surgeries.
2. The waiting time for total joint replacement refers to the 90th percentile waiting time for patients who underwent the surgery in the past 12 months.

Specialist out-patient (SOP) services

The table below sets out the number of new SOP cases in the HA triaged as Priority 1 (urgent), Priority 2 (semi-urgent) and Routine (stable) as well as the respective median (50th percentile) waiting time in 2024-25 (up to 31 December 2024).

2024-25 (up to 31 December 2024)

Specialty	Priority 1		Priority 2		Routine	
	Number of new cases	Median waiting time (week)	Number of new cases	Median waiting time (week)	Number of new cases	Median waiting time (week)
ENT	11 677	<1	13 785	5	53 381	40
MED	7 433	1	19 910	6	90 378	48
GYN	5 312	<1	6 566	6	32 962	36
OPH	35 943	<1	22 858	5	57 736	64
ORT	11 262	<1	11 076	4	57 976	35
PAE	2 459	<1	4 762	5	16 337	17
PSY	1 676	1	6 935	3	31 255	41
SUR	10 552	1	23 747	6	111 885	40

(2)

Hong Kong's public hospitals has been one of the world's most efficient healthcare systems. The HA will continue promoting reforms to improve the service level of public hospitals. On 25 March this year, the Government announced the fees and charges reform for public healthcare which aims to guide the public to make optimal use of healthcare resources, reduce wastage and abuse, and enhance healthcare protection for "poor, acute, serious, critical" patients on all fronts, thereby enhancing the sustainability of the healthcare system.

The fees and charges reform for public healthcare covers the following 3 major areas:

1. Reforming the subsidisation structure: Reforming the subsidisation structure from a systemic perspective by setting the levels of government subsidisation and the proportion of co-payments by members of the public for various public healthcare services to rationalise the relative demands for in-patient, A&E, as well as different tiers of out-patient services;
2. Reducing waste and abuse: Introducing a co-payment model for non-urgent diagnostic radiology and pathology services, adjusting the charges for and quantities of standard drugs, making use of the fees and charges to drive changes to the public's behaviour in seeking medical treatment to guide the optimal use of resources; and
3. Enhancing healthcare protection: Strengthening protection for "poor, serious, critical" patients on all fronts by enhancing the fee waiver mechanism, introducing an annual cap on fees and charges at \$10,000, and increasing subsidies on drugs and medical devices for the critically ill, with a view to preventing "patients with serious conditions falling into poverty".

The HA will continue to promote reforms and strive to provide high quality and safe healthcare services to patients. Meanwhile, the HA has adopted various measures to proactively manage public hospital services, including the waiting time for A&E services, elective surgeries and SOP services.

A&E services

To further improve A&E's service quality and optimise the use of precious resources, the HA has actively implemented a series of measures including:

1. Strengthening manpower for doctors, nurses, allied health professionals and supporting staff where necessary so as to increase service capacity;
2. Enhancing support to A&E departments from geriatric departments and setting up observation areas in A&E departments to reduce unnecessary hospital admissions;
3. Centrally publishing the waiting time of A&E departments of public hospitals through multiple platforms, including the HA website, "HA Go" mobile application and A&E registration counters, to strengthen communication with the public and manage public expectations about the waiting time of A&E departments, such that patients with mild illnesses can decide whether to seek medical treatment in A&E departments;
4. Implementing special measures during service demand surges, including special refund arrangements at the A&E departments of public hospitals to provide patients in stable conditions with the flexibility in choosing alternative consultation arrangements; and
5. Providing the public with information on opening hours of general out-patient clinics and private clinics during service demand surges, to encourage patients with mild

illnesses to consider seeking treatment at general out-patient clinics or private doctors to alleviate the pressure on A&E departments.

Elective surgeries

When prioritising patients on the waiting list, the HA takes into account their clinical conditions and needs, and makes arrangements having regard to the urgency of their conditions. The HA has been closely monitoring the service demand and waiting time for patients, and taking measures actively to manage the waiting time for elective surgeries in order to cope with the increasing service demand more effectively.

The HA has also introduced a series of measures, such as adopting the high-volume surgical model, promoting non-surgical treatments, implementing public-private partnership programmes, enhancing transparency by displaying the waiting time for elective surgeries on the HA's website and continuing to increase service capacity for surgical services.

SOP services

The HA has been implementing a triage system for new referrals to SOP clinics to ensure that priority is given to treating patients in urgent conditions and requiring early intervention. Under the triage system, newly referred patients are usually screened by a nurse and then examined by a specialist doctor of the relevant department, before being classified into Priority 1 (urgent), Priority 2 (semi-urgent) and Routine (stable) cases. The HA's target is to keep the median waiting time for Priority 1 and Priority 2 cases within 2 weeks and 8 weeks respectively. The HA has been able to meet the target regarding the median waiting time for Priority 1 and Priority 2 cases, and will continue to implement this effective triage system to ensure timely treatment for patients most in need.

Apart from implementing the triage system, the HA has been taking measures actively to manage and improve the waiting time for SOP patients, such as enhancing public primary healthcare services, strengthening manpower, optimising appointment booking and scheduling, and displaying the latest waiting time on the HA's website and at SOP clinics to help patients consider their treatment plans and options. Under the strategy of "narrowing upstream, collaborating downstream, diverting midstream", the HA has introduced doctor-led multi-disciplinary integrated clinics, and will allocate more resources for new cases, streamline referral arrangements for cross-specialty cases, set up more integrated clinics to provide multi-disciplinary support, and enhance primary healthcare to follow up on patients in stable conditions.

The HA will review the effectiveness of these measures in a timely manner and implement supplementary measures as appropriate and necessary to further shorten the waiting time for SOP clinics.

Abbreviations

ENT – Ear, Nose and Throat

MED – Medicine

GYN – Gynaecology

OPH – Ophthalmology

ORT – Orthopaedics and Traumatology

PAE – Paediatrics
PSY – Psychiatry
SUR – Surgery

- End -

CONTROLLING OFFICER'S REPLY

HHB050

(Question Serial No. 2228)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in the Budget Speech that “in recent years, the Government has increased the number of medical training places on several occasions. The number of places will increase to 650 in the 2025/26 academic year. The public healthcare sector will leverage the revised legislative framework to admit non-locally trained healthcare professionals.” In this connection, will the Government inform this Committee of:

- (a) considering the many procedures and administrative costs (including for interviews and adaptive training) involved in the plan to admit non-locally trained healthcare professionals, the estimated annual recurrent expenditure;
- (b) the number of appointment letters issued to non-locally trained nurses in the past 3 years; and;
- (c) the Government's plan to ensure that the 650 additional medical training places will be effectively translated into actual manpower resources for the public healthcare system, the employment arrangements for these medical graduates, and the mechanism to co-ordinate with the Hospital Authority?

Asked by: Hon CHAN Wing-yan, JoePHY (LegCo internal reference no.: 26)

Reply:

(a)

The Department of Health (DH) and the Hospital Authority (HA) will leverage the revised legislative framework to attract non-locally trained healthcare talents from different regions to work in Hong Kong, and will provide them with training and development opportunities. The expenditure involved is subsumed under the overall provision of the DH and the HA, and hence no breakdown is available.

(b)

The Government amended the Nurses Registration Ordinance (Cap.164) in July 2024 to provide new pathways for admission of non-locally trained nurses (i.e. limited registration/enrolment nurses and special registration/enrolment nurses) for practising in Hong Kong. As at 31 December 2024, the HA has issued appointments letters to 79 non-locally trained nurses, 18 of whom have submitted applications for limited registration or special registration.

(c)

According to the Medical Registration Ordinance, medical graduates must be employed in a resident medical capacity and, after obtaining provisional registration, work for one year in an approved hospital or institution. Only upon obtaining a certificate of experience thereafter can they be granted full registration. At present, the HA will employ all medical graduates arranged by the 2 medical schools for internship training, and about 90% of them will continue to stay in the public healthcare system for specialist training. With the increase in the number of local medical graduates, the HA has accordingly increased the number of Resident Trainee posts, with a view to employing all qualified local medical graduates. The HA will review its manpower and continue to provide local medical graduates with training opportunities.

- End -

CONTROLLING OFFICER'S REPLY

HHB051

(Question Serial No. 2229)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is stated in the Budget Speech that the Greater Bay Area Clinical Trial Collaboration Platform jointly established by Hong Kong and Shenzhen is seeking to establish a Real-World Study and Application Centre (Centre) by the end of this year. In this connection, please advise this Committee on the following:

- (a) What are the upcoming estimated provisions and related funding allocations (in respect of equipment procurement, manpower provision and operating cost) for the Centre?
- (b) In the course of setting up and running the Centre, how will the Government attract and nurture research talent in relevant fields? What are the relevant talent attraction programmes and training arrangements?
- (c) How will the Government and its Shenzhen counterpart divide responsibilities and collaborate among themselves to ensure the smooth establishment and operation of the Centre? What are the roles of both sides and the coordination mechanism?

Asked by: Hon CHAN Wing-yan, JoePHY (LegCo internal reference no.: 27)

Reply:

The Chief Executive proposed in the 2024 Policy Address the establishment of the Real-World Study and Application Centre (Application Centre) to foster collaboration between Hong Kong and Shenzhen by integrating the data generated from the “special measure of using Hong Kong-registered drugs and medical devices used in Hong Kong public hospitals in the Greater Bay Area (GBA)”, and promote the conduct of real-world studies by leveraging this data, thereby expediting the approval for market launch of new drugs in Hong Kong, the Mainland and overseas.

By analysing real-world data such as electronic medical records, real-world studies make up for the limitations of traditional randomised controlled trials (such as long durations, high costs, and insufficient samples for rare disease) by providing the necessary scientific evidence for the evaluation of new drugs. The Application Centre will capitalize on Hong Kong's

advantage in medical data and promote the opening up of extensive and standardised local medical databases (including the integrated electronic medical record system of the Hospital Authority which encompasses an accumulated total of more than 11 million medical records over the years, and data from the Hong Kong Genome Project) to support clinical diagnosis and treatment, new drug development and public health research. At the same time, the “GBA Clinical Trial Collaboration Platform” will connect healthcare institutions across the GBA to integrate real-world data generated from the “special measure of using Hong Kong-registered drugs and medical devices used in Hong Kong public hospitals in the GBA”, which will facilitate the application of real-world studies in drug and medical device approvals, new drug development and other areas.

The establishment of the Application Centre is one of key initiatives by the Hong Kong Special Administrative Region Government to provide support on all fronts for research and development, clinical trials and application of advanced biomedical technology (including advanced therapy products) in Hong Kong. Through a series of measures such as deepening reform of the approval mechanism for drugs and medical devices, opening access to local medical databases, establishing highly efficient collaboration mechanisms across bureaux and departments, and strengthening medical collaboration within the GBA, the Government aims to improve the ecosystem for supporting the development of advanced biomedical technologies in Hong Kong, with a view to attracting world-leading innovative enterprises and research institutions to establish their presence in Hong Kong.

The Health Bureau (HHB) has earmarked approximately \$12 million in 2025-26 as the start-up resources for the first-phase work of establishing the Application Centre. The HHB is currently consulting key stakeholders as planned to formulate the detailed construction plans and estimates for the Application Centre, including the staffing for professional and supporting personnel, and other operational expenses. The Application Centre is expected to be established by the end of 2025.

- End -

CONTROLLING OFFICER'S REPLY

HHB052

(Question Serial No. 2230)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is stated under Matters Requiring Special Attention in 2025-26 that the Hospital Authority (HA) will, in accordance with the Primary Healthcare Blueprint, enhance the primary healthcare services at General Outpatient Clinics for the underprivileged, including introducing chronic disease screening services and strengthening nurse clinic services in consultation with the Primary Healthcare Commission. In this connection, please advise this Committee on the following:

- (a) Last year, a drug that was included in the national medical insurance catalogue and widely used for treating patients with chronic renal anaemia was successfully introduced to Hong Kong through the “1+” new drug approval mechanism. Will the Government allocate additional resources in 2025-26 to give the HA scope for including more similar drugs in the HA Drug Formulary and provide drug subsidies so that patients with chronic kidney disease can receive more suitable treatments? If yes, what are the relevant action plans, indicators for the tasks and estimated expenditure? If no, why not?
- (b) What were the details of treatment support, including the types of drugs used and the expenditure incurred, provided by public hospitals for patients with chronic renal anaemia in the past 3 years?
- (c) What were the numbers of referrals to public hospitals for specialist follow-up services in respect of chronic kidney disease, the number of patients hospitalised due to chronic kidney disease, and the number of cases of chronic renal anaemia complications associated with chronic kidney disease in the past 3 years?

Asked by: Hon CHAN Wing-yan, JoePHY (LegCo internal reference no.: 28)

Reply:

(a)

The Government heavily subsidises the healthcare services provided by public hospitals under the Hospital Authority (HA) to ensure that citizens are not denied adequate medical care due

to lack of means. As the major provider of publicly-funded public healthcare services, the HA allocates substantial resources to the provision of healthcare services and drugs every year, providing appropriate treatment to all patients (including chronic kidney disease patients) while ensuring patients have equitable access to cost-effective drugs of proven safety and efficacy under the highly subsidised public healthcare system.

The Government and the HA will press ahead with the implementation of the fees and charges reform for public healthcare announced recently, which aims to guide the public to make optimal use of healthcare resources through 3 aspects, namely reforming the subsidisation structure, reducing wastage and abuse, and enhancing healthcare protection. It also seeks to strengthen the healthcare protection on all fronts for patients who are “poor, acute, serious or critical”, with a view to ensuring that the limited healthcare resources can be directed in a more targeted manner to assist those patients most in need, thereby enhancing the sustainability of the healthcare system so as to cope with the challenges posed by an ageing population, inflation of healthcare cost, etc., and serve as a safety net for all.

As part of the healthcare reform, the HA will review the coverage of the HA Drug Formulary (HADF) and the safety net continuously to enhance patient protection. The HA will also actively evaluate new drugs, including those approved for registration in Hong Kong under the “1+” mechanism, thereby striving to expand the coverage of the HADF and facilitate good drugs for use in Hong Kong. The review process follows an evidence-based approach, having regard to the safety, efficacy and cost-effectiveness of drugs and other relevant considerations, including international recommendations and practices as well as professional views, so as to ensure equitable and effective use of public resources in providing optimal treatment for patients.

(b) and (c)

The table below sets out the numbers of patients with chronic kidney disease who received treatments in the HA from 2022 to 2024, and the numbers of hospital admissions among these patients in the reporting years.

	2022	2023	2024 ⁴
Number of patients with chronic kidney disease who received treatments in the HA ^{1, 2}	317 600	329 400	336 300
Number of hospital admissions among the above patients in the reporting years ^{2, 3}	141 200	155 600	160 000

Note:

1. Including patients with stage 3 or above chronic kidney disease who used the HA’s services in the year, but the services may not necessarily be targeted at treating diseases related to chronic kidney disease.
2. Figures are rounded to the nearest hundred.
3. The reasons for hospital admissions may not be related to chronic kidney disease.
4. The figures for 2024 are estimated figures.

At present, the drugs for treating chronic renal anaemia mainly include erythropoiesis-stimulating agents and iron supplements.

The table below sets out the numbers of patients with both end-stage kidney disease and anaemia who received treatments in the HA from 2022 to 2024, and the numbers of patients on drug treatments for anaemia.

	2022	2023	2024 ¹⁰
Number of patients with both end-stage kidney disease and anaemia who received treatments in the HA ^{5, 6, 7}	20 500	20 800	21 100
Number of the above patients on drug treatments for anaemia ^{7, 8, 9}	14 100	14 600	15 000

Note:

5. Including patients with end-stage kidney disease and anaemia who used the HA's services in the year, but the services may not necessarily be targeted at treating diseases related to end-stage kidney disease and anaemia.
6. There are various causes for anaemia, and end-stage kidney disease may be one of them.
7. Figures are rounded to the nearest hundred.
8. Including relevant patients on drug treatments using erythropoiesis-stimulating agents and/or iron supplements.
9. The drug treatment options are determined having regard to clinical conditions and patients' needs.
10. The figures for 2024 are estimated figures.

The HA deploys multi-disciplinary teams across various departments to treat patients with chronic diseases, including those diagnosed with chronic kidney disease and anaemia. Such patients may suffer from multiple chronic diseases, and doctors will arrange for different examinations and treatment options for them having regard to their individual conditions. As such, the HA does not maintain figures on the expenditure involved for the relevant treatments as requested in the question.

Note:

In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA adjusted its services to cope with the outbreak. This should be taken into consideration when comparing the service capacity of the HA in the years concerned. With the cessation of anti-epidemic measures in early 2023, the public healthcare services of the HA have gradually returned to full normalcy.

- End -

CONTROLLING OFFICER'S REPLY

HHB053

(Question Serial No. 2231)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in the Matters Requiring Special Attention in 2025-26 that the Government will oversee the establishment of the Hong Kong Centre for Medical Products Regulation and the roadmap towards “primary evaluation” for drugs and medical devices. In this connection, will the Government inform this Committee of the following:

(a) As there is still room for further enhancement regarding the evaluation speed as well as benefits and convenience for the public of the “1+” mechanism, has the Government set any specific indicators for the mechanism in 2025-26? If yes, what are the related work plan and estimated expenditure? If not, what are the reasons?

(b) The numbers of enquiries on the “1+” mechanism received by the Government, registration applications, successful registrations and pharmaceutical companies involved (set out by year) since the launch of the mechanism on 1 November 2023;

(c) For cases of registration applications made through the “1+” mechanism but eventually rejected since the launch of the mechanism on 1 November 2023, the specific reasons for the rejection (categorised and tabulated by different reasons); the number of cases of applications re-submitted for registration after rejection, along with the success rate of re-submission and the related data; and

(d) The number of drugs successfully registered through the “1+” mechanism and eventually included in the Hospital Authority Drug Formulary (HADF), the categories they belong to in the HADF, the cumulative number of persons prescribed with such drugs and the related expenditure data?

Asked by: Hon CHAN Wing-yan, Joephy (LegCo internal reference no.: 29)

Reply:

As mentioned in the Chief Executive’s 2023 Policy Address and the Chief Executive’s 2024 Policy Address, the Government of the Hong Kong Special Administrative Region (HKSAR) would enhance the approval and registration mechanism for drugs and establish an internationally renowned regulatory authority of drugs and medical devices (medical products). To this end, the HKSAR Government has set up the Preparatory Office for the Hong Kong Centre for Medical Products Regulation (CMPR) under the Department of Health (DH) in June 2024. The Preparatory Office is proactively reviewing the regulatory functions

on Chinese and Western medicines and medical devices under the DH, and studying the potential restructuring and strengthening of the current regulatory and approval regimes for medical products and medical technologies. The Preparatory Office will also put forward proposals and steps for the establishment of the CMPR which will be a step towards the transition to the “primary evaluation” approach in approving applications for registration of new medical products. This will help accelerate the clinical application of new medical products, and foster the development of emerging industries relating to the research and development and testing of medical products. The Preparatory Office is drawing up the timetable for establishing the CMPR and the roadmap towards adoption of “primary evaluation”, which will be announced in the first half of 2025 as planned.

(a), (b) and (c)

According to the Pharmacy and Poisons Ordinance (Cap. 138), pharmaceutical products must satisfy the criteria of safety, efficacy and quality, and registered with the Pharmacy and Poisons Board of Hong Kong (the Board) before they can be sold or supplied in the HKSAR. The DH is responsible for providing professional and administrative support to the Board, including the approval of drugs. Applications for registration of pharmaceutical products (including new drugs) need to be initiated by pharmaceutical companies. Applicants for registration of pharmaceutical products are required to submit the necessary documents in accordance with the Guidance Notes on Registration of Pharmaceutical Products/Substances as promulgated by the Board. In general, applicants for registration of new drugs are required to provide necessary information including documentary proof for registration issued by at least two drug regulatory authorities of reference places in accordance with the Guidance Notes on Registration of Pharmaceutical Products Containing a New Chemical or Biological Entity as promulgated by the Board, in order to provide supporting evidence that the product has been rigorously evaluated before placing in the market (i.e. the “secondary evaluation” approach).

To enhance the drug regulatory regime and adopt “primary evaluation” approach in the long run, the Board launched the “1+” mechanism on 1 November 2023 and has widened its applicability to all new drugs with effect from 1 November 2024. For pharmaceutical products containing new chemical or biological entities, if they are supported with local clinical data and their scopes of application are recognised by local relevant experts, the applicants are only required to submit approval from one reference drug regulatory authority (instead of two or more) for application for registration in Hong Kong. Besides, to enhance the efficiency in new drug approval, the DH held the first briefing seminar on the “1+” mechanism for new drugs in March this year. The DH will also organise workshops starting from June and offer to hold pre-NDA meetings with potential “1+” registration applicants starting from the second half of this year onwards. These assist applicants in processing their applications of registration through advanced consultation. The Board has also put in place a “stop-clock” mechanism to enhance the transparency of the processing time. The target processing time for applications for registration has been set at 150 working days, excluding the response time of the applicants.

Since the implementation of the “1+” mechanism (as at 28 February 2025), the DH has received more than 390 enquiries from 110 pharmaceutical companies, including those from overseas and the Mainland. Under the mechanism, the Board has approved 11 new drugs, including six for the treatment of cancer, one for the treatment of haematology, two for the

treatment of hypercalcaemia and two for the treatment of anaemia caused by chronic kidney disease, bringing new hope for treatment to patients and facilitating good drugs for use in Hong Kong. The Board has not rejected any application for registration submitted under the mechanism so far. Details are tabulated below:

	2023 (since 1 November*)	2024#	2025 (as at 28 February)	Total number (number of pharmaceutical companies^)
Number of enquiries on the “1+” mechanism	117	247	29	393 (110)
Number of “1+” applications for registration of new drugs received	2	11	1	14 (7)
Number of “1+” registrations of new drugs approved	2	7	2	11 (5)

- Note: * The “1+” mechanism, applicable to new drugs treating life-threatening or severely debilitating diseases, came into effect on 1 November 2023.
 # The “1+” mechanism has been extended to all new drugs, including vaccines and advanced therapy products since 1 November 2024.
 ^ A pharmaceutical company might make more than one enquiry or submit more than one application at different times.

(d)

The following table sets out the drugs approved for registration in Hong Kong under the “1+” mechanism and included in the Hospital Authority Drug Formulary (HADF), their purposes of treatment and their categories in the HADF as at 28 February 2025:

	Hong Kong Registration No.	Purposes of treatment	Category of Drugs
1.	HK-68111	Metastatic colorectal cancer	Special Drugs
2.	HK-68112		
3.	HK-68402	Paroxysmal nocturnal haemoglobinuria	Self-financed Item covered by Community Care Fund (CCF) Medical Assistance Programme

The above two drugs for treating metastatic colorectal cancer have been categorised as special drugs in the HADF since October 2024, and patients are only required to pay the standard fee (currently \$15 for each drug for a maximum dispensing limit of 16 weeks) if these two drugs

are prescribed under specified clinical indications. The drug for treating paroxysmal nocturnal haemoglobinuria has been included in the HADF as an item supported by the CCF Medical Assistance Programme since January this year, and patients who meet specific clinical criteria and are facing financial difficulties will receive financial assistance on the relevant drug expenses. In introducing the above three drugs, the Hospital Authority (HA) succeeded not only in reducing the procurement cost of the drugs by nearly 30% after price negotiation, but also in triggering a voluntary price reduction of nearly 40% in another HADF drug for treating paroxysmal nocturnal haemoglobinuria, thereby effectively enhancing the cost-effectiveness of the drugs as well as making better use of public resources. Since the inclusion of these drugs in the HADF, as at 28 February 2025, about 300 HA patients had been prescribed with the drugs, involving a drug expenditure of about \$8.4 million.

The HA will review the coverage of the HADF and the safety net on an on-going basis in accordance with the established mechanism, and actively evaluate new drugs approved for registration in Hong Kong under the “1+” mechanism, with a view to expanding the coverage of the HADF and facilitating good drugs for use in Hong Kong. The review process follows an evidence-based approach, having regard to the safety, efficacy, cost-effectiveness and other relevant considerations, which include international recommendations and practices, professional views, etc., so as to ensure equitable and effective use of public resources in providing optimal treatment for patients.

- End -

CONTROLLING OFFICER'S REPLY

HHB054

(Question Serial No. 2232)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

To provide convenience for people living in Guangdong or Macao with needs for drugs and medical devices, the Guangdong Provincial Government launched the “measure of using Hong Kong registered drugs and medical devices used in Hong Kong public hospitals in the Guangdong-Hong Kong Macao Greater Bay Area (GBA)” (the Measure) in co-ordination with the governments of the Special Administrative Region of Hong Kong and Macao in September 2021. As at December 2024, 45 drugs and 47 medical devices (3 batches in total) were approved for use by patients in the 45 designated healthcare institutions through the Measure. With regard to the following, will the Government inform this Committee:

- (a) of the annual expenditures and staffing allocation for implementing the Measure in the past 3 years; whether the Government will consider increasing the estimated provision in the future so as to expand the scope or enhance the effectiveness of the Measure;
- (b) of the respective numbers of cases involving the use of approved drugs and medical devices by Hong Kong residents living in Guangdong or Macao in the past 3 years; and
- (c) whether the Government has submitted bulk applications by disease area deemed suitable so that more drugs will be allowed for use in designated hospitals/healthcare institutions in the Mainland cities of the GBA?

Asked by: Hon CHAN Wing-yan, Joephy (LegCo internal reference no.: 30)

Reply:

(a), (b) and (c)

The National Medical Products Administration announced the Work Plan for Regulatory Innovation and Development of Pharmaceutical and Medical Device in the Guangdong-Hong Kong Macao Greater Bay Area (GBA) in November 2020. It allows designated healthcare institutions operating in the Mainland cities of the GBA to use drugs registered in Hong Kong and Macao with urgent clinical use, and medical devices used in Hong Kong and Macao public hospitals with urgent clinical use, subject to the approval of the Guangdong Province.

This policy is known as the “measure of using Hong Kong registered drugs and medical devices used in Hong Kong public hospitals in the GBA” (the Measure).

The Measure is a national policy under the purview of the Guangdong Provincial Medical Products Administration (GDMPA), which is responsible for, inter alia, evaluating and approving drugs and medical devices under the Measure. As at 28 February 2025, 49 drugs and 48 medical devices have been allowed to be used in 45 designated healthcare institutions through the Measure, which is a significant increase as compared with the time when the current-term Government took office (i.e. 20 drugs and 13 medical devices allowed to be used in 5 healthcare institutions).

The Government of the Hong Kong Special Administrative Region (HKSAR Government) maintains constant liaison and co-operation with relevant Mainland authorities and the GDMPA, effectively utilising the national policy of the Measure to enable more dealers of drugs and medical devices to enter the Mainland market through Hong Kong, thereby providing more choices for patients. In addition, the Government facilitates the implementation of the Measure by allocation of internal resources to introduce the Measure to overseas pharmaceutical companies and government departments, and maintains close communication with the Mainland authorities on the implementation and enhancement of the Measure. The Health Bureau does not maintain relevant statistical breakdowns on the expenditures and staffing allocation. The approved drugs and medical devices under the Measure can be used in designated healthcare institutions in the GBA by all applicable patients. The Health Bureau does not maintain statistics on the use of approved drugs and medical devices under the Measure in these institutions by Hong Kong residents.

The HKSAR Government will continue to closely communicate with the relevant Mainland approval authorities on the Measure and the progress of Hong Kong in reforming the approval mechanism for drugs and medical devices and developing into an international health and medical innovation hub, with a view to enabling more qualified Hong Kong drugs and medical devices to be used in designated healthcare institutions operating in the Mainland cities of the GBA.

- End -

CONTROLLING OFFICER'S REPLY

HHB055

(Question Serial No. 0179)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

1. Please list, by each cluster of the Hospital Authority, the average waiting time and the longest waiting time for specialist outpatient services in the past 3 years (2022, 2023 and 2024).
2. Please list the additional quotas for consultation at general outpatient clinics, specialist outpatient clinics and Accident and Emergency departments, as well as the quotas for general outpatient services, in hospitals of all clusters in 2024-25.

Asked by: Hon CHEUNG Yu-yan, Tommy (LegCo internal reference no.: 20)

Reply:

1.

The tables below set out the number of specialist out-patient (SOP) new cases triaged as Priority 1 (urgent), Priority 2 (semi-urgent) and Routine (stable) cases, and their respective median (50th percentile) and longest (90th percentile) waiting time in each hospital cluster of the Hospital Authority (HA) in 2022-23, 2023-24 and 2024-25 (up to 31 December 2024).

Hospital Cluster	Specialty	Priority 1			Priority 2			Routine Cases		
		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)	
			50th	90th		50th	90th		50th	90th
			percentile			percentile			percentile	
HKEC	ENT	488	<1	<1	3 502	4	7	4 910	14	77
	MED	963	1	1	3 178	5	7	10 668	48	94
	GYN	695	<1	1	541	6	8	3 904	25	28
	OPH	4 482	<1	1	3 041	5	8	7 584	52	85
	ORT	1 311	1	1	1 293	5	7	6 688	55	92
	PAE	76	1	2	673	4	7	286	9	14
	PSY	302	<1	1	897	3	7	3 296	19	60
	SUR	999	1	2	3 168	7	8	10 867	46	84
HKWC	ENT	961	<1	1	2 085	7	7	3 605	65	83
	MED	1 802	<1	1	1 793	4	8	11 414	34	105
	GYN	1 244	<1	1	907	6	7	3 859	34	50
	OPH	2 454	1	2	1 777	4	8	6 669	55	75
	ORT	1 265	1	2	1 409	4	7	7 808	20	84
	PAE	103	<1	1	361	5	7	1 122	11	17
	PSY	363	1	2	687	4	7	1 920	41	87
	SUR	2 441	<1	2	2 999	4	7	10 716	26	86
KCC	ENT	1 985	<1	1	2 088	4	7	13 181	37	93
	MED	1 210	1	1	3 593	6	7	21 992	71	96
	GYN	934	<1	1	2 944	6	7	7 482	30	64
	OPH	6 983	<1	1	6 604	2	4	10 388	71	86
	ORT	1 978	1	1	1 977	4	7	11 819	51	98
	PAE	1 145	<1	1	1 605	4	7	2 748	10	25
	PSY	195	<1	1	1 318	4	7	2 347	18	55
	SUR	2 561	1	2	5 434	5	10	27 365	37	111
KEC	ENT	1 611	<1	1	2 606	6	7	6 742	86	92
	MED	1 804	1	2	4 788	6	8	19 030	58	108
	GYN	1 574	1	1	834	4	7	5 798	57	78
	OPH	5 520	<1	1	5 238	6	7	10 786	71	97
	ORT	2 975	<1	1	2 571	3	7	9 969	71	95
	PAE	731	<1	1	531	4	7	2 959	10	44
	PSY	265	1	2	2 322	3	7	5 238	52	95
	SUR	1 814	1	1	5 204	7	7	18 083	71	105

Hospital Cluster	Specialty	Priority 1			Priority 2			Routine Cases		
		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)	
			50th	90th		50th	90th		50th	90th
			percentile			percentile			percentile	
KWC	ENT	2 024	<1	1	2 303	5	7	10 662	62	97
	MED	1 752	1	2	5 585	6	8	15 897	72	95
	GYN	222	<1	2	1 595	6	7	7 468	46	88
	OPH	6 194	<1	<1	5 886	5	23	9 144	167	216
	ORT	1 860	<1	2	3 251	4	7	12 632	54	79
	PAE	1 334	<1	1	1 138	4	7	2 840	9	19
	PSY	232	<1	1	909	4	7	13 129	29	93
	SUR	1 874	1	2	5 953	5	7	21 840	52	100
NTEC	ENT	2 469	<1	1	3 040	4	7	12 300	50	89
	MED	2 407	<1	2	3 201	6	8	21 681	48	114
	GYN	2 216	<1	1	981	6	8	7 629	57	89
	OPH	6 635	<1	2	4 053	4	8	15 941	52	96
	ORT	4 524	<1	1	1 360	4	7	14 346	45	86
	PAE	107	<1	2	407	6	11	3 701	16	29
	PSY	828	1	2	2 427	4	7	6 342	64	93
	SUR	2 166	1	2	2 992	5	8	26 850	32	75
NTWC	ENT	3 808	<1	1	1 380	4	7	8 828	61	76
	MED	1 013	<1	1	2 404	6	7	9 591	38	80
	GYN	1 169	<1	1	353	6	8	4 814	62	66
	OPH	10 901	<1	1	3 449	4	7	8 243	59	88
	ORT	1 896	1	2	1 793	6	7	9 791	31	76
	PAE	265	<1	1	1 059	6	7	1 951	23	32
	PSY	377	1	1	1 459	3	7	6 027	55	87
	SUR	1 986	1	2	5 057	5	8	18 527	49	78
Overall HA	ENT	13 346	<1	1	17 004	5	7	60 228	50	93
	MED	10 951	1	2	24 542	6	7	110 273	54	102
	GYN	8 054	<1	1	8 155	6	7	40 954	39	80
	OPH	43 169	<1	1	30 048	4	8	68 755	55	100
	ORT	15 809	<1	1	13 654	4	7	73 053	48	91
	PAE	3 761	<1	1	5 774	4	7	15 607	12	29
	PSY	2 562	1	1	10 019	4	7	38 299	40	91
	SUR	13 841	1	2	30 807	5	8	134 248	46	101

Hospital Cluster	Specialty	Priority 1			Priority 2			Routine Cases		
		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)	
			50th	90th		50th	90th		50th	90th
			percentile			percentile			percentile	
HKEC	ENT	394	<1	<1	3 903	4	7	5 701	14	57
	MED	699	1	2	3 412	5	7	11 750	37	91
	GYN	662	<1	1	559	6	8	3 903	25	32
	OPH	4 817	<1	1	3 799	7	8	8 817	42	85
	ORT	1 247	1	1	1 314	5	7	6 329	51	87
	PAE	43	<1	2	834	6	8	522	12	19
	PSY	240	1	1	766	3	7	3 655	26	86
	SUR	878	1	2	3 078	7	8	11 116	44	85
HKWC	ENT	1 154	<1	1	2 466	7	7	3 802	26	58
	MED	1 776	<1	1	1 946	4	7	11 123	30	83
	GYN	1 431	<1	1	1 046	5	7	3 385	27	51
	OPH	2 433	1	2	1 714	6	8	6 607	61	66
	ORT	1 023	1	2	1 759	4	7	8 267	20	89
	PAE	96	1	1	306	4	7	1 444	16	19
	PSY	348	1	2	811	4	7	1 914	40	83
	SUR	2 570	<1	2	3 218	5	7	11 190	17	69
KCC	ENT	1 991	<1	1	2 218	4	8	13 327	38	85
	MED	1 451	1	1	4 220	6	7	24 333	57	94
	GYN	924	<1	1	2 885	6	7	8 097	35	78
	OPH	7 328	<1	1	6 380	2	4	13 655	85	101
	ORT	1 307	1	1	2 378	3	7	11 901	36	98
	PAE	1 090	<1	1	1 930	6	7	3 480	12	40
	PSY	271	<1	1	1 204	3	6	2 394	20	81
	SUR	2 369	1	2	5 907	5	8	29 556	33	111
KEC	ENT	1 996	<1	1	2 959	4	7	7 932	70	91
	MED	1 346	1	2	5 059	5	7	21 385	56	94
	GYN	1 465	1	1	905	5	7	5 447	36	81
	OPH	5 764	<1	1	5 464	6	7	12 707	84	102
	ORT	3 233	<1	1	2 147	4	7	11 351	57	75
	PAE	718	<1	1	545	4	7	3 544	12	59
	PSY	272	1	1	2 066	3	7	5 455	47	91
	SUR	1 953	1	1	5 616	6	7	19 290	59	106

Hospital Cluster	Specialty	Priority 1			Priority 2			Routine Cases		
		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)	
			50th	90th		50th	90th		50th	90th
			percentile			percentile			percentile	
KWC	ENT	2 517	<1	1	2 966	4	7	12 440	33	99
	MED	1 631	1	2	6 007	6	8	16 300	62	94
	GYN	181	<1	1	1 696	6	7	7 475	58	94
	OPH	6 357	<1	<1	4 887	5	12	7 961	74	180
	ORT	2 086	<1	2	2 672	3	7	13 386	50	92
	PAE	1 259	<1	1	1 167	6	7	3 199	11	22
	PSY	256	<1	1	795	3	7	12 947	26	95
	SUR	1 872	1	2	5 506	5	8	23 999	53	97
NTEC	ENT	2 404	<1	1	3 104	5	8	13 897	36	92
	MED	1 876	1	2	3 283	6	8	20 158	40	85
	GYN	2 057	<1	1	1 028	5	7	7 687	59	85
	OPH	7 005	<1	2	3 444	4	8	18 595	78	101
	ORT	4 632	<1	1	1 419	5	7	14 818	58	90
	PAE	93	<1	2	394	7	8	4 759	23	45
	PSY	829	1	2	2 310	4	8	6 701	73	97
	SUR	2 246	1	2	3 236	5	8	27 342	30	86
NTWC	ENT	4 317	<1	1	1 743	4	7	10 089	35	69
	MED	1 309	<1	1	2 517	6	7	10 474	27	65
	GYN	1 062	<1	1	314	5	8	5 030	60	62
	OPH	11 555	<1	1	6 686	3	7	8 051	82	93
	ORT	2 006	1	2	1 990	6	7	9 961	36	58
	PAE	210	1	1	1 052	6	7	2 929	21	26
	PSY	390	1	1	1 597	3	7	5 873	34	95
	SUR	1 947	1	1	4 625	5	8	19 741	35	91
Overall HA	ENT	14 773	<1	1	19 359	5	7	67 188	36	92
	MED	10 088	1	2	26 444	6	7	115 523	49	92
	GYN	7 782	<1	1	8 433	5	7	41 024	39	82
	OPH	45 259	<1	1	32 374	4	8	76 393	66	102
	ORT	15 534	<1	1	13 679	4	7	76 013	45	89
	PAE	3 509	<1	1	6 228	6	7	19 877	15	41
	PSY	2 606	1	1	9 549	3	7	38 939	40	93
	SUR	13 835	1	2	31 186	5	8	142 234	40	98

2024-25 (up to 31 December 2024)

Hospital Cluster	Specialty	Priority 1			Priority 2			Routine Cases		
		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)	
			50th	90th		50th	90th		50th	90th
			percentile			percentile			percentile	
HKEC	ENT	491	<1	1	2 568	5	7	4 519	26	51
	MED	586	1	2	2 496	5	7	9 484	29	91
	GYN	481	<1	1	366	7	8	3 091	25	33
	OPH	3 517	<1	1	2 718	7	8	6 270	30	90
	ORT	926	1	1	975	5	7	5 254	30	58
	PAE	40	<1	1	679	6	7	436	15	24
	PSY	106	1	1	437	3	6	3 037	39	84
	SUR	693	1	2	2 545	7	8	8 724	39	87
HKWC	ENT	929	<1	1	1 907	7	7	3 148	41	49
	MED	1 319	<1	2	1 729	4	7	8 581	30	79
	GYN	1 176	1	2	899	5	6	2 627	28	50
	OPH	2 040	1	2	1 229	6	8	4 086	61	65
	ORT	692	1	2	1 498	4	7	5 991	23	70
	PAE	59	1	2	207	4	7	1 185	20	23
	PSY	230	1	2	569	3	7	1 522	42	91
	SUR	1 916	<1	2	2 641	4	7	8 889	19	71
KCC	ENT	1 272	<1	1	1 388	4	7	10 035	40	71
	MED	1 002	1	1	3 190	6	7	18 566	61	94
	GYN	713	<1	1	2 295	6	7	6 464	31	90
	OPH	5 717	<1	1	4 759	3	5	10 007	91	100
	ORT	789	1	2	1 993	4	7	8 659	24	92
	PAE	869	<1	1	1 742	5	7	3 468	10	43
	PSY	212	<1	<1	925	3	4	1 813	21	90
	SUR	1 685	1	2	4 296	5	8	23 396	37	102
KEC	ENT	1 472	<1	1	1 993	4	7	7 131	80	81
	MED	922	1	2	3 331	6	8	15 866	47	91
	GYN	1 000	1	1	785	5	7	4 508	31	87
	OPH	4 738	<1	1	4 216	7	7	9 079	74	100
	ORT	2 324	<1	1	1 494	5	7	8 781	51	73
	PAE	498	<1	1	446	4	6	2 715	11	41
	PSY	197	1	1	1 353	3	5	4 520	45	84
	SUR	1 506	1	1	4 277	6	7	14 463	58	99

Hospital Cluster	Specialty	Priority 1			Priority 2			Routine Cases		
		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)	
			50th	90th		50th	90th		50th	90th
			percentile			percentile			percentile	
KWC	ENT	2 523	<1	1	2 378	4	7	8 901	39	80
	MED	1 039	1	2	4 351	6	7	12 486	67	93
	GYN	149	<1	1	1 259	6	7	5 982	70	96
	OPH	4 820	<1	<1	3 807	8	16	7 815	35	185
	ORT	1 399	1	2	2 132	3	7	10 150	53	76
	PAE	781	<1	1	503	6	7	3 015	17	25
	PSY	158	<1	1	395	2	6	10 266	25	91
	SUR	1 303	1	2	3 931	5	8	19 591	58	101
NTEC	ENT	1 900	<1	1	2 570	5	7	10 775	31	74
	MED	1 407	1	2	2 778	6	7	16 953	49	86
	GYN	1 475	<1	1	689	5	7	6 066	61	87
	OPH	5 556	<1	2	2 815	6	8	13 958	74	114
	ORT	3 581	<1	1	1 493	5	8	10 716	29	73
	PAE	72	<1	1	293	6	8	3 502	36	50
	PSY	482	1	1	1 858	4	7	5 531	78	103
	SUR	2 147	1	2	2 767	5	8	20 216	32	90
NTWC	ENT	3 090	<1	1	981	5	7	8 872	52	54
	MED	1 158	<1	1	2 035	6	7	8 442	38	75
	GYN	318	<1	1	273	4	7	4 224	58	61
	OPH	9 555	<1	1	3 314	4	7	6 521	75	87
	ORT	1 551	1	2	1 491	6	7	8 425	33	64
	PAE	140	<1	1	892	5	7	2 016	28	31
	PSY	291	<1	1	1 398	2	7	4 566	39	81
	SUR	1 302	1	1	3 290	5	8	16 606	39	65
Overall HA	ENT	11 677	<1	1	13 785	5	7	53 381	40	79
	MED	7 433	1	2	19 910	6	7	90 378	48	91
	GYN	5 312	<1	1	6 566	6	7	32 962	36	87
	OPH	35 943	<1	1	22 858	5	8	57 736	64	108
	ORT	11 262	<1	1	11 076	4	7	57 976	35	73
	PAE	2 459	<1	1	4 762	5	7	16 337	17	43
	PSY	1 676	1	1	6 935	3	7	31 255	41	91
	SUR	10 552	1	2	23 747	6	8	111 885	40	96

Note:

- (1) The HA uses 90th percentile to denote the longest waiting time for SOP services.
- (2) With effect from 1 October 2022, the waiting time for new case booking at integrated clinics has been incorporated in those at SOP clinics.
- (3) In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA has adjusted its services to cope with the outbreak. This should be taken into consideration when comparing the service capacity of the HA in relevant years. With the cessation of anti-epidemic measures in early 2023, the HA's services have returned to normality gradually.

2.

As regards general out-patient (GOP) services, the target number of additional attendances at all the HA's general out-patient clinics (GOPCs) in 2024-25 was 9 500. The HA will, later on in this financial year, commence the preparatory work for the successive commissioning of the newly-built GOPCs/Community Health Centres (CHCs), such as the CHC in the New Acute Hospital in Kai Tak Development Area and the GOPC in the Joint-user Government Office Building in Tseung Kwan O Area 67, with the aim to providing additional GOP attendances in 2025-26.

As for SOP services, the target number of total additional attendances at the HA's SOP clinics in 2024-25 was 22 000.

With respect to the services of accident and emergency (A&E) departments, to ensure that citizens with urgent needs can receive timely services, A&E departments implement a patient triage system under which patients are classified into 5 categories, namely Critical, Emergency, Urgent, Semi-urgent and Non-urgent, based on their clinical conditions, and will receive treatment as prioritised by their urgency category. The HA's service target specifies that all Critical patients (i.e. 100 per cent) will receive immediate treatment while those categorised as Emergency and Urgent will also be given priority for receiving treatment upon arrival at A&E departments. The target is that most of the Emergency (95 per cent) and Urgent (90 per cent) patients will be treated within 15 and 30 minutes respectively. A&E departments prioritise treatment of patients and the injured with urgent need and there is no service quota. The HA has met its service targets for both Critical and Emergency patients, but the target achievement rate for Emergency cases is 76.6%, indicating that some emergency patients could not be treated within 30 minutes.

Abbreviations

Specialty

ENT – Ear, Nose & Throat

MED – Medicine

GYN – Gynaecology

OPH – Ophthalmology

ORT – Orthopaedics & Traumatology

PAE – Paediatrics

PSY – Psychiatry

SUR – Surgery

Cluster

HKEC – Hong Kong East Cluster

HKWC – Hong Kong West Cluster

KCC – Kowloon Central Cluster

KEC – Kowloon East Cluster

KWC – Kowloon West Cluster

NTEC – New Territories East Cluster

NTWC – New Territories West Cluster

- End -

CONTROLLING OFFICER'S REPLY

HHB056

(Question Serial No. 0180)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the manpower and remuneration package of the Hospital Authority (HA), please provide the following details:

1. the respective total numbers of doctors, nurses and allied health professionals in 2024-25, and their respective manpower shortfall in the same year;
2. in table form, the wastage rates of doctors in 2022-23, 2023-24 and 2024-25 by department;
3. in table form, the numbers of non-locally trained doctors recruited under limited registration in 2024-25 by department;
4. in table form, the respective salary expenditures on doctors, nursing staff, allied health professionals and care-related support staff in 2024-25; and
5. the remunerations of key management personnel in 2022-23, 2023-24 and 2024-25 respectively, and the percentage of such expenses in HA's overall remuneration expenditure in each year.

Asked by: Hon CHEUNG Yu-yan, Tommy (LegCo internal reference no.: 21)

Reply:

1.
The Hospital Authority (HA) delivers healthcare services through a multi-disciplinary team approach involving doctors, nurses, allied health (AH) professionals and care-related support staff. The HA regularly assesses the manpower situation and flexibly deploys its staff having regard to the service and operational needs.

In 2024-25, there were had 7 140 doctors, 29 580 nurses and 10 050 AH professionals (revised estimates) in the HA. The attrition (wastage) rate for full-time doctors in 2024-25 was 5.2% (rolling 12 months from January to December 2024), equivalent to 350 full-time doctors. For nurses, the attrition (wastage) rate for full-time nurses in 2024-25 was 7.5% (rolling 12 months from January to December 2024), equivalent to 2 033 full-time nurses. For AH professionals, the attrition (wastage) rate for full-time AH professionals in 2024-25 was 5.8% (rolling 12 months from January to December 2024), equivalent to 537 full-time AH professionals.

Note:

- (1) Attrition (Wastage) includes all types of cessation of service (including retirement) from HA for permanent and contract staff on headcount basis.
- (2) Rolling Attrition (Wastage) Rate = (Total number of staff left HA in the past 12 months / Average strength in the past 12 months) x 100%
- (3) From January 2024 onwards, the attrition (wastage) figures have excluded the number of staff under the Extending Employment Beyond Retirement (EER) arrangement. The relevant figures prior to that month can only be taken as references and are not directly comparable to those figures compiled with the now revised method.
- (4) Doctors exclude Interns and Dental Officers.
- (5) Nurses include Senior Nursing Officers, Department Operations Managers, Nurse Consultants, Associate Nurse Consultants, Ward Managers, Nursing Officers, Advanced Practice Nurses, Registered Nurses, Enrolled Nurses, Nurse Trainees, etc.
- (6) AH professionals include radiographers, medical technologists/medical laboratory technicians, occupational therapists, physiotherapists, pharmacists, medical social workers, etc.

2.

The table below sets out the attrition (wastage) rates of full-time doctors by major specialty and by rank in 2022-23, 2023-24 and 2024-25 (rolling 12 months from January to December 2024) ⁽¹⁾⁽²⁾⁽³⁾.

Major specialty	2022-23			
	Consultant	Senior Medical Officer/ Associate Consultant	Medical Officer/ Resident	Overall
Accident & Emergency	5.5%	11.7%	8.9%	9.5%
Anaesthesia	9.2%	11.3%	4.2%	7.5%
Cardiothoracic Surgery	29.4%	0.0%	5.8%	10.4%
Family Medicine	3.4%	6.7%	8.4%	7.7%
Intensive Care Unit	7.9%	7.9%	3.9%	5.9%
Internal Medicine	6.4%	9.1%	4.1%	6.0%
Neurosurgery	12.9%	0.0%	3.7%	4.9%
Obstetrics & Gynaecology	10.6%	16.8%	4.7%	9.4%
Ophthalmology	6.9%	21.7%	1.0%	7.6%
Orthopaedics & Traumatology	1.5%	6.8%	1.8%	3.1%
Paediatrics	12.7%	3.6%	4.6%	5.6%
Pathology	10.9%	13.8%	1.8%	7.5%
Psychiatry	0.0%	7.3%	7.3%	6.4%
Radiology	15.5%	15.8%	0.6%	7.2%
Surgery	8.2%	10.1%	3.9%	6.5%
Others	6.1%	20.3%	6.1%	9.9%
Overall	8.2%	9.8%	4.8%	6.9%

Major specialty	2023-24 ⁽⁴⁾			
	Consultant	Senior Medical Officer/ Associate Consultant	Medical Officer/ Resident	Overall
Accident & Emergency	5.2%	4.5%	8.2%	6.6%
Anaesthesia	7.3%	14.8%	5.5%	8.9%
Cardiothoracic Surgery	13.0%	14.0%	5.4%	10.3%
Family Medicine	0.0%	6.1%	8.0%	7.0%
Intensive Care Unit	7.9%	1.9%	2.5%	3.2%
Internal Medicine	4.8%	4.1%	4.9%	4.6%
Neurosurgery	0.0%	8.1%	0.0%	1.9%
Obstetrics & Gynaecology	4.1%	8.0%	2.6%	4.4%
Ophthalmology	17.6%	11.6%	2.0%	7.3%
Orthopaedics & Traumatology	4.2%	5.8%	1.8%	3.3%
Paediatrics	1.4%	7.3%	6.0%	5.7%
Pathology	5.8%	3.3%	2.6%	3.8%
Psychiatry	0.0%	11.2%	1.1%	4.6%
Radiology	3.2%	4.9%	1.1%	2.4%
Surgery	7.7%	8.9%	2.5%	5.2%
Others	2.9%	6.4%	4.3%	4.5%
Overall	4.9%	6.9%	4.4%	5.2%

Major specialty	2024-25 (rolling 12 months from January to December 2024) ⁽⁴⁾⁽⁵⁾			
	Consultant	Senior Medical Officer/ Associate Consultant	Medical Officer/ Resident	Overall
Accident & Emergency	0.0%	5.6%	8.3%	6.4%
Anaesthesia	8.3%	10.1%	3.4%	6.4%
Cardiothoracic Surgery	0.0%	0.0%	0.0%	0.0%
Clinical oncology	0.0%	2.8%	0.0%	0.6%
Ear, Nose and Throat	0.0%	13.8%	1.7%	4.5%
Family Medicine	0.0%	3.6%	6.6%	5.4%
Intensive Care Unit	7.0%	1.8%	3.5%	3.6%
Internal Medicine	4.2%	3.8%	5.5%	4.7%
Neurosurgery	0.0%	0.0%	0.0%	0.0%
Obstetrics & Gynaecology	11.7%	13.4%	4.2%	8.3%
Ophthalmology	10.7%	20.1%	0.0%	7.0%
Orthopaedics & Traumatology	6.5%	6.8%	2.3%	4.2%
Paediatrics	2.6%	6.7%	10.0%	7.6%
Pathology	5.7%	14.6%	4.3%	7.2%
Psychiatry	0.0%	6.0%	2.5%	3.4%

Major specialty	2024-25 (rolling 12 months from January to December 2024) ⁽⁴⁾⁽⁵⁾			
	Consultant	Senior Medical Officer/ Associate Consultant	Medical Officer/ Resident	Overall
Radiology	9.5%	19.3%	0.0%	5.9%
Surgery	7.3%	8.5%	2.0%	4.7%
Others	0.0%	9.6%	8.5%	5.6%
Overall	5.0%	7.0%	4.4%	5.2%

Note:

- (1) Attrition (Wastage) includes all types of cessation of service (including retirement) from HA for permanent and contract staff on headcount basis.
- (2) Rolling Attrition (Wastage) Rate = (Total number of staff left HA in the past 12 months / Average strength in the past 12 months) x 100%
- (3) Doctors exclude Interns and Dental Officers.
- (4) From January 2024 onwards, the attrition (wastage) figures have excluded the number of staff under the EER arrangement. The relevant figures prior to that month can only be taken as references and are not directly comparable to those figures compiled with the now revised method.
- (5) From 2024-25 onwards, the figures for Ear, Nose and Throat and clinical oncology specialties have been extracted from the “Others” category. The relevant figures for the “Others” category prior to that year can only be taken as references and are not directly comparable to those compiled under the now revised method.

3.

The table below sets out the numbers of non-locally trained doctors, including those coming to Hong Kong for exchange, who provided services in the HA in 2024-25 (up to 31 December 2024).

Cluster	Specialty	2024-25 (Up to 31 December 2024)
HKEC	Anaesthesia	3
	Family Medicine	2
	Intensive Care Unit	1
	Internal Medicine	10
	Ophthalmology	2
	Orthopaedics & Traumatology	1
	Psychiatry	2
	Radiology	2
	Surgery	2
HKWC	Anaesthesia	8
	Cardiothoracic Surgery	4
	Clinical oncology	1
	Ear, Nose and Throat	2
	Accident & Emergency	2
	Family Medicine	1
	Internal Medicine	6
	Neurosurgery	1
	Obstetrics & Gynaecology	1

Cluster	Specialty	2024-25 (Up to 31 December 2024)
	Ophthalmology	4
	Orthopaedics & Traumatology	1
	Paediatrics	1
	Psychiatry	1
	Radiology	6
	Surgery	13
KCC	Anaesthesia	5
	Cardiothoracic Surgery	1
	Ear, Nose and Throat	2
	Family Medicine	1
	Intensive Care Unit	1
	Internal Medicine	6
	Neurosurgery	3
	Obstetrics & Gynaecology	2
	Ophthalmology	3
	Orthopaedics & Traumatology	2
	Paediatrics	9
	Pathology	1
	Psychiatry	1
	Radiology	4
	Surgery	5
KEC	Anaesthesia	2
	Ear, Nose and Throat	1
	Accident & Emergency	2
	Family Medicine	4
	Internal Medicine	9
	Ophthalmology	3
	Orthopaedics & Traumatology	1
	Paediatrics	2
	Pathology	1
	Radiology	4
	Surgery	2
KWC	Anaesthesia	3
	Accident & Emergency	3
	Family Medicine	1
	Intensive Care Unit	1
	Internal Medicine	5
	Neurosurgery	1
	Obstetrics & Gynaecology	1
	Psychiatry	1
	Radiology	4
	Surgery	1
NTEC	Anaesthesia	9
	Cardiothoracic Surgery	1
	Accident & Emergency	5
	Family Medicine	3
	Intensive Care Unit	1
	Internal Medicine	6
	Neurosurgery	2

Cluster	Specialty	2024-25 (Up to 31 December 2024)
	Obstetrics & Gynaecology	1
	Ophthalmology	2
	Orthopaedics & Traumatology	3
	Paediatrics	1
	Pathology	3
	Radiology	3
	Surgery	7
NTWC	Anaesthesia	9
	Cardiothoracic Surgery	1
	Clinical oncology	2
	Family Medicine	4
	Intensive Care Unit	1
	Internal Medicine	6
	Obstetrics & Gynaecology	1
	Ophthalmology	2
	Orthopaedics & Traumatology	1
	Paediatrics	1
	Pathology	1
	Psychiatry	1
	Radiology	4
	Surgery	6
Total		262

Note:

The above figures include non-locally trained doctors providing services in the HA by different ways of registration.

4.

The table below sets out the salary expenditure on doctors, nursing staff, AH professionals and care-related support staff of the HA in 2024-25 (full year projection):

Staff Group	Total Salary Expenditure (\$million) (Full Year Projection)
Doctors	15,803
Nursing	24,892
Allied Health Professionals	9,045
Care-related Support Staff	5,489

Note:

- (1) “Doctors” include Consultants, Senior Medical Officers / Associate Consultants, Medical Officers / Residents, etc., but exclude Interns and Dental Officers.
- (2) The “Nursing” group includes Senior Nursing Officers, Department Operations Managers, Nurse Consultants, Associate Nurse Consultants, Ward Managers, Nursing Officers, Advanced Practice Nurses, Registered Nurses, Enrolled Nurses, Nurse Trainees, etc.

- (3) The “AH Professionals” group includes Radiographers, Medical Technologists / Medical Laboratory Technicians, Occupational Therapists, Physiotherapists, Pharmacists, Medical Social Workers, etc.
- (4) “Care-related Support Staff” includes Health Care Assistants, Ward Attendants, Patient Care Assistants, etc.
- (5) Total salary expenditure includes basic salary, allowance, gratuity and other on-costs such as provision of housing benefit and death & disability benefit. The figures for 2024-25 represent full-year projection.

5.

The table below sets out the remuneration of the key management personnel of the HA for 2022-23 and 2023-24. The actual expenditure for 2024-25 will only be available after the close of the financial year.

Year	Remuneration Expenditure (\$million)	Percentage in HA’s Overall Staff Costs
2022-23	76.4	0.13%
2023-24	75.8	0.12%

Note:

- (1) Remuneration expenditure includes salaries, allowances, contributions for retirement scheme and other benefits.
- (2) Key management personnel refers to those listed in the HA Annual Report with the authority and responsibility for planning, directing and controlling the activities of HA. The group comprises the Chief Executive, Cluster Chief Executives, Directors and other Division Heads of the Head Office.
- (3) HA’s overall staff costs refer to the staff costs set out in the HA Annual Report.

Abbreviations

HKEC – Hong Kong East Cluster
 HKWC – Hong Kong West Cluster
 KCC – Kowloon Central Cluster
 KEC – Kowloon East Cluster
 KWC – Kowloon West Cluster
 NTEC – New Territories East Cluster
 NTWC – New Territories West Cluster

- End -

CONTROLLING OFFICER'S REPLY

HHB057

(Question Serial No. 3225)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Due to the increased provision for primary healthcare development and The Chinese Medicine Hospital of Hong Kong, as well as the increased cash flow requirement for the general non-recurrent item on Health and Medical Research Fund (HMRF), the provision for 2025-26 is \$849.7 million (24.0%) higher than the revised estimate for 2024-25. Please list the research projects currently being conducted under the HMRF, as well as the staff establishment and estimated expenditure involved.

Asked by: Hon CHOW Ho-ding, Holden (LegCo internal reference no.: 28)

Reply:

From the establishment of the Health and Medical Research Fund (HMRF) in 2011 to end 2024, the HMRF has provided funding support to about 2 200 investigator-initiated projects, 27 commissioned programmes and about 90 research fellowship awards, with a total commitment of over \$3,500 million. Among them, about half of investigator-initiated projects, 11 commissioned programmes and 55 research fellowship awards are on-going. These funded projects cover the following research areas:

- (a) public health, human health and health services (e.g. primary healthcare, non-communicable diseases, Chinese medicine);
- (b) prevention, treatment and control of infectious diseases with public health implications;
- (c) advanced medical research which applies advanced technologies to facilitate the translation of knowledge generated from health and health services or infectious diseases studies into clinical practice and to inform health policy;
- (d) health promotion that facilitates mobilisation of local resources to promote good health and prevention of illness in the community; and
- (e) evaluation of specific government programmes, e.g. Chronic Disease Co-Care Pilot Scheme and Hong Kong Genome Project.

Details of the funded projects and reports of closed projects are available at the Research Fund Secretariat website (<https://rfs.healthbureau.gov.hk>)

The HMRF has a direct operation cost of about \$4 million per annum and receives operational support from the Research and Data Analytics Office of the Health Bureau (HHB). The HHB does not maintain a separate breakdown for manpower and expenditure solely for supporting the HMRF.

- End -

CONTROLLING OFFICER'S REPLY

HHB058

(Question Serial No. 3226)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Due to the additional provision to the Hospital Authority (HA) for implementing various measures to meet the increasing demand for hospital services and to improve the quality of clinical care, the provision for 2025-26 is \$2,836.5 million (2.9%) higher than the revised estimate for 2024-25. Will the Government inform this Committee of the measures to be implemented by the HA in order to meet the demand for hospital services and improve the quality of clinical care?

Asked by: Hon CHOW Ho-ding, Holden (LegCo internal reference no.: 29)

Reply:

In 2025-26, the Government provides a recurrent subvention of \$99 billion to the Hospital Authority (HA), an increase of 3.7% as compared to the 2024-25 revised estimate of \$95.4 billion. The HA will implement the following key initiatives in 2025-26:

- (a) implementing the reform on governance and management, with a view to enhancing the quality of public healthcare services and sustainable development to strengthen support to patients;
- (b) pressing ahead with driving forward the fees and charges reform for public healthcare to guide the public to make optimal use of healthcare resources, reduce wastage and abuse, and enhance healthcare protection for “poor, acute, serious, critical” patients on all fronts, thereby enhancing the sustainability of the healthcare system;
- (c) fully dovetailing with the Government’s policy and development direction, continuing to enhance the capacity and quality of public healthcare services to cope with the demand by, inter alia, providing around 330 additional hospital beds as well as additional operating theatres and endoscopy sessions, and increasing service capacity for cataract surgeries; enhancing clinical services such as oncology, ophthalmology, psychiatry, radiology, nuclear medicine and pathology, genetic and genomic services, as well as non-clinical support services; rolling out measures to reduce the waiting time

for specialist out-patient services; enhancing the role of general out-patient clinics as primary healthcare service providers for the underprivileged by introducing chronic disease screening services and strengthening nurse clinic services; and integrating paediatric services at the Hong Kong Children's Hospital;

- (d) further expanding the integrated Chinese-Western medicine services, progressively extending the cancer care programme to all hospital clusters, and launching pilot programmes for the treatment of other disease areas where Chinese medicine has an advantage;
- (e) strengthening centralised procurement of drugs and medical devices to boost cost-effectiveness and ensure optimal use of healthcare resources;
- (f) developing smart hospital initiatives, with the aim of enhancing patient experience and improving operational workflow and efficiency with the use of advanced technologies;
- (g) continuing the review and planning of Second Hospital Development Plan projects;
- (h) augmenting the workforce by attracting and retaining staff; recruiting healthcare professionals to work in Hong Kong through Mainland and global healthcare talent visiting programmes, with a view to establishing a regional talent hub of healthcare professionals in the long run to meet future public demand for healthcare services; and
- (i) continuing the Preceptorship Programme under which clinical preceptors are recruited to provide guidance for newly-recruited and junior nurses and to familiarise them with ward procedures and environment.

The HA will allocate existing staffing resources and recruit additional manpower to implement the above measures.

- End -

CONTROLLING OFFICER'S REPLY

HHB059

(Question Serial No. 1533)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the matter that the Government will continue to monitor the demand and supply of healthcare professionals, will the Government inform this Committee:

1. of the numbers of staff, intake, attrition (and wastage rate) (including retirement and non-retirement), and vacancy (and vacancy rates) of doctors, nurses, dentists, and other allied health professionals (including but not limited to occupational therapists, physiotherapists, speech therapists, educational psychologists) serving under the Government, including public institutions such as the Department of Health (DH) and the Hospital Authority (HA) in 2024- 25;
2. of the annual numbers of first-year-first-degree subsidised places provided by the 8 universities funded by the University Grants Committee (UGC) for various healthcare professions (including but not limited to medicine, nursing, occupational therapy, physiotherapy, speech therapy, educational psychology) for the previous triennium (2022-25) and the next triennium (2025-28), actual student enrolments (if applicable), and the considerations involved in adjusting the number of places;
3. of the current number of first-year-first-degree intake places offered by self-financing institutions for various healthcare professions, and actual student enrolments;
4. of the number of students enrolled in the Professional Diploma in Nursing Programmes of the 3 nursing schools under the HA, with a breakdown by year of study, and the average training cost per student in 2024-25; and
5. whether it has assessed if the market can fully absorb the graduates in medical and allied health professions (including but not limited to medicine, nursing, occupational therapy, physiotherapy, speech therapy, educational psychology) from UGC-funded and self-financing institutions in the future; if so, of the details?

Asked by: Hon CHOW Man-kong (LegCo internal reference no.: 17)

Reply:

(1):

The manpower position of doctors, nurses, dental officers and various grades of allied health professionals serving under public healthcare institutions including the Department of Health (DH) and the Hospital Authority (HA) in 2024-25 is set out below:

DH

Category	Strength	New intake	Number of attrition	Attrition rate Note (1)	Vacancy	Vacancy rate
Doctors	462	39	31	6.7%	151	24.6%
Nurses	1 376	49	109	7.9%	175	11.3%
Dental Officers	290	46	24	8.3%	82	22.0%
Allied health professionals Note (2)	1 226	35	62	5.1%	208	14.5%

Note:

- (1) Attrition rate refers to the percentage of the number of attrition during 2024-25 (as at 1 February 2025) over strength on that date. Attrition covers retirement and non-retirement.
- (2) Various grades of allied health professionals include Dental Hygienist, Dental Surgery Assistant, Dental Technician, Dental Therapist, Dispenser, Medical Laboratory Technologist, Scientific Officer (Medical), Clinical Psychologist, Dietitian, Speech Therapist, Occupational Therapist, Physiotherapist, Orthoptist, Optometrist and Radiographer.

HA (figures as at 31 December 2024)

Category	Strength (including full-time and part-time staff) Note (1) (2)	New intake (including full-time and part-time staff) Note (3) (5)	Number of attrition Note (6) (7)	Attrition rate Note (11)	Number of vacancies Note (12)
Doctors Note (8)	7 184	672 Note (4)	244	5.2%	619
Nurses Note (9)	29 538	2 374	1 502	7.5%	3 868
Dental Officers	14	1	1	15.3%	1
Allied health professionals Note (10)	9 886	830	416	5.8%	664

Note:

- (1) The above manpower figures are calculated on a full-time equivalent basis including permanent, contract and temporary staff in the HA.
- (2) Starting from January 2024, the full-time equivalent for all temporary part-time staff is calculated on the basis of their actual working hours. Information of the previous years, if provided, is for reference only and cannot be directly compared with the data under the revised compilation method.

- (3) Intake refers to the total number of permanent and contract staff joining the HA on a headcount basis during the period. Transfers, promotions and movements within the HA are not counted.
- (4) Intake of doctors includes the number of Interns appointed as Residents.
- (5) Intake excludes staff retired and rehired under “Extending Employment Beyond Retirement” (EER) with effect from January 2024. Information of the previous years, if provided, is for reference only and cannot be directly compared with the data under the revised compilation method.
- (6) Attrition includes all types of cessation of service from the HA for full-time permanent and contract staff on a headcount basis.
- (7) Full-time attrition excludes staff retired and rehired under EER with effect from January 2024. Information of the previous years, if provided, is for reference only and cannot be directly compared with the data under the revised compilation method.
- (8) The manpower figures of “doctors” exclude those of Interns and Dental Officers.
- (9) The manpower figures of “nurses” include those of Senior Nursing Officers, Department Operations Managers, Nurse Consultants, Associate Nurse Consultants, Ward Managers, Nursing Officers, Advanced Practice Nurses, Registered Nurses, Enrolled Nurses, Nursing Trainees, etc.
- (10) The “allied health professionals” group includes Radiographers, Medical Technologists / Medical Laboratory Technicians, Occupational Therapists, Physiotherapists, Pharmacists, Medical Social Workers, etc.
- (11) Rolling attrition rate = (total number of full-time staff left the HA in the past 12 months / average strength in the past 12 months) (i.e. the rolling 12 months from January to December 2024) x 100%.
- (12) The vacancy figures are calculated on a full-time equivalent basis including permanent, contract and temporary staff in the HA.

(2) to (5):

The Health Bureau regularly conducts healthcare manpower projections for the 13 healthcare disciplines that are subject to statutory regulation (i.e. doctors, dentists, nurses, midwives, Chinese medicine practitioners, chiropractors, dental hygienists, medical laboratory technologists, occupational therapists, optometrists, pharmacists, physiotherapists and radiographers¹). The projection comprehensively takes into account factors such as local population and demographic changes, known and planned services and development direction, etc. to systematically project the future healthcare manpower required to meet relevant service needs. In adopting the model for manpower projection, consideration has been given to training places provided by University Grants Committee (UGC)-funded and self-financing post-secondary institutions. The number of Government-funded intake places in designated degree programmes related to healthcare professions subject to statutory registration in the past 3 years is tabulated as follows: ⁽¹⁾

¹ Practitioners of professions related to speech therapy and educational psychology are not covered by healthcare manpower projections conducted by the Health Bureau.

Programme	Academic year		
	2022/23	2023/24	2024/25
Medicine	590	590	590
Dentistry	90	90	90
Nursing ⁽²⁾	2 070	2 370	2 385
Medical laboratory science	105	165	165
Occupational therapy	160	160	160
Physiotherapy	300	320	320
Radiology	135	135	135
Chinese medicine	84	84	84

Note:

- (1) Includes designated student intake places of UGC-funded manpower-planned healthcare-related programmes, as well as subsidised places of the designated undergraduate programmes in the healthcare discipline under the Study Subsidy Scheme for Designated Professions/Sectors (SSSDP) launched by the Education Bureau, which are related to healthcare professions subject to statutory registration.
- (2) Refers to registered nurses (RN) degree programmes. In addition to RN degree programmes, a total of 1 070 places are available across 8 enrolled nurse (general) non-degree programmes offered by various institutions in the 2024-25 academic year. Among them, 605 places are subsidised through the Social Welfare Department's "Enrolled Nurse Training Programme for the Welfare Sector" or the SSSDP, and 100 places are offered by the Enrolled Nurse Training Programme organised by the HA, with full subsidy provided by the HA on the tuition fees of each student.

Subject to the projection results, the Government will review the strategies for increasing the manpower of healthcare professions in Hong Kong, including considering whether to further adjust the number of healthcare training places in the next triennial planning cycle of the UGC and provide subsidies to allied health-related programmes offered by self-financing institutions.

According to the results of the Healthcare Manpower Projection 2023, which was the latest round of projection, the shortage of medical practitioners, dentists, nurses, medical laboratory technologists, occupational therapists, physiotherapists, radiographers and Chinese medicine practitioners persisted, with the manpower shortage of medical practitioners and nurses set to persist in the long term. The Government will continue to regularly conduct healthcare manpower projections and make reference to the outcome when making long-term planning for the future manpower supply of healthcare professionals to meet future healthcare service demands.

The numbers of approved first-year-first-degree (FYFD) intake places of healthcare-related specific disciplines with manpower demand and speech therapy-related programmes provided by the 8 UGC-funded universities and actual student enrolments for the 2022-25 and 2025-28 triennia are set out in the **Annex**.

Regarding the allied health-related FYFD programmes provided by various self-financing institutions, their numbers of places subsidised under the SSSDP and actual student enrolments in the 2023/24 - 2024/25 academic year are tabulated as follows:

Programme	2024/25 academic year	
	Number of subsidised places	Actual student enrolment
Nursing	1 565	1 597
Medical laboratory science	105	108
Therapeutic radiography	20	25
Physiotherapy	170	177
Occupational therapy	60	68

The Professional Diploma in Nursing Programme provided by the nursing schools of the HA admits about 300 nursing students annually, with its principal training costs covered by student tuition fees. The HA charges a tuition fee of about \$112,000 per student for the whole course.

Numbers of approved first-year-first-degree intake places of University Grants Committee-funded healthcare-related specific disciplines with manpower demand and speech therapy-related programmes and actual student enrolments for the academic years from 2022/23 to 2027/28 ⁽¹⁾

(Full-time equivalent)

Programme	2022-25 triennium						2025-28 triennium	
	2022/23 academic year		2023/24 academic year		2024/25 academic year		2025/26, 2026/27 and 2027/28 academic years	
	Approved intake place	Actual student enrolment	Approved intake place	Actual student enrolment	Approved intake place	Actual student enrolment (provisional figures)	Approved intake place	Actual student enrolment
Medicine	590	597	590	608	590	627	650	Not yet available
Dentistry	90	89	90	90	90	90	90	
Nursing	690	723	690	751	690	765	690	
Medical laboratory science	60	72	60	75	60	61	60	
Occupational therapy	100	101	100	103	100	98	100	
Physiotherapy	150	165	150	171	150	161	150	
Radiology	115	125	115	127	115	126	115	
Chinese medicine	84	91	84	102	84	101	85	
Speech therapy ⁽²⁾	Not applicable (N/A)	132	N/A	130	N/A	143	N/A	

Note:

- (1) Educational psychology-related programmes are at taught postgraduate level and relevant undergraduate programmes are not provided by the 8 University Grants Committee (UGC)-funded universities.
- (2) Among the 60 increased UGC-funded intake places of undergraduate medicine programmes for the 2025-28 triennium, 50 will be allocated to 2 existing medical schools, namely The Chinese University of Hong Kong and The University of Hong Kong, to introduce a graduate entry track for holders of bachelor's degree to pursue medicine as their "second degree".
- (2) Speech therapy is not a specific discipline with manpower demand.

- End -

CONTROLLING OFFICER'S REPLY

HHB060

(Question Serial No. 1138)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (1) Director of Bureau's Office

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in paragraph 126 of the 2025-26 Budget Speech that the public healthcare sector will leverage the revised legislative framework to admit non-locally trained healthcare professionals. In this connection, will the Government inform this Committee:

1. of the number of non-locally trained healthcare professionals successfully admitted into the public healthcare sector since 2022, their places of origin and specialties;
2. of the follow-up measures it has taken to retain talents after the admission of non-locally trained healthcare professionals; and
3. in view of the continued acute shortage of healthcare professionals, whether it has considered pursuing legislative amendments to further expand the scope of the admission of non-locally trained healthcare professionals; if so, of the plan; if not, the reasons for that?

Asked by: Hon HO Kwan-yiu, Junius (LegCo internal reference no.: 9)

Reply:

1 & 3.

The Government amended the Medical Registration Ordinance (Cap. 161) in 2021 and then the Dentists Registration Ordinance (Cap. 156) and the Nurses Registration Ordinance (Cap. 164) in 2024 to create new pathways for qualified non-locally trained doctors, dentists and nurses to practise in the public healthcare system in Hong Kong, with a view to increasing manpower supply. The Government has also introduced the Supplementary Medical Professions (Amendment) Bill into the Legislative Council earlier, proposing to open up new pathways for allied health professionals (namely medical laboratory technologists, occupational therapists, optometrists, radiographers and physiotherapists) to practise in the public healthcare system in Hong Kong. The numbers of doctors, dentists and nurses who have been admitted to practise in Hong Kong under special registration (SR)/enrolment (SE) and limited registration (LR)/enrolment (LE) are set out below.

Doctors

According to the information provided by the Medical Council of Hong Kong (MCHK), the figures of SR and LR in relation to the number of applications, the number of approved applicants, the countries/places where the medical qualifications were obtained and the number of applicants who have acquired specialist qualifications as at 31 December 2024 are as follows:

	SR			LR
	Holding recognised medical qualifications	Bridging from LR	Total	
Number of applications				
- Number of applicants ^{Note (1)}	108	13	121	436
- Number of approved applicants	106	13	119 ^{Note (2)}	436
- Number of applicants with registration in effect	93 ^{Note (3)}	13	106	315 ^{Note (4)}
Countries/places where the medical qualifications were obtained				
- China (except Hong Kong) ^{Note (5)}	9	1	10	128
- United Kingdom	63	6	69	72
- Australia	15	0	15	15
- New Zealand	0	0	0	2
- Canada	2	2	4	5
- United States	2	2	4	8
- Singapore	0	0	0	2
- South Africa	2	1	3	3
- India	0	0	0	7
- Others	Not applicable	1 ^{Note (6)}	1	73 ^{Note (7)}
Total	93	13	106	315
Specialist qualifications acquired ^{Note (8)}				
- Anaesthesiology	4	0	4	1
- Clinical Oncology	1	0	1	0
- Emergency Medicine	0	1	1	0
- Family Medicine	1	0	1	0
- Gastroenterology & Hepatology	1	2	3	0
- General Surgery	0	0	0	1
- Geriatric Medicine	0	1	1	0
- Intensive Care	0	0	0	1
- Medical Oncology	0	1	1	0
- Neurosurgery	1	0	1	0
- Obstetrics & Gynaecology	0	0	0	1
- Ophthalmology	0	1	1	2

	SR			LR
	Holding recognised medical qualifications	Bridging from LR	Total	
- Otorhinolaryngology	0	1	1	0
- Paediatrics	0	1	1	2
- Pathology	0	0	0	1
- Public Health Medicine	0	2	2	0
- Radiology	1	3	4	1
- Rheumatology	0	0	0	1
- Urology	1	0	1	0
Total	10	13	23	11

Note:

- (1) Refers to the number of applicants and approved applicants from 1 January 2022 to 31 December 2024, excluding renewal applications.
- (2) Among the 121 SR applications, 1 application was not approved, and 1 application was approved in January 2025.
- (3) Among the 106 approved SR doctors holding recognised medical qualifications, the SR of 9 applicants came into effect only after 31 December 2024; 3 applicants had their SR terminated before 31 December 2024; and 1 applicant passed the MCHK's Licensing Examination and became a doctor with full registration in February 2024. The number of applicants with SR in effect includes renewal applications.
- (4) Among the 436 approved LR doctors, 20 had their LR came into effect only after 31 December 2024; 101 had their LR terminated on or before 31 December 2024 due to expiry of registration or resignation. The number of doctors with LR in effect includes renewed applications.
- (5) Including the Mainland China, the Macao SAR and the Taiwan region.
- (6) The doctor with SR obtained his/her medical qualification in the Czech Republic.
- (7) Regarding the 73 doctors with LR, the countries/regions involved are the Czech Republic (2), the Philippines (13), Sri Lanka (2), Ireland (13), France (1), Italy (1), the Netherlands (2), Argentina (1), Malaysia (15), Thailand (3), Saudi Arabia (2), Russia (3), Japan (1), Turkey (3), Poland (2), Germany (2), Myanmar (1), Indonesia (2), Pakistan (1), Colombia (1), Hungary (1) and Nigeria (1).
- (8) It refers to the number of specialists whose names are included in the Specialist Register of the MCHK as at 31 December 2024 and their relevant specialties.

Dentists

Relevant provisions on SR and LR in the Dentists Registration Ordinance came into operation on 1 January 2025. According to the information provided by the Dental Council of Hong Kong (DCHK), figures for SR and LR as at 28 February 2025 are as follows:

	SR	LR	Total
Number of applications			
- Number of applicants	0	4	4 ^{Note (1)}
- Number of approved applicants	0	3	3
- Number of applicants with registration effected	0	0	0 ^{Note (2)}

Note:

- (1) The DCHK received another 23 applications. However, due to incomplete information in these applications, they have yet to be processed.
- (2) The registration of 3 approved applicants took effect on 10 March 2025. Their employing institution is the Department of Health (DH) and they are not specialist dentists. The countries/places where the 3 applicants obtained their dental qualifications are China (including the Mainland China, the Macao Special Administrative Region and the Taiwan region) (2) and the United Kingdom (1).

Nurses

According to the information provided by the Nursing Council of Hong Kong (NCHK), the number of applications for SR/SE and LR/LE as at 31 December 2024 are as follows:

	SR	SE	LR	LE	Total
Number of applications ^{Note (1)}					
- Number of applicants	3	0	1	1	5 ^{Note (2)}
- Number of approved applicants	3	0	1	1	5 ^{Note (3)}
- Number of applicants with registration/enrolment effected	0	0	0	0	0

Note:

- (1) The number of applicants and approved applicants are figures as at 31 December 2024 after the passage of the Nurses Registration (Amendment) Bill in 2024-25. The Register of Registered/Enrolled Nurses does not provide a breakdown by specialty.
- (2) It refers to applications received with complete information. At the same time, the NCHK has been further following up with the applicants on the 54 applications requiring supplementary/verification of information. The NCHK will include these cases to the formal application figures upon receipt of complete application information.
- (3) The 5 approved applications took effect only after 31 December 2024. Among them, the countries/places where the 3 applicants approved for SR obtained their nursing qualifications are the Mainland China (2) and Singapore (1). As for the 1 applicant approved for LR and the 1 applicant approved for LE, the countries/places where they obtained their nursing qualifications are the United Kingdom and the Mainland China respectively.

2.

The DH and the Hospital Authority (HA) have been retaining healthcare professionals through various channels. In recent years, the DH has granted increments to newly appointed doctors and dentists with recognised experience, and has provided on-the-job training, study leave, etc. to serving doctors, dentists and nurses.

Moreover, the HA has introduced enhancement measures to provide training information and clinical observation learning opportunities for non-locally trained healthcare professionals appointed, so as to allow them to familiarise themselves with the daily operation of the departments and integrate into the working environment as soon as possible. Dedicated liaison teams have been set up in the HA head office and clusters to provide information to non-locally trained healthcare professionals and assist them in settling down in Hong Kong. After onboarding, the HA facilitates interaction and experience sharing among non-locally trained healthcare professionals through communication platforms or partnership programmes, and at the same time provides clinical psychology services for non-locally trained healthcare professionals with mental health needs. Having regard to the performance and professional development needs of individual staff, the HA will provide timely assistance such as posting transfers, thereby enabling them to give full play to their strengths in suitable posts.

- End -

CONTROLLING OFFICER'S REPLY

HHB061

(Question Serial No. 1142)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Hospital Authority (HA) invites healthcare professionals, including those from the Mainland especially the Greater Bay Area, through various talent exchange programmes for professional and clinical exchange with local healthcare personnel to foster mutual professional enhancement and, in the long run, establish a regional healthcare talent pool. In this connection, will the Government inform this Committee of the following:

1. the details, including the dates, locations, target participants and themes of the talent exchange programmes organised by the HA in 2024-2025;
2. whether the HA has established a regional healthcare talent pool; if not, the timetable for taking it forward; and
3. whether the HA will, in view of the serious shortage of healthcare staff, explore opportunities for healthcare professionals in the aforementioned talent pool to practise in HA public hospitals and institutions?

Asked by: Hon HO Kwan-yiu, Junius (LegCo internal reference no.: 13)

Reply:

1, 2 and 3:

The Hospital Authority (HA) has all along been actively promoting the exchange of healthcare talents and, with support from the Health Commission of Guangdong Province (GDHC) and the Health Bureau of the HKSAR Government, has implemented the Greater Bay Area (GBA) Healthcare Talents Visiting Programmes since the fourth quarter of 2022. The Programmes cover healthcare personnel of various disciplines, including doctors, nurses, allied health professionals and CM practitioners, and were well received by participating healthcare professionals of both places. Having worked in concerted efforts, the healthcare professionals conducted exchanges with their counterparts to achieve the anticipated outcomes. Details of the Programmes are set out below:

GBA Visiting Doctors Programme

This programme aims to establish a mechanism for doctors working in the public healthcare system in the Guangdong Province and Hong Kong to undergo exchanges in public hospitals of the other place. A participating GBA doctor must be a holder of a Bachelor of Medicine degree in clinical western medicine or equivalent academic qualifications serving in a Tier III Class A hospital in the Mainland at the rank of Attending Physician or above, and having met the clinical experience requirements of the relevant speciality.

Under the first batch launched in April 2023, 10 GBA doctors nominated by the GDHC successfully completed a year of exchange in April 2024. Their specialties include Respiratory Medicine, Infectious Disease, Nephrology, Cardiology, Anaesthesiology and Radiology. In view of the desirable outcomes of exchange from the first batch, the HA conducted a trial of an ophthalmology pilot exchange programme with Zhongshan Ophthalmic Center of Sun Yat-Sen University in March 2024. 2 participating ophthalmologists completed a half-year exchange in Hong Kong in August 2024, during which they performed a number of ophthalmology operations and procedures, providing optimal treatment to patients whilst having fostered the development of ophthalmology services in Hong Kong.

Building on the success from the above exchange programmes, the HA has progressively explored the expansion of the visiting doctors programme with stakeholders in the GBA since 2024. Under the co-ordination of the GDHC, the second phase of the exchange programme has expanded to cover 9 GBA cities, with 34 selected doctors from 8 clinical specialties participating in the exchange. Their specialties include Ophthalmology, Cardiology, Anaesthesiology, Integrated Medicine, Emergency Medicine, Hepatobiliary Surgery, Endoscopy, and Radiology.

In addition, according to the co-operation agreement signed between the HA and the First Affiliated Hospital of Sun Yat-sen University (FAHSYU) in the first quarter of 2024, the hospital has also nominated the first batch of 13 doctors from various specialties for exchange in Hong Kong. Their specialties include Cardiology, Anaesthesiology, Integrated Medicine, Emergency Medicine, Hepatobiliary Surgery, Endoscopy, Radiology, Intensive Care Medicine, Clinical Oncology, and Cardiothoracic Surgery. After obtaining the required licences of registration and relevant visas, the above 47 GBA visiting doctors (including 34 doctors under the second phase of the exchange programme and 13 doctors from FAHSYU) came to Hong Kong in batches between the fourth quarter of 2024 and the first quarter of 2025 to commence a year of clinical exchange.

These visiting doctors work with local healthcare teams to provide optimal clinical services or perform proper medical procedures for patients. Some of the more experienced visiting doctors share their professional skills with local doctors to strengthen the clinical capabilities of local teams. On the other hand, these visiting doctors gain insight into the management model and health information technology of Hong Kong's public healthcare system. The programme showcases the enhanced professional exchange between the two places and fully realises the spirit of mutual learning and enrichment with a patient-centred and professional-minded approach.

GBA Specialty Nursing Knowledge-Exchange Programme

The HA have recruited a total of 300 experienced nurses in 3 cohorts from the Guangdong Province to join the exchange programme within the two years starting from 2023, providing them with online learning followed by 45-week on-site clinical practicum at selected service areas of HA hospitals. All exchange visitors must hold a Bachelor Degree in Nursing and possess at least 3 years of post-registration nursing experience in related specialty area. Priority is given to those currently working in Tier III Class A hospitals in the Mainland.

The HA will organise online briefings by specialty tutors on nursing care in the relevant specialty areas for exchange nurses before their departure. After their arrival, practicum hospitals will offer induction training to familiarise them with the organisation structure and daily operation of the hospitals. On adaptation to life in Hong Kong and clinical practicum, cluster coordinators and clinical tutors will provide exchange nurses with appropriate support.

The first cohort of 70 nurses completed clinical practicum in Geriatric Nursing in February 2024. Another 99 exchange nurses of the second cohort completed clinical practicum in Geriatric Nursing, Peri-operative Nursing, Critical Care, Cardiac Critical Care, Ophthalmology and Endoscopy in January 2025. During the exchange period, the Guangdong and HA nurses worked closely. Their clinical expertise and application of skills were elevated through mutual interactions.

With the implementation of the amended Nurses Registration Ordinance, the HA and the GDHC have reached the consensus to further expand the programme beyond the above specialties to cover Emergency Care, Nephrology and Stroke Care. The HA will also assist the entire third cohort of about 130 Guangdong nurses in their applications for limited registration, thereby enabling them to engage intensively in clinical work for a more comprehensive experience during their stay. To further raise the nursing standards in the GBA and foster professional development, the HA is exploring with the GDHC on the possibility of regularising and further expanding the programme, while also planning to initiate exchange and collaborative programmes with other potential partners.

Furthermore, the HA sent a 26-strong delegation to visit 4 Tier III Class A hospitals in Guangdong Province in January 2024 for a 3-day study tour so as to deepen its nursing leaders' understanding of the modus operandi of Mainland hospitals. Later in December 2024, 17 nurses specialising in Neonatal Care or Obstetrics and Gynaecology also visited the Guangzhou Women and Children's Medical Center and Guangzhou's breast milk bank for clinical observation. The HA will keep engaging various stakeholders to explore the development of two-way exchange programmes, envisioning a multi-win situation with ongoing interflow of nursing talents between Hong Kong and other GBA cities.

GBA Visiting Radiographer (Diagnostic) Programme

The GBA Visiting Radiographer (Diagnostic) Programme was successfully completed in August 2023. Subjects of exchange in the first phase include: Radiology (different categories of radiological imaging) and Medical Physics. 5 diagnostic radiographers from Tier III Class A hospitals were nominated by the GDHC for a 2-week technical exchange. Subsequently, in January 2024, the HA sent 14 radiographers and 5 medical physicists to several Tier III Class A hospitals in the Guangdong Province for a two-way exchange.

Building on the successful experience of the first phase of the two-way exchange programme, which has laid a solid foundation for future exchange in the radiography and oncology professions between the two places, the HA and the GDHC have discussed and further expanded the second phase of the two-way exchange programme to include radiotherapists and enhanced it as the Guangdong-Hong Kong Allied Healthcare Talents Visiting Programme (「粵港專職醫療人才交流計劃」), so as to foster exchange in the radiography and oncology professions between the two places in a more comprehensive manner. Subjects of exchange in the second phase include: Radiology (different categories of radiological imaging), Clinical Oncology (different categories of radiation therapy techniques), and Medical Physics. The GDHC sent a total of 35 allied health professionals for a one-week exchange in Hong Kong, including 5 radiation therapists, 5 physiotherapists and 25 radiographers in August, September and November 2024 respectively. Separately, the HA also arranged to send 17 radiographers, 11 medical physicists and 13 radiotherapists for a one-week in-depth exchange at Tier III Class A hospitals in the Guangdong Province in January 2025, so as to enhance their understanding about the practice and service models in the Mainland.

In view of the successful experience and positive response of the Guangdong-Hong Kong Allied Healthcare Talents Visiting Programme, the HA is actively preparing for the implementation of the next phase with the GDHC, including inviting the third batch of allied health personnel from the Guangdong Province for exchange in Hong Kong. The HA is also exploring the feasibility of in-depth exchange and placement for the third batch of its allied healthcare teams at Tier III Class A hospitals in the Guangdong Province.

GBA CM Visiting Scholars Programme

To expedite the development of local core CM clinical talents, the HA launched the GBA CM Visiting Scholars Programme in November 2022. This “mentoring and shadowing model” CM in-patient training programme, being the first of its kind in Hong Kong, enhances the professional competency of our CM practitioners (CMPs) and fosters the development of our Integrated Chinese-Western Medicine (ICWM) services by inviting CM experts from Tier III Class A CM hospitals in the GBA and under limited registration granted by the Chinese Medicine Council of Hong Kong to coach and provide in-patient clinical training in our public hospitals for CMPs from the CM Clinics cum Training and Research Centres (CMCTRs) across 18 districts.

Since the launch of the programme, around 20 experienced CM experts have joined the CM expert pool and come to Hong Kong in phases with around 130 local CMPs having received training so far.

Nominated by the GDHC, visiting scholars have to be at the rank of Associate Chief Physician or above, and with solid clinical experience in renowned hospitals or institutions. Their specialties include Respiratory Medicine, Neurology, Oncology, Orthopaedics & Traumatology, and Acupuncture. With a view to nurturing more CM clinical talents, the HA will continue to maintain close liaison and collaboration with the current CM hospitals in the GBA, and explore the feasibility of exchange and cooperation with provinces and cities beyond GBA for training of talents and extension to more types of diseases subject to the development of ICWM services.

CM Enhanced In-patient Training Programme with the GBA

In April 2024, the HA launched the CM Enhanced In-patient Training Programme with the GBA, a first-of-its-kind training programme that makes a breakthrough in arranging CMPs selected from the 18 CMCTRs to obtain Mainland practising qualifications, enabling them to participate in the clinical teams of CM hospitals in the GBA for clinical work and receive advanced in-patient clinical training. The Guangdong Provincial Hospital of Traditional Chinese Medicine is the collaborating training partner for the first phase of the Programme. At present, a total of 16 local CMPs have joined the Programme, and the training covers neurology, acupuncture and oncology.

The HA will maintain close liaison and collaboration with CM hospitals in the GBA to dovetail with the development of ICWM for training of talents and extension to various types diseases.

HK-Shanghai and HK-Beijing Two-Way Exchange Programmes

The HA has all along dovetailed the policy directions of the HKSAR Government, and strived to press ahead with the two-way training and exchange of healthcare talents between Hong Kong and the Mainland. Since the announcement of the relevant directions in the Chief Executive's Policy Address 2023, the HA has actively discussed with different Mainland cities, including Beijing and Shanghai, on establishing a two-way talent exchange mechanism, with a view to enhancing exchanges with healthcare talents in terms of depth and breadth.

In respect of Shanghai, the arrangements for exchanges with healthcare talents were formalised after a consensus had been reached between the HA and the Shanghai Municipal Health Commission on the launch of the two-way healthcare talents training and exchange programme between the two places in the first quarter of 2024. Since March 2024 (as at 31 December 2024), 6 doctors have either completed or been participating in the exchange in Hong Kong, and their specialties covering Endoscopy, Cardiology, Organ Transplantation and Anaesthesiology; while the HA has also arranged for 3 doctors in Cardiology and Organ Transplantation to participate in clinical exchange in Shanghai, with 2 of them for practice exchange and 1 for clinical observation. With regard to nurses, the HA sent 4 nurses to Shanghai to engage in clinical observation from June to September 2024, with 2 Advanced Practice Nurses (Perfusionist) and 2 Advanced Practice Nurses (Perfusionist Trainee) having completed their exchange in 1 week and 4 weeks respectively.

As for Beijing, the details of two-way exchange between Beijing and Hong Kong have been implemented progressively over the past year, with specialties covering Orthopaedics & Traumatology, Neurosurgery, and Rare Diseases. In August 2024, the Beijing Municipal Health Commission sent 5 orthopaedic doctors to Hong Kong to engage in clinical observation, while the HA also plans to send more than 10 doctors to Beijing for exchange within the said specialty. As at 31 December 2024, 5 HA doctors have either started or completed their exchange in Beijing, with more doctors about to start in 2025 progressively. In addition, the HA signed a collaborative agreement with the Peking Union Medical College Hospital (PUMCH) in January 2024 on strengthening exchanges and co-operation between the two parties in the development and management of public hospitals. Currently, the arrangements for the two-way exchanges with healthcare talents between the HA and the

PUMCH are being implemented in an orderly manner. It is expected that, in 2025, the first batch of PUMCH doctors will visit Hong Kong for clinical exchange, at the same time the HA will continue to identify suitable doctors in their respective specialties and send them for exchange in Beijing.

Looking Ahead

Looking ahead to 2025, the HA is actively exploring with more stakeholders to establish two-way exchange, including short-term observation exchange, medium-term clinical practice exchange and sending healthcare professionals from Hong Kong to the Mainland for mutual learning and exchange in the latter's public hospitals, with a view to expanding the talent pool of Hong Kong's public healthcare system.

- End -

CONTROLLING OFFICER'S REPLY

HHB062

(Question Serial No. 1158)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (514) Hospital Authority

Programme: (1) Director of Bureau's Office

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the Health Bureau's sustained efforts to enhance healthcare-related teaching facilities and increase, as appropriate, the number of training places for local healthcare professionals, this Committee raises the following questions:

- 1) Can an increase in the number of training places for local healthcare professionals effectively meet the growing demand for healthcare?
- 2) In addition to increasing the number of training places, has the Government put any plans for continuing education in place for current healthcare staff to keep them abreast of their professional skills?
- 3) What can the Government do to entice and retain the locally trained healthcare staff to prevent brain drain?

Asked by: Hon HO Kwan-yiu, Junius (LegCo internal reference no.: 29)

Reply:

1)

The Government regularly conducts healthcare manpower projections for the 13 healthcare disciplines that are subject to statutory regulation (i.e. doctors, dentists, nurses, midwives, Chinese medicine practitioners, chiropractors, dental hygienists, medical laboratory technologists, occupational therapists, optometrists, pharmacists, physiotherapists and radiographers). The projection comprehensively takes into account factors such as local population and demographic changes, known and planned services and development directions, etc. to systematically project the future healthcare manpower required to meet relevant service needs.

The Government has continuously enhanced the training of healthcare professionals and suitably increased the number of places in government-funded healthcare-related undergraduate programmes to cope with the rising demand for healthcare services. Results of the latest round of Healthcare Manpower Projection 2023 shows that manpower shortage of doctors, general nurses, dental hygienists, medical laboratory technologists and optometrists persist. Manpower of dentists, Chinese medicine practitioners and pharmacists will still be in shortage in the short to medium term, but will gradually improve in the medium

to long term. Manpower of psychiatric nurses, occupational therapists and physiotherapists will still be in shortage in the short term, but will gradually improve in the short to medium term. As for midwives and chiropractors, their manpower remains adequate.

The Government will continue to conduct healthcare manpower projections on a regular basis and make reference to the results to review the strategies for increasing the manpower of healthcare professions in Hong Kong, including considering whether to adjust the number of healthcare training places in the next triennial planning cycle of the University Grants Committee and provide subsidies to allied health-related programmes offered by self-financing institutions.

2)

Among healthcare professionals subject to statutory registration, there are statutory mandatory continuing professional development (CPD) requirements for specialists, specialist dentists and registered Chinese medicine practitioners; the 5 supplementary medical professions (including optometrists, physiotherapists, occupational therapists, radiographers and medical laboratory technologists) implement or plan to implement the mandatory CPD requirements by the boards of their respective professions; and non-specialists, non-specialist dentists, pharmacists, medical laboratory technologists, nurses, midwives and chiropractors have voluntary CPD programmes to maintain their professional standards and competence. The newly amended Nurses Registration Ordinance and Dentists Registration Ordinance have both included provisions for establishing mandatory CPD. The Supplementary Medical Professions (Amendment) Bill introduced into the Legislative Council earlier also proposes to make CPD requirements of supplementary medical professionals a criterion for renewal of their practising certificates.

3)

The Department of Health (DH) and the Hospital Authority (HA) have been closely monitoring the manpower situation and actively attracting and retaining healthcare manpower through various channels. In September 2019, September 2021 and February 2024, the DH launched a year-round recruitment exercise for doctors, dentists and registered nurses respectively. The DH has also liaised with local universities and organised regular briefing sessions to introduce the work, on-the-job training and promotion opportunities, etc. of the DH to medical, dental and nursing students. The HA has also introduced a series of measures to attract, train and retain talents, including recruiting non-locally trained healthcare professionals to supplement local recruitment, improving promotion opportunities to retain staff, hiring part-time healthcare staff (e.g. via recruitment of locum staff), offering flexible full-time work arrangements, offering further employment to suitable staff beyond retirement, enhancing the Home Loan Interest Subsidy Scheme and provision of more training opportunities for various grades by establishing the HA Academy.

In addition, having regard to the circumstances of individual grades, the DH and the HA will adopt targeted measures to attract and retain healthcare manpower. For example, to attract more young people to join the dental hygienists and dental therapists professions, the DH has been offering full sponsorship on tuition fee since the 2023/24 academic year to students studying dental hygienist and dental therapist programmes. Dental hygienists and dental therapists who have received the sponsorship are required to work in dental clinics of the DH or designated non-governmental organisations for at least 1 year after graduation. The DH also grants incremental credits to newly recruited doctors and dentists based on recognised

work experience and provides on-the-job training and study leave, etc. to serving doctors, dentists and nurses. To retain experienced healthcare talents and to support the HA in addressing the service needs, the HA will, in 2025-26, continue to create opportunities for Associate Consultants to be promoted to the Consultant rank; provide Specialty Nurse Allowance to eligible registered nurses; and increase promotion opportunities for allied health professionals, as well as provide Specialist Allied Health Professionals Allowance for eligible resident physiotherapists, occupational therapists and radiographers.

- End -

CONTROLLING OFFICER'S REPLY

HHB063

(Question Serial No. 3082)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It was mentioned that the Hospital Authority would also set up the first stroke centre and the second chest pain centre. Please provide details of such an initiative including the budgets of the centres, implementation timetable and required number of staff.

Asked by: Hon HO Kwan-yiu, Junius (LegCo internal reference no.: 39)

Reply:

Our country has formulated guidelines for the establishment and management of stroke centres and chest pain centres to strengthen the quality control and assessment in respect of the diagnosis and treatment of stroke and chest pain, thereby enhancing healthcare quality and safety. The Policy Addresses of 2023 and 2024 respectively put forward the establishment of stroke centres and chest pain centres in accordance with the national accreditation standards. The Hospital Authority (HA) is pressing ahead in full steam with the relevant set-up work, including establishing a steering committee on development of stroke centres and a steering committee on development of chest pain centres. The steering committees are responsible for planning and co-ordinating stroke and cardiology services among hospital clusters, as well as overseeing the setting up of stroke centres and chest pain centres in the clusters to ensure that the national accreditation standards for such centres are met. The stroke centres and chest pain centres would centralise resources to handle urgent cases by establishing a “green channel” for acute stroke and chest pain patients and rationalising the workflow for diagnosis and treatment to shorten the time required for urgent cases to receive treatment, thereby reducing the mortality rate, number of days of hospitalisation and readmission rate of patients.

Stroke Centres

Tuen Mun Hospital and Queen Mary Hospital (QMH) have officially established a “green channel” in June 2024 and January 2025 respectively. Besides, Tuen Mun Hospital and Queen Mary Hospital have each established a cluster-based stroke centre committee to co-ordinate the setting up of the stroke centre while ensuring that the stroke centre can meet the national accreditation standards. In the first quarter of 2025, the HA held a meeting with

representatives of the Million Disability Reduction Initiative Expert Committee of the National Health Commission to discuss the accreditation work of Hong Kong and implementation of related workflow. The HA aims to submit a formal application for accreditation of the stroke centres to the relevant Mainland authorities in 2025.

Chest Pain Centres

The HA has set up the first chest pain centre at QMH in 2024, with reference to the national accreditation standards, and plans to submit an application for accreditation to the relevant Mainland authorities in 2025.

Prince of Wales Hospital (PWH) is actively making preparations for the setting up of the second chest pain centre in Hong Kong, including preparing to establish a “green channel” in the Accident and Emergency Department and rationalising the hospital’s workflow for treating acute chest pain patients. The HA estimates that PWH will provide the “green channel” for acute chest pain patients starting from the fourth quarter of 2025 and operate the chest pain centre in the second quarter of 2026. The HA aims to submit an application for accreditation of the chest pain centre to the relevant Mainland authorities in 2026.

The estimated expenditure and number of staff involved in setting up the stroke centres and chest pain centres cannot be separately quantified as they are part of the HA’s overall expenditure on provision of healthcare services.

- End -

CONTROLLING OFFICER'S REPLY**HHB064****(Question Serial No. 1296)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: Not SpecifiedControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

The Government has implemented the Voluntary Health Insurance Scheme (VHIS) since April 2019 to encourage the public to purchase hospital insurance and, when necessary, opt for private healthcare services. In this connection, will the Government inform this Committee of the following:

1. the number of policies under the Standard Plan and Flexi Plan of the VHIS by age of insured persons for the financial years 2019-20 to 2024-25;
2. the number of taxpayers claiming tax deductions for purchasing plans under the VHIS and its proportion in the total number of taxpayers for the financial years 2019-20 to 2024-25;
3. the total amount of tax deductions for qualifying premiums paid under the VHIS policy for the financial years 2019-20 to 2024-25; and
4. whether the Government will review the effectiveness of the VHIS and consider adjusting the amount of tax deductions and introducing a "high-risk pool".

Asked by: Hon IP LAU Suk-ye, Regina (LegCo internal reference no.: 20)Reply:

1. According to the latest statistics, the number of policies of the Voluntary Health Insurance Scheme (VHIS) Certified Plans reached 1 341 000 as at 31 March 2024. The breakdown by the age of insured persons is as follows:

Statistics on VHIS Standard Plan (by financial year)

Age of insured persons	As at 31 March 2020	As at 31 March 2021	As at 31 March 2022	As at 31 March 2023	As at 31 March 2024
0-9	1 400	2 100	2 500	2 700	3 000
10-19	1 000	1 500	1 800	2 000	2 200
20-29	2 200	3 400	4 200	4 400	4 500
30-39	2 800	4 200	5 400	6 100	6 600
40-49	3 000	4 600	5 900	6 100	6 200
50-59	3 200	5 000	6 600	6 900	7 000
60 or above	3 100	4 700	6 200	7 300	8 000
Total	16 700	25 400	32 700	35 500	37 600

Statistics on VHIS Flexi Plan (by financial year)

Age of insured persons	As at 31 March 2020	As at 31 March 2021	As at 31 March 2022	As at 31 March 2023	As at 31 March 2024
0-9	61 000	84 000	102 000	113 000	126 000
10-19	45 000	68 000	91 000	109 000	120 000
20-29	68 000	106 000	143 000	164 000	175 000
30-39	99 000	153 000	208 000	245 000	271 000
40-49	97 000	150 000	201 000	235 000	257 000
50-59	83 000	124 000	161 000	187 000	205 000
60 or above	51 000	80 000	107 000	132 000	149 000
Total	505 000	766 000	1 012 000	1 185 000	1 304 000

Note: Breakdown figures may not add up to the total due to rounding.

2 and 3. According to the latest information provided by the Inland Revenue Department, the data on tax deduction (based on year of assessment) is as follows:

	No. of taxpayers claimed tax deduction (A)	Total amount of VHIS qualifying premiums allowed (HK\$ billion)	Total no. of taxpayers (B)	Percentage share of taxpayers claimed tax deduction in total no. of taxpayers (A/B)
Year of assessment 2019-20	155 000	1.019	1 910 000	8%
Year of assessment 2020-21	247 000	1.693	1 821 000	14%
Year of assessment 2021-22	329 000	2.355	1 807 000	18%
Year of assessment 2022-23	404 000	2.987	1 834 000	22%
Year of assessment 2023-24 (preliminary figures)	456 000	3.480	1 896 000	24%

4. The VHIS has been fully implemented since April 2019, aiming to provide the general public with a choice of individual indemnity hospital insurance products which are subject to specific regulation and of high market transparency. It offers consumers with greater confidence in purchasing health insurance and using private healthcare services when in need, thereby alleviating pressure on public healthcare system in the long run.

Since the full implementation of the VHIS, the number of policies under the scheme has been increasing. That said, the period is still relatively short and affected by the three-year long COVID-19 epidemic. The Health Bureau will closely monitor the implementation of the VHIS and the market response, collect market data and listen to the views of various stakeholders. We will review the effectiveness of the VHIS and possible areas for refinement in due course, so as to respond to the latest trends in the healthcare market and dovetail with the various public health policies of the Government.

- End -

CONTROLLING OFFICER'S REPLY

HHB065

(Question Serial No. 1310)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

With the number of suicide cases in Hong Kong rising in recent years, the mental health of Hong Kong people has been a cause for concern. In this connection, will the Government inform this Committee of the following:

1. the manpower establishment of doctors, nurses and allied health professionals of the psychiatric services of the Hospital Authority (HA) in 2023-24 and 2024-25;
2. the expenditure on mental health services in 2023-24 and 2024-25 and the estimated expenditure for 2025-26;
3. the total number of psychiatric patients receiving treatment in 2023-24 and 2024-25 by hospital cluster; and
4. HA's initiatives and expenditure on enhancing mental health services in 2024-25, as well as the planned and estimated expenditure for 2025-26.

Asked by: Hon IP LAU Suk-ye, Regina (LegCo internal reference no.: 35)

Reply:

Suicidal behaviour is a complex social phenomenon involving a multitude of factors such as problems related to emotions, personal health, family relationship, romantic relationship, finances, work and studies. The Government attaches great importance to suicide prevention and has been providing multi-disciplinary and cross-sectoral support to persons with suicidal tendency and their families through co-ordination and collaboration among various bureaux and departments (including the Education Bureau, the Health Bureau, the Department of Health, the Labour and Welfare Bureau and the Social Welfare Department), public organisations and other stakeholders in the community.

(1)

The table below sets out the numbers of doctors, nurses and allied health professionals working in the psychiatric stream in the Hospital Authority (HA) in 2023-24 and 2024-25 (as of 31 December 2024).

Year	Psychiatric Doctors ^{1,2,3}	Psychiatric Nurses ^{1,2,4} (including Community Psychiatric Nurses)	Allied Health Professionals		
			Clinical Psychologists ^{1,6}	Medical Social Workers ⁵	Occupational Therapists ^{1,6}
2023-24	399	3 064	108	257	300
2024-25 (as of 31 December 2024)	414	3 147	116	257	338

Note:

1. The manpower figures above are calculated on full-time equivalent (FTE) basis including permanent, contract and temporary staff in all HA clusters, but excluding those in the HA Head Office.
2. FTE for temporary part-time staff is calculated based on their actual working hours starting from January 2024. The relevant figures prior to that month are for reference only and cannot be directly compared with the current revised calculation.
3. Psychiatric doctors refer to all doctors working for the specialty of psychiatry except interns.
4. Psychiatric nurses include all nurses working in psychiatric hospitals (i.e. Kwai Chung Hospital, Castle Peak Hospital and Siu Lam Hospital), nurses working in psychiatric departments of other non-psychiatric hospitals, as well as all nurses in psychiatric stream.
5. Information on the number of medical social workers supporting psychiatric services in the HA are provided by the Social Welfare Department.
6. Clinical psychologists and occupational therapists working in psychiatric stream include those working in psychiatric hospitals (i.e. Kwai Chung Hospital, Castle Peak Hospital and Siu Lam Hospital), those working in psychiatric departments of other non-psychiatric hospitals, as well as those engaging in psychiatric-related work.

(2)

The table below sets out the expenditure for providing mental health services by the HA from 2023-24 to 2025-26.

Year	Expenditure on Mental Health Services (\$ million)
2023-24	6,585
2024-25 (Revised Estimate)	7,042
2025-26 (Estimate)	7,321

The expenditure on mental health services includes direct staff costs (such as doctors, nurses and allied health professionals) for providing services to patients; expenditure incurred for

various clinical support services (such as pharmacy); and other operating costs (such as meals for patients, utility expenses and repair and maintenance of medical equipment).

(3)

The table below sets out the total number of psychiatric patients receiving treatment in each hospital cluster under the HA in 2023-24 and 2024-25 (projection as of 31 December 2024).

Year	Hospital Cluster							HA Overall
	HKEC	HKWC	KCC	KEC	KWC	NTEC	NTWC	
2023-24	27 200	25 900	23 400	45 200	85 000	57 700	50 800	309 400
2024-25 (projection as of 31 December 2024)	28 300	26 300	24 400	46 800	88 000	60 100	53 000	320 600

Note:

1. Including inpatients, patients at specialist outpatient clinics and day hospitals.
2. Figures are rounded to the nearest hundred.
3. The figures for each hospital cluster may not add up to the total as patients may be treated in more than one hospital cluster.

(4)

The table below sets out the initiatives of the HA to enhance mental health services in 2024-25 and 2025-26:

Year	Initiatives	Additional Funding
2024-25	(a) Enhancing the community psychiatric services by further recruiting additional case managers; (b) Strengthening nursing manpower as well as allied health and peer support for psychiatric inpatient and outpatient services; and (c) Enhancing the use of long-acting injectable antipsychotics in the treatment of mental illness.	Around \$127 million
2025-26	(a) Optimising nursing manpower as well as allied health support for psychiatric inpatient and outpatient services; (b) Enhancing Child and Adolescent Psychiatric Service; and (c) Enhancing Mental Health Direct Hotline service.	Around \$25 million

- End -

CONTROLLING OFFICER'S REPLY

HHB066

(Question Serial No. 3086)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

To make use of technology to enhance patient experience, the Hospital Authority (HA) has been promoting the development of telehealth services since 2021-22 and introduced medication delivery services in March 2023. In this connection, will the Government inform this Committee of the following:

1. the number of telehealth attendances from the 2021-22 to 2024-25 financial years;
2. the number of elderly home residents using telehealth services from the 2021-22 to 2024-25 financial years;
3. the number of patients using medication delivery services in the 2023-24 and 2024-25 financial years;
4. the expenditure on promoting telehealth and medication delivery services from the 2021-22 to 2024-25 financial years; and
5. the estimated expenditure on promoting telehealth and medication delivery services for the 2025-26 financial year.

Asked by: Hon IP LAU Suk-yee, Regina (LegCo internal reference no.: 40)

Reply:

1. and 2.

The Hospital Authority (HA) has all along been striving to optimise the use of technology to enhance service quality and patient experience. The HA is actively promoting telehealth to provide an additional option for suitable patients, so that they may receive healthcare services from the HA without making in-person visits to hospitals or clinics for medical consultation. Telehealth services have been introduced in different out-patient, day-patient, inpatient and outreach services. The table below sets out the number of attendances for the HA's telehealth services in the past 4 years:

Year	Number of telehealth service attendances ^{Note}
2021-22	5 111
2022-23	91 645
2023-24	119 581
2024-25 (up to 31 December 2024)	96 885

As for the application of telehealth in residential care homes for the elderly (RCHEs), the HA provides telehealth services to elderly patients in RCHEs in accordance with their clinical needs and actual operation conditions. The services are now extended to RCHEs in all districts in Hong Kong. The Community Geriatric Assessment Teams (CGAT) of the HA provide comprehensive multi-disciplinary care (including medical consultations, nursing assessments and treatments, as well as community rehabilitation services by allied health professionals) to elderly patients in need through regular visits to RCHEs in various districts. The primary target group is frail elderly patients in RCHEs with complex health problems and poor functional and mobility status. The HA does not maintain the statistics on attendances for telehealth services provided by the CGAT prior to April 2022. The numbers of attendances for telehealth services provided by the HA's CGAT in the past 3 years are set out in the table below:

Year	Numbers of attendances for telehealth services provided by the CGAT ^{Note}
2022-23	51 707
2023-24	60 839
2024-25 (up to 31 December 2024)	34 554

Note:

In view of the emergence of the COVID-19 epidemic in Hong Kong since early 2020, the HA adjusted its services in response to the epidemic. This should be taken into account when comparing the HA's service throughout in relevant years. With the cessation of anti-epidemic measures in early 2023, the HA's services have returned to normal gradually.

3.

At present, the HA's medication delivery services are applicable to patients attending specialist out-patient clinics, general out-patient clinics, discharged from hospitals, and receiving accident and emergency services in all hospitals and clinics under the HA. Meanwhile, the medication delivery services also fully support the out-patient clinics with telehealth services. Patients can arrange delivery of their medications to their homes or other specified addresses through the HA's mobile application "HA Go", and also choose to collect HA-dispensed medications at community collection points. The figures on the HA's medication delivery services used by patients in 2023-24 and 2024-25 (as at 31 December 2024) are tabulated below:

Year	Count of medication delivery services used by patients
2023-24	12 008
2024-25 (up to 31 December 2024)	21 775

4. and 5.

The HA is actively promoting telehealth, and regularly reviews the effectiveness of application of telehealth and its associated support services like medication delivery services. The efforts include exploring application of information technology in appropriate healthcare services progressively, such as in different out-patient, day-patient, inpatient and outreach services, with a view to benefitting more patients in need.

Meanwhile, the HA also carefully takes into account the limitations of telehealth, and decides whether and how telehealth should be applied having regard to the doctors' professional criteria and the patients' conditions. For example, patients who need to undergo clinical examinations are required to visit hospitals in person to ensure the accuracy of consultation.

The HA adopts an integrated and multi-disciplinary approach in service provision which allows flexible deployment of staff to cope with service needs and operational requirements. As supporting and promoting telehealth services under the HA also provide support for other services, the HA cannot separately quantify the manpower and relevant expenditure for supporting and promoting telehealth services cannot be separately quantified.

- End -

CONTROLLING OFFICER'S REPLY

HHB067

(Question Serial No. 1257)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: Not Specified

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Hong Kong Genome Institute (HKGI) was established in 2020 and launched the Hong Kong Genome Project in 2021. A provision of \$1.2 billion was earmarked to cover expenses until 2024-25. It is learnt that over 28 000 participants from about 18 000 families have been recruited as at last year to commence the local genome sequencing project. In this connection, will the Government please inform this Committee of the following:

1. How many samples and clinical data have been collected in the HKGI's database so far?
2. The provision earmarked for the project covers the period ending this year and the outstanding balance is small. In the face of the financial pressure, will the Government explore working with institutions such as large pharmaceutical enterprises in the next phase of research to obtain more financial or research support?
3. Hong Kong is planning to establish a third medical school. How will the HKGI participate in the development plan so as to nurture local professional talents in genomics in support of the city's development in medical innovation?
4. As the project involves a huge amount of private personal data, the Government stated earlier that it would consider legislating on genome data privacy. What progress has been made?

Asked by: Hon KONG Yuk-foon, Doreen (LegCo internal reference no.: 19)

Reply:

1. Launched in 2021, the Hong Kong Genome Project (HKGP) is the first large-scale whole genome sequencing project in Hong Kong. It aims to lay a foundation for the development of genomic medicine and collect 40 000 to 50 000 samples by 2025 for whole genome sequencing. As at 1 March 2025, the HKGP has recruited over 44 000 participants, and the relevant samples and clinical data have been stored at the HKGI.

2. As the HKGP progresses into the next stage, the HKGI is now actively building a genome database, such as encrypting relevant data and implementing stringent data management measures and procedures, with a view to facilitate the sharing of de-identified data, thereby promoting and supporting collaboration with researchers and enterprises (such as health technology and medical research companies). This is expected to provide new sources of income for the HKGI.
3. Established in October 2024, the Task Group on New Medical School (the Task Group) is responsible for devising the direction and parameters for a new medical school and selecting a suitable university for setting up the new medical school. The Task Group has received a total of 3 proposals for the establishment of the third medical school which are submitted by Hong Kong Baptist University, the Hong Kong Polytechnic University, and the Hong Kong University of Science and Technology respectively. The Task Group will adopt a holistic and comprehensive approach for evaluating the proposals submitted by universities from various perspectives, in accordance with the 10 key parameters set (including innovative strategic positioning and research excellence).

The HKGI has been actively collaborating with local universities and professional institutions (such as the University of Hong Kong, the Chinese University of Hong Kong, the Hong Kong Academy of Medicine and the Hong Kong College of Physicians) to establish scholarships, research grants, training programmes and internship programmes, etc., aiming at nurturing talents in genomic medicine. When the third local medical school is officially established, the HKGI will explore to closely collaborate with it to further promote the long-term development of genomic medicine.

4. The Health Bureau has earlier commissioned an independent consultant to conduct an evaluation on the HKGP. The third phase of study will examine international regulatory requirements and applications regarding genetic confidentiality, and it is expected to be completed in the second half of 2025. The Government will refer to the recommendations in the report to explore the directions for regulating the collection, access and use of human genetic data.

- End -

CONTROLLING OFFICER'S REPLY

HHB068

(Question Serial No. 1267)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The estimate for the Health Bureau in 2025-26 is \$4.085 billion, a nearly 30% increase on the revised estimate for the previous year. In this connection, please advise this Committee of the following:

- (1) given the estimated expenditure on primary healthcare development has increased by nearly \$568 million over the previous year, how the increased expenditure is to be spent?
- (2) What are the details of the increased funding for The Chinese Medicine Hospital of Hong Kong? What are the specific timetable for its opening and service plans?
- (3) What are the details of the 3 posts to be created in 2025-26 including their ranks, job descriptions and staff remuneration expenditure?
- (4) What are the estimated annual number of beneficiaries and expenditure of the 2 new schemes, namely the Primary Dental Co-care Pilot Scheme for Adolescents and Community Dental Support Programme?
- (5) Has the Government allocated more resources to the policies and initiatives for mental health in 2025-26? Are there any plans for the Government to conduct a comprehensive statistical survey to get all the data on mental health across Hong Kong for more timely policy formulation?

Asked by: Hon KONG Yuk-foon, Doreen (LegCo internal reference no.: 29)

Reply:

(1)

The estimates for 2025-26 includes expenditures related to the development of primary healthcare. The increase as compared to last year is mainly due to the expansion of the District Health Centre (DHC) network and its multidisciplinary service network, as well as the Chronic Disease Co-Care Pilot Scheme (CDCC Pilot Scheme) to accommodate the

anticipated increase in the number of service users in 2025-26 and the requirements of the Scheme expansion.

The Government set up DHCs and smaller interim DHC Expresses (DHCEs) across the territory by the end of 2022, thereby attaining the interim goal of “covering all 18 districts”. The Primary Healthcare Commission (PHCC) continues to take forward the plan of establishing DHCs in all districts, including the preparation for upgrading the 3 DHCEs in the Central and Western District, Yau Tsim Mong District and Eastern District to DHCs within 2025. By then, 10 out of the 18 Districts in Hong Kong will have DHCs in place to serve members of the public. Each DHC will set up several satellite centres/service points and DHCEs will set up service points to expand public reach.

The PHCC will commence the integration of women health services within this year in an orderly manner. The services, operated by non-governmental organisations engaged by open tender, will be rendered through 3 service points named Women Wellness Satellites (WWSs) to provide primary healthcare services for women. The 3 WWSs in Chai Wan, Lam Tin and Tuen Mun will progressively start service in 2025 to replace the Woman Health Centres of the Department of Health (DH). The Chai Wan WWS will commence operation in the second quarter while the Lam Tin and Tuen Mun WWSs are expected to be open in the third quarter. DHCs and DHCEs across all 18 districts will enhance promotion and education on women’s health, and provide new dedicated nurse clinics for women’s health services to encourage and support members of the public to manage their own health. DHCs and DHCEs will also identify women in need through basic health assessments and individual consultations, and refer them to WWSs or General Out-patient Clinics (GOPCs) of the Hospital Authority (HA) to receive women’s health services.

The Government has launched the Chronic Disease Co-Care Pilot Scheme (CDCC Pilot Scheme) since 13 November 2023 to provide subsidised diabetes mellitus (DM) and hypertension (HT) screening services in the private healthcare sector to Hong Kong residents aged 45 or above with no known medical history of DM or HT. Since 20 January 2025, the dedicated nurse clinic and allied health services (including optometrists, physiotherapists and dietitians) have been introduced to devise more comprehensive chronic disease management programmes for the CDCC Pilot Scheme’s participants. From 28 March 2025, the CDCC Pilot Scheme has been further expanded to cover blood lipid testing for eligible participants, allowing a more comprehensive approach to the assessment and proper management of cardiovascular disease risk factors, including the “three highs” (high blood pressure, high blood sugar and high cholesterol). Starting from the same day, the Scheme will be expanded in phases to provide preventive screening and care services in GOPCs of the HA for the underprivileged group. The 2025-26 estimates cover the medical service expenditures required for the scheme expansion, including doctor consultations, laboratory tests, medications, nurse clinics, and allied health services, etc.

(2)

The Chinese Medicine Hospital of Hong Kong (CMHHK) is constructed by the Government and operated under a public-private-partnership model. In 2021, Hong Kong Baptist University (HKBU) was selected through tendering procedures as the Contractor for operation of the CMHHK. In the same year, HKBU incorporated the HKBU Chinese Medicine Hospital Company Limited as the Operator. HKBU and the Operator have since been working together on the commissioning tasks as stipulated in the service deed. The

Hospital Chief Executive and other core management team members (the Core Management Team) were in post in January 2024. The Core Management Team is in the process of formulating hospital structure and systems and undertaking preparatory work having regard to the hospital service commencement plan.

The construction works of the CMHHK commenced in June 2021, with the hospital building expected to be handed over in batches to the Health Bureau (HKB) starting in mid-2025. The CMHHK is expected to commence services in phases from the end of 2025 and, depending on the progress, and demand and supply, will operate in full scale within 5 years after service commencement. The expected timetable for the opening of the hospital and the service programmes are as follows:

Timetable	Outpatient service attendance	Day bed	Inpatient bed	Clinical Trial and Research Centre (CTRC) bed	High dependency bed	Community outreach service attendance
During the first 12 months	48 900	25	0	0	0	0
During the second year	81 400	35	93	20	2	0
During the third year	162 800	35	185	20	3	Add-on market-oriented services: 300
During the fourth year	244 200	35	185	20	3	Subsidised services: 600 Add-on market-oriented services: 300
During the fifth year	310 000	100	276	20	4	Subsidised services: 2 000 Add-on market-oriented services: 1 000

The CMHHK will serve as a local flagship Chinese medicine (CM) institution for promoting the development of CM including Chinese medicines. It will also play the role of a change driver to foster the development of CM services, education and training, innovation and research in Hong Kong. Apart from providing quality clinical services, the CMHHK will also establish a collaborative network with Chinese Medicine Clinics cum Training and Research Centres, universities and the CM sector to further promote the development of CM in the areas of clinical services, education and training, research, collaboration and creating health values.

The clinical services of the CMHHK cover primary, secondary and tertiary care, offering pure CM services, services with CM playing the predominant role and integrated Chinese-Western medicine services. The CMHHK will provide inpatient and outpatient services, as well as specialised CM services including Internal Medicine in CM, External Medicine in CM, Gynecology in CM, Paediatrics in CM, Orthopedics and Traumatology in CM, and Acupuncture and Moxibustion in CM. The CMHHK will launch special disease programmes for strategic development, in the light of the medical needs of the Hong Kong population, advantages and strengths of CM, as well as the availability of talents and collaborative support with other institutions.

The clinical services of the CMHHK will be provided by Chinese medicine practitioners (CMPs) as clinicians-in-charge, in collaboration with a multi-disciplinary team, comprising of CMPs, doctors, nurses, staff of CM and western medicine professionals and other allied health professionals. The teams of CMPs and doctors will collaborate to provide services through consultation. The CMHHK will also provide community outreach services and comprehensive rehabilitation services, including physiotherapy, occupational therapy, speech therapy and other allied health services. However, accident and emergency services, general anaesthetic surgical services, intensive care services and child delivery services will not be provided in the CMHHK.

Regarding the financial resources to support the CMHHK project, the Finance Committee of the Legislative Council approved the following commitments in 2021 under the Capital Works Reserve Fund Head 703 Buildings, Capital Works Reserve Fund Head 710 Computerisation, and the subhead of General non-recurrent of Head 140 respectively:

Item	Amount
The Development of Chinese Medicine Hospital (CMH) in Tseung Kwan O	\$8.62 billion
IT support for the new CMH	\$383.9 million
Preparation for Service Commencement of the CMH	\$80.445 million

In its estimate for 2025-26, the HHB has earmarked about \$203 million to cater for the relevant expenditure on the CMHHK project, an increase of approximately HK\$171.9 million compared to the revised estimate for 2024-2025, in order to facilitate the commissioning of the CMHHK.

(3)

There will be a net increase of 3 posts in the HHB in 2025-26. Details are as follows:

Rank	Number	Notional Annual Mid-point Salary (\$)	Purpose/Reason
Creation of 5 posts			
Senior Administrative Officer (Time-limited post)	+1	1,645,020	To provide policy support for matters on manpower planning for healthcare professionals, including the establishment of a new medical school
Senior Executive Officer (Time-limited post)	+1	1,221,300	To provide administrative support to the Clinical Trial Development Team
Senior Executive Officer (Time-limited post)	+1	1,221,300	To assist in monitoring the Hong Kong Genome Institute (HKGI) and provide administrative support for genomic medicine-related policies
Senior Executive Officer (Time-limited post)	+1	1,221,300	To provide administrative support for the implementation of primary healthcare-related policies
Executive Officer I	+1	892,140	To provide administrative support for policies related to end-of-life care
Deletion of 2 posts			
Nursing Officer	-1	852,120	Upon several years of operation, the HKGI has established its publicity and genetic counselling teams. The time-limited post thus does not need to be extended and will lapse accordingly
Assistant Information Officer	-1	564,120	Lapse of a time-limited post in the Secretariat Press Office
Total:	+3		

(4)

The DH launched the Primary Dental Co-care Pilot Scheme for Adolescents (PDCC) on 20 March this year as an interface with the School Dental Care Service by providing partial subsidies for private dental check-up services for adolescents aged between 13 and 17 on a co-payment basis to foster their partnership with dentists and maintain the good life-long habit of regular oral check-ups for prevention of dental diseases. Adolescents aged 13 to 17 (or will turn 13 in the calendar year when applying to join the PDCC) who hold a valid Hong Kong Identity Card and have registered in the Electronic Health Record Sharing System (eHealth) are eligible to join the PDCC. About 370 000 adolescents are eligible to join each year. While the Government will provide a subsidy of \$200 each time, participants have to pay a co-payment fee as determined by their selected dentists. The co-payment for the subsidised services each time as recommended by the Government is \$200. As at 18 March, there are around 270 registered dentists whose application to participate in the PDCC has been accepted by the DH, providing services at over 370 service locations. Among these dentists,

over 67% charge a co-payment amount of \$200 or less while the minimum co-payment amount is \$50. The DH has publicised the PDCC in collaboration with the Education Bureau (EDB) to all secondary school students and their parents in the territory. The final number of participants will depend on the response from students and their parents.

On top of the existing dental grants under the Comprehensive Social Security Assistance Scheme and the emergency dental service provided through General Public Sessions by government dental clinics, the DH will increase the dental services to underprivileged groups with financial difficulties by launching the Community Dental Support Programme (CDSP) in 2025 and enhancing service capacity, increasing service points and expanding service scope, aiming to additionally offer at least twice the current number of quotas provided by the General Public Sessions of government dental clinics (i.e. 40 000 per year). The CDSP leverages the networks of non-governmental organisations and social welfare organisations serving underprivileged groups to provide services to persons with financial difficulties more effectively. In addition to tooth extraction, the CDSP provides dental fillings where dentists consider appropriate to encourage tooth retention.

With regard to the implementation of PDCC and CDSP, the Government earmarks a financial provision of \$136.3 million for 2025-26.

(5)

The Government attaches great importance to the mental well-being of the public. It adopts an integrated approach in the promotion of mental health through a service delivery model that covers prevention, early identification, timely intervention and treatment, and rehabilitation for persons in need. From promoting self-care, primary care and community support to offering specialist care and institutionalised services, the Government seeks to provide multi-disciplinary and cross-sectoral services to persons with mental health needs through collaboration and co-operation among the HHB, the DH, the Labour and Welfare Bureau (LWB), the EDB, the Social Welfare Department (SWD), the HA, non-governmental organisations (NGOs) and other stakeholders in the community.

The Government has introduced a number of mental health-related policy initiatives, and will extend integrated services based on a medical-educational-social collaboration model to promote mental health. Key measures include:

- (a) The HA enhanced manpower and further optimised the ratio of case manager under the Case Management Programme to patients to no higher than 1:40 in the fourth quarter of 2023. The HA has earmarked additional funding of around \$127 million in 2024-25 to enhance mental health services. Relevant measures include: (i) enhancing the community psychiatric services by further recruiting additional case managers; (ii) strengthening nursing manpower as well as allied health and peer support for psychiatric inpatient and outpatient services; and (iii) enhancing the use of long-acting injectable antipsychotics in the treatment of mental illness. An additional funding of around \$25 million is earmarked in 2025-26 to further enhance the nursing manpower and allied health support for psychiatric inpatient and outpatient services, enhance mental health services for children and adolescents, and strengthen the “Mental Health Direct” hotline service;

- (b) Through cross-departmental collaboration of the HHB, the EDB and the SWD, the Three-Tier School-based Emergency Mechanism was implemented in December 2023 to provide support to students with higher suicidal risks as early as possible. The initiative has been extended to end-2025. A breakdown is not available as the expenditure and manpower involved in the Three-Tier School-based Emergency Mechanism are absorbed by existing resources of the relevant departments;
- (c) The HHB launched the “18111 - Mental Health Support Hotline” in December 2023 to provide one-stop, round-the-clock support for people with mental needs, rendering immediate mental health support and referral services. The time-limited recurrent expenditure for 2023-24, 2024-25 and 2025-26 is about \$9.9 million;
- (d) The HHB set up a service centre dedicated to emotional support and counselling services for ethnic minorities in December 2023, with a multi-professional team comprising social workers, counsellors and support staff conversant in ethnic minority languages, to provide mental health support and counselling services to ethnic minorities and refer cases to other service platforms for additional support and/or treatment if needed. The time-limited recurrent expenditure for 2023-24, 2024-25 and 2025-26 is about \$8.1 million;
- (e) The HHB launched the Healthy Mind Pilot Project in 3 District Health Centres in August 2024 in collaboration with community organisations, to provide mental health assessments for the public and ensure early follow-up and referral of high-risk cases, so that the individuals in question can receive support as appropriate in a timely manner. The time-limited recurrent expenditure for 2024-25 and 2025-26 is about \$9.6 million;
- (f) The HHB provided Care Team members with mental health support training (including Mental Health First Aid training) in 2024 to assist in the early referral of persons in need in the local community for support. The time-limited recurrent expenditure for 2024-25 is about \$290,000;
- (g) In 2023-24, the SWD increased the manpower of clinical psychologists in 24 Integrated Community Centres for Mental Wellness (ICCMWs) to strengthen professional support and training, and provided additional funding to assist the ICCMWs in enhancing the application of information technology in service delivery so as to strengthen the support for persons in mental recovery and their carers. The additional annual recurrent expenditure incurred is about \$23 million;
- (h) The SWD enhanced the services of ICCMWs in 2024-25, including strengthening early identification of persons with mental health needs and early intervention, and scaling up the training of social workers in community mental health service units to raise their capacity in handling complicated cases. The annual expenditure incurred is about \$60 million;
- (i) The SWD strengthened peer support services in 2024-25 by creating additional full-time peer supporter positions, including those of senior level and dedicated to carers. The SWD will also set up 4 additional Parents/Relatives Resource Centres for carers of those in mental recovery in the second quarter of 2025 to support persons in mental recovery

and their carers. The annual expenditure incurred in these 2 projects is about \$26 million;

- (j) The SWD plans to enhance the services of Cyber Youth Support Teams in the second quarter of 2025 by providing an online support platform for the emotional wellness of young people, which offers real-time online counselling services to students or young people facing emotional distress or at immediate risk. The estimated expenditure for 2025-26 is about \$25.88 million; and
- (k) The SWD plans to set up an additional ICCMW in the first quarter of 2026 to provide one-stop district-based community support services ranging from prevention to risk management. Additionally, the SWD will regularise the Pilot Project on Transitional Support Service for Persons in Mental Recovery in the first quarter of 2026 to offer sustained support to persons preparing to be discharged from hospitals while are on the waiting list for halfway house services. The annual expenditure involved in these 2 projects is about \$37 million.

On mental health promotion and public education, the Government has earmarked an annual recurrent funding of \$50 million for the implementation of the “Shall We Talk” mental health promotion and public education initiative. Launched in July 2020 with the support of the Advisory Committee on Mental Health (ACMH), the initiative aims to step up public engagement in promoting mental well-being; to enhance public awareness of mental health, with a view to encouraging help-seeking and early intervention; and to reduce stigma towards people with mental health needs. The initiative continues to make use of both offline channels and emerging online platforms to reach out to people from all walks of life, which includes (a) launching a one-stop mental health thematic website (shallwetalk.hk) to provide one-stop information and resources on mental health to the public and broadcasting videos on social media platforms, featuring the sharing of personal experiences and feelings by various stakeholders (including artists and key opinion leaders) to encourage the public to recognise mental health issues; (b) implementing the “Mental Health Workplace Charter” (Charter) to promote mental well-being at workplace. Additionally, as announced in the Chief Executive’s 2024 Policy Address, an annual promotional theme will be set for the Charter and recognition will be given to participating organisations for achieving targets; (c) broadcasting promotional videos on the television, the radio and other media; and (d) organising tours in different districts, primary schools, secondary schools and tertiary institutions to promote mental health messages.

At the same time, the LWB collaborates with NGOs in organising public education programmes to enhance the public’s awareness of mental health and disability inclusion, such as the annual “Mental Health Month” programme in support of the “World Mental Health Day”. The SWD also subsidises NGOs to set up mobile vans for publicity across the territory to promote mental health in the community.

Regarding statistical surveys, the DH conducts regular territory-wide population health survey, which includes the collection of data on self-reported and doctor-diagnosed mental health issues from respondents. The Student Health Service of the DH also covers mental health-related assessments. Through clinical examinations and questionnaire screenings, individual students are assessed/referred based on aspects such as their psychosocial behaviours, and relevant data are taken into account in adjusting the health messages and

service arrangements for students. These surveys are conducted on a regular basis and are effective in providing information for continuous assessment of the mental health status of the public.

Furthermore, on the recommendation of the ACMH, the Government commissioned the University of Hong Kong and the Chinese University of Hong Kong to conduct 3 mental health surveys in 2019, covering children and adolescents aged 6 to 17, youth aged 15 to 24, and elderly persons aged 60 or above to collect data on the mental health status of the Hong Kong population. The 3 surveys were completed in 2023 and the survey findings have been released. In collaboration with the relevant government bureaux and departments, the HHB will proactively follow up on the survey reports and the recommendations made by the ACMH, and fully utilise the data obtained from the surveys to formulate comprehensive and targeted policies and support measures, with a view to enhancing the mental health of different age groups in society. The Government will consult the ACMH in a timely manner to consider the need and methodology for conducting longitudinal surveys in the future.

- End -

CONTROLLING OFFICER'S REPLY

HHB069

(Question Serial No. 1649)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

In respect of the matters requiring special attention in 2025-26 under Programme (2), it is mentioned that the Health Bureau will continue to take forward and implement the five-year plan of eHealth+ aiming to develop a personalised eHealth account for every resident to manage their digital health data, and to integrate the healthcare service processes in both public and private sectors. In this connection, will the Government inform this Committee of:

1. the total number of public hospitals, public clinics, private hospitals and private healthcare institutions (including clinics, residential care homes for the elderly and welfare organisations providing healthcare services) in Hong Kong which have registered as healthcare providers since the launch of eHealth in 2016; and
2. the total number of doctors, dentists, Chinese medicine practitioners and healthcare professionals in Hong Kong who have registered with access to the electronic health records (eHRs) in eHealth since it was launched in 2016.
3. At present, the number of eHRs uploaded by private healthcare institutions remains very low, accounting for less than 1% of the total number of eHRs. This is a major obstacle to patients' access to a continuum of care. What targeted measures or incentives will the Bureau consider to encourage more private healthcare institutions to upload patients' medical records to eHealth;
4. Although some 6 000 000 members of the public have registered for eHealth, about 70% of them have not yet given 'sharing consent' to any private healthcare institutions. In this connection, will the Bureau consider amending the Electronic Health Record Sharing System Ordinance to further streamline the current sharing consent process on the premise that members of the public participate in eHealth voluntarily;
5. As a sophisticated system with more functions, eHealth+ will inevitably incur additional recurrent expenses, such as staff costs, as well as hardware and software maintenance costs. How much recurrent and non-recurrent funding is expected to be earmarked for the

development of eHealth+ in the coming 5 years? Please provide a breakdown by expenditure type.

Asked by: Hon KOON Ho-ming, Peter Douglas (LegCo internal reference no.: 1)

Reply:

eHealth is a territory-wide electronic health record sharing system launched by the Government in 2016 that enables citizens to authorise healthcare providers (HCPs) in the public and private sectors to view and share their electronic health records (eHRs) for healthcare purposes. Building on the strengths of the existing infrastructure of eHealth, the Government announced in the 2023 Policy Address the initiative to roll out a five-year development plan of eHealth+ to transform eHealth into a comprehensive healthcare information infrastructure that integrates multiple functions of data sharing, service delivery and care journey management. eHealth+ aims to facilitate care coordination, cross-sector collaboration, as well as active health management and surveillance, thereby better serving our citizens in obtaining optimal healthcare services, and supporting the healthcare reform and various healthcare policies more effectively, such as primary healthcare and cross-boundary healthcare services. The Government is taking forward the eHealth+ development in phases in accordance with the patient-centric principle and 4 strategic directions, namely, “One Health Record”, “One Care Journey”, “One Digital Front Door to Empowering Tool” and “One Health Data Repository”.

The reply to the question raised by the Hon Peter Douglas Koon is as follows:

(1) and (2) As of end-February 2025, eHealth has covered over 80% of the Hong Kong population and the majority of public and private HCPs. The number of HCPs registered with eHealth by the type of organisation is tabulated as follows:

Type of HCPs	Number of HCPs Registered with eHealth (on an Organisational Basis)	Number of Healthcare Service Locations Registered with eHealth
Public hospitals (i.e. hospitals under the Hospital Authority (HA))	1	43
Public clinics (e.g. clinics under the HA and the Department of Health)	11	390
Other public HCPs (e.g. District Health Centres)	20	217
Private hospitals	13	43
Other private HCPs (e.g. clinics, residential care homes for the elderly, and social welfare organisations providing healthcare services)	3 681	6 018
Total	3 726	6 711

Besides, as of end-February 2025, about 58 800 healthcare professionals (HCProfs) have registered with eHealth. The number of registered HCProfs by profession is tabulated as follows:

Type of HCProfs	Number of HCProfs Registered with eHealth	Percentage of Registered HCProfs
Doctor	13 190	82%
Dentist	1 731	60%
Chinese medicine practitioner	966	9%
Other HCProfs (e.g. nurse, pharmacist, and radiographer)	42 940	48%
Total	58 827	49%

(3) and (4) Under the strategic development direction of “One Health Record”, we seek to consolidate the longitudinal eHRs of citizens spread across a multitude of healthcare processes into their personal eHealth accounts. A comprehensive and complete eHR profile enables the HCPs authorised by citizens to respond to their health needs more effectively, thus enhancing clinical outcomes and saving costs of the care process. Nevertheless, while private HCPs have been actively using eHealth in supporting clinical processes as evidenced by the fact that nearly 60% of eHR access by HCPs as of end-February 2025 were by private HCPs, more than 99% of some 4.5 billion eHRs shared on eHealth are from public HCPs.

The Government has been taking a multi-pronged approach to incentivise and facilitate the provision of citizens’ eHRs into eHealth by private HCPs, thereby assisting citizens in accessing, managing and using their own eHRs during the healthcare process more conveniently. Last year, the Government launched a platform enabling self-service data compliance testing to simplify the technical testing procedures, and provided dedicated technical support to healthcare institutions. When taking forward various public-private partnership programmes, the Government would require HCPs to deposit the related medical records of the participating citizens into eHealth. The Government also rolled out the eHealth Adoption Sponsorship Pilot Scheme (the Pilot Scheme) by partnering with electronic medical record (eMR) solutions vendors and medical groups to co-fund system enhancements in achieving seamless eHR sharing between eHealth and eMR systems in the market. From July 2023 to February 2025, about 80 private HCPs (involving around 480 private doctors and 200 service locations) connected to eHealth and provided more than 1.12 million eHRs under the Pilot Scheme.

With the Government’s endeavours, the eHRs provided by private HCPs in a year increased from 2.19 million in 2023 to 3.67 million in 2024. The Government will continue to collaborate with the private healthcare sector to enhance the connectivity between eHealth and their eMR solutions. In particular, given the positive impacts of the Pilot Scheme, we have progressively expanded the scheme to include more eMR solution vendors, medical groups and other sectors, including Chinese medicine. We will also launch the eHealth+ accreditation scheme in 2025 to enable citizens to easily identify if an HCP has the capability to deposit health records into their personal eHealth accounts and the extent of data involved. Citizens can make reference to such information in choosing a suitable HCP, to ensure that their medical records will be deposited in their personal eHealth accounts.

Besides, the Government introduced the Electronic Health Record Sharing System (Amendment) Bill 2025 (the Amendment Bill) into the Legislative Council this year to provide a legal framework to assist citizens in building a more comprehensive eHR profile.

Among other things, the Amendment Bill will streamline the consent mechanism such that once citizens agree to join eHealth, their HCPs will be able to deposit health data into their personal eHealth accounts. Meanwhile, citizens will continue to retain full control over their personal data and can grant individual HCPs access to their eHealth records at their own will. The Amendment Bill will also empower the Secretary for Health to require specified HCPs to provide specified important health data into the personal eHealth accounts of citizens registered with eHealth and with their consents, in order to facilitate citizens' easy access and control of their key health information.

The Government will continue to provide support and collaborate with the private healthcare sector to enable the majority of private HCPs to seamlessly connect with eHealth; and will consider providing additional assistance to healthcare institutions and HCProfs that are less prepared for digitalisation.

(5) In July 2024, the Finance Committee of the Legislative Council approved a commitment of \$1,395.8 million for the eHealth+ development. A breakdown of the estimated expenditure is tabulated below:

Item	Expenditure (\$'000)
(a) Hardware	44,495
(b) Software	80,194
(c) Communication network	19,291
(d) Development team	
(i) Programme Office, project management and external engagement	92,188
(ii) Product, clinical services design and architect	115,237
(iii) Product development and implementation	115,235
(iv) Security and quality assurance	138,283
(e) Implementation services	
(i) Technical consultancy and services	63,232
(ii) Software development services	252,930
(iii) Cybersecurity and quality assurance	126,465
(iv) Rollout, engagement and implementation	189,696
(f) Training	1,784
(g) Others	29,895
Sub-total	1,268,925
(h) Contingency	126,893
Total	1,395,818

We expect that upon full implementation of the five-year plan of eHealth+, the system operation of eHealth+, as a comprehensive and integrated healthcare information infrastructure with more features and complexity, will incur additional recurrent expenditures such as those on hardware and software maintenance, system maintenance and professional

support services as well as communication network. The actual expenditure required will depend on the nature and quantity of new features developed, the pace of project development, prevailing technology advancement, market changes and the progress and effectiveness of service transformation and system process integration. When the development of the eHealth+ is more mature, we will adhere to the value for money principle and review in detail the recurrent expenditure required for the project.

- End -

CONTROLLING OFFICER'S REPLY

HHB070

(Question Serial No. 1650)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in the Matters Requiring Special Attention in 2025-26 under Programme (2) that the Health Bureau will continue to take forward and enhance the development of District Health Centres (DHCs) and District Health Centre Expresses (DHCEs) across the territory, and integrate the services of Woman Health Centres and Elderly Health Centres into DHC Network. In this connection, will the Government inform this Committee:

1. of the following information on various DHCs: (i) the number of attendances, (ii) the number of referrals received from public hospitals, and (iii) the types of such referrals since their commencement of service;
2. whether the Bureau will increase resources and manpower in the coming year to enhance the services provided by various DHCs and DHCEs, and whether it will set relevant Key Performance Indicators (KPIs) for the services provided by them; if yes, of the estimated expenditure involved; if not, the reasons for that;
3. whether the Bureau has reserved suitable sites for setting up DHCs given that primary healthcare co-ordination work in many districts in Hong Kong is still undertaken by interim DHCEs at present; and
4. as the Government mentioned earlier that it will upgrade the 3 DHCEs in Central and Western District, Yau Tsim Mong District and Eastern District into DHCs this year, of the estimated recurrent and non-recurrent funding requirements in the future and the estimated staffing and expenditure involved for the coming year?

Asked by: Hon KOON Ho-ming, Peter Douglas (LegCo internal reference no.: 2)

Reply:

(1)

The cumulative numbers of attendances of District Health Centres (DHCs) and District Health Centre Expresses (DHCEs) are set out in the table below:

DHC/DHCE Service Commencement Date	Cumulative Number of Attendances Notes 1, 2, 3, 4, 5 (as at 31 December 2024) [Provisional Figures]
<i>DHC</i>	
Kwai Tsing 24 September 2019	498 300
Sham Shui Po 30 June 2021	296 600
Tuen Mun 31 May 2022	344 100
Wong Tai Sin 30 June 2022	200 900
Southern 17 October 2022	175 300
Yuen Long 24 October 2022	255 000
Tsuen Wan 30 December 2022	175 700
<i>DHCE</i>	
Sai Kung 1 September 2021	84 900
Kowloon City 1 October 2021	57 300
Yau Tsim Mong 1 October 2021	48 500
Wan Chai 4 October 2021	53 000
North 18 October 2021	53 700
Islands 18 October 2021	35 900
Kwun Tong 21 October 2021	49 300
Tai Po 22 October 2021	45 000
Sha Tin 30 October 2021	71 400
Central and Western 30 October 2021	50 200
Eastern 30 October 2021	54 700
Total	2 549 900

Note:

1. Figures are rounded to the nearest hundred.
2. The figures only include service figures captured from the DHC/DHCE information system, and do not include those relating to medical laboratory tests.
3. As different services are provided by the 11 DHCEs, the attendance figures are not directly comparable.
4. The service figures above have included services provided by DHCs/DHCEs for participants of the Chronic Disease Co-care Pilot Scheme which was launched on 13 November 2023.
5. The figures include cases referred by the Hospital Authority. The Health Bureau (HHB) does not maintain other separate breakdown mentioned in the question.

(2)

The Primary Healthcare Commission (PHCC) was established in July 2024 to oversee primary healthcare service delivery, standard setting and quality assurance, etc. under one roof. Regarding the services of DHCs, the PHCC appoints non-governmental organisations as operators through open tender. The relevant operation service contracts have specified the facilities and service requirements, including the qualifications and relevant experience of key staff, the districts and number of ancillary centres/service points to be set up, the staffing establishment of the centres, etc.

The PHCC continuously reviews the services of DHCs so as to strengthen their role as the co-ordinators of community primary healthcare services and case managers. As such, the PHCC has adjusted the terms of the operating service contracts, including adjusting the categorisation of service targets to tie in with the enhancement of DHC services, such as the pairing of family doctors with citizens and the provision of nurse clinic services. Also, operators are required to achieve or exceed the predetermined service targets within the contract period to be eligible for contract gratuities and incentive payment, so as to encourage the operators to actively enhance their service standards. The contract also states that the Government shall have the right to terminate the contract if an operator fails to comply with the contract requirements.

The PHCC uploaded the DHC performance indicators, including “DHC new members received information and knowledge on life course preventive care (LCPC) together with individualised LCPC health advice” and “Seasonal flu vaccination rate”, onto the DHC website for public access in December 2024. In addition, the PHCC is progressively enhancing the performance monitoring mechanism of the DHCs by regularly reviewing a number of quantitative and qualitatively related aspects, including service volume, operational effectiveness and health-related outcomes, to assess the performance of the DHCs, and to make timely recommendations to the operators for improvement. The PHCC will take into account the relevant assessment results when renewing the operating service contracts.

(3) and (4)

The Government set up 7 DHCs and 11 smaller interim DHCEs in rented properties across the territory by 2022, thereby attaining the interim goal of covering all 18 districts of Hong Kong. The Government will upgrade the 3 DHCEs in the Central and Western District,

Eastern District, and Yau Tsim Mong District to DHCs within 2025. In April 2024, the HHB launched a tender exercise for the operation of the Central and Western DHC and three women's health service points named Women Wellness Satellites located in Chai Wan, Lam Tin and Tuen Mun. A 3-year operation service contract with a total value of approximately \$531.7 million was subsequently awarded in January 2025. The Central and Western DHC is expected to commence operation in the third quarter of this year. In July 2024, the HHB conducted tender exercises for the operation of the Eastern and Yau Tsim Mong DHCs. The operation service contracts for these 2 DHCs are expected to be awarded this year.

Upon the upgrading of the three DHCEs to DHCs this year, the 11 existing DHCEs will gradually reduce to 8, while the number of DHCs will increase to 10. The estimated expenditure for DHCs and DHCEs (including provisions for service contracts, site maintenance and rental cost) for 2025-26 are \$1.083 billion and \$213 million respectively.

In addition, the funding proposals for the construction projects of Wan Chai, Kwun Tong, Sai Kung and North District DHCs were approved by the Finance Committee of the Legislative Council (LegCo) in January and October 2021, and in April and July 2024 respectively. These projects will be completed gradually in the next few years. To achieve the long-term development goal of having DHCs in all 18 districts as early as possible, the Government is actively taking forward the plan to establish DHCs in the remaining four districts and will seek LegCo's funding approval in due course. Before the remaining DHCs are set up, the Government will continue to subsidise non-governmental organisations to operate DHCEs in those districts. The services provided by DHCEs will be migrated as appropriate to DHCs in respective districts at a later stage. The PHCC will, together with the operators of DHCEs, draw up and implement transition plans for upgrading DHCEs to DHCs to ensure a smooth transition of services.

The above work is carried out by the PHCC as part of its overall functions, and there is no separate staff establishment. Therefore, information on the expenditure and staff establishment involved in the related work is not available.

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CONTROLLING OFFICER'S REPLY

HHB071

(Question Serial No. 1652)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding specialist services, will the Government inform this Committee of:

1. the number of specialist out-patient (clinical) attendances in each hospital cluster of the Hospital Authority (HA) in each of the past 3 years, with a breakdown by major speciality, including (i) Ear, Nose and Throat, (ii) Gynaecology, (iii) Medicine, (iv) Ophthalmology, (v) Orthopaedics and Traumatology, (vi) Surgery, (vii) Paediatrics and (viii) Psychiatry;
2. the numbers of inpatient discharges and deaths in each hospital cluster of the HA in each of the past 3 years, with a breakdown by major specialty, including (i) Ear, Nose and Throat, (ii) Gynaecology, (iii) Medicine, (iv) Ophthalmology, (v) Orthopaedics and Traumatology, (vi) Surgery, (vii) Paediatrics and (viii) Psychiatry; and
3. the number of new cases and the median waiting time for specialist out-patient services in each hospital cluster of the HA in each of the past 3 years, with a breakdown by major specialty, including (i) Ear, Nose and Throat, (ii) Gynaecology, (iii) Medicine, (iv) Ophthalmology, (v) Orthopaedics and Traumatology, (vi) Surgery, (vii) Paediatrics and (viii) Psychiatry?

Asked by: Hon KOON Ho-ming, Peter Douglas (LegCo internal reference no.: 4)

Reply:

1.
The tables below set out the number of specialist out-patient (clinical) attendances in each hospital cluster of the Hospital Authority (HA) in 2022-23, 2023-24 and 2024-25 (up to 31 December 2024):

2022-23

Specialty	Number of specialist out-patient (clinical) attendances							
	HKEC	HKWC	KCC	KEC	KWC	NTEC	NTWC	HA Overall
ENT	45 557	30 839	54 379	45 479	52 565	67 374	44 393	340 586
GYN	27 726	42 878	68 315	38 424	28 361	40 803	32 798	279 305
MED	313 234	302 004	404 847	259 346	477 275	413 247	338 790	2 508 743
OPH	127 407	88 581	267 654	137 661	175 571	182 611	201 094	1 180 579
ORT	66 746	64 059	109 214	92 954	124 766	121 663	89 729	669 131
PAE	13 351	23 367	76 790	33 253	34 727	36 031	30 525	248 044
PSY	92 888	73 226	74 586	128 875	253 461	165 866	178 297	967 199
SUR	89 730	132 757	185 616	119 787	158 996	144 179	117 774	948 839
All Specialties (including specialties other than those stated above)	855 718	881 886	1 487 946	922 340	1 403 480	1 353 969	1 138 405	8 043 744

2023-24

Specialty	Number of specialist out-patient (clinical) attendances							
	HKEC	HKWC	KCC	KEC	KWC	NTEC	NTWC	HA Overall
ENT	49 776	34 117	52 061	50 094	59 091	67 327	47 210	359 676
GYN	27 212	43 296	68 826	40 487	29 175	40 828	33 896	283 720
MED	314 576	309 706	416 331	268 773	489 828	437 344	351 378	2 587 936
OPH	137 803	92 348	273 312	143 292	190 472	195 264	214 200	1 246 691
ORT	70 242	64 963	114 424	99 332	132 263	125 690	92 480	699 394
PAE	14 681	24 518	80 892	37 333	37 692	38 453	34 268	267 837
PSY	94 251	71 823	76 648	128 748	259 951	167 940	179 598	978 959
SUR	96 257	136 885	199 320	127 214	165 574	149 285	123 846	998 381
All Specialties (including specialties other than those stated above)	885 236	899 870	1 547 024	968 181	1 465 256	1 412 468	1 190 072	8 368 107

2024-25 (Up to 31 December 2024)

Specialty	Number of specialist out-patient (clinical) attendances							
	HKEC	HKWC	KCC	KEC	KWC	NTEC	NTWC	HA Overall
ENT	38 340	29 623	39 229	39 434	48 560	53 660	37 935	286 781
GYN	21 402	33 125	54 524	34 458	22 974	32 986	25 352	224 821
MED	246 469	240 159	317 718	208 698	372 481	339 166	274 494	1 999 185
OPH	105 236	75 881	215 746	115 592	149 879	150 800	168 398	981 532
ORT	54 076	48 539	86 811	74 183	105 132	99 599	72 737	541 077
PAE	11 825	19 718	65 295	31 861	28 645	29 939	27 610	214 893
PSY	72 618	56 319	60 688	99 557	202 718	130 419	141 536	763 855
SUR	77 652	109 716	159 953	103 240	126 210	116 172	95 839	788 782
All Specialties (including specialties other than those stated above)	692 065	706 097	1 206 800	764 023	1 136 342	1 097 539	932 473	6 535 339

2.

The following tables set out information with breakdown by specialty in each hospital cluster of the HA in 2022-23, 2023-24 and 2024-25 (up to 31 December 2024) regarding:

- (i) the number of in-patient discharges and deaths; and
- (ii) the number of day in-patient discharges and deaths.

2022-23

Specialty	Number of in-patient discharges and deaths							
	HKEC	HKWC	KCC	KEC	KWC	NTEC	NTWC	HA Overall
ENT	460	1 174	1 055	729	1 082	1 380	1 721	7 601
GYN	2 531	2 752	5 949	3 384	4 420	2 878	4 374	26 288
MED	46 606	47 107	84 327	57 621	84 284	76 865	54 013	450 823
OPH	717	581	834	368	861	665	871	4 897
ORT	9 326	8 025	16 978	12 343	18 179	17 380	11 832	94 063
PAE	3 263	3 097	11 718	6 827	7 981	7 422	5 434	45 742
PSY	1 642	565	2 994	537	4 309	3 787	2 743	16 577
SUR	15 634	18 200	29 799	19 198	32 584	23 188	22 832	161 435

Specialty	Number of day in-patient discharges and deaths							
	HKEC	HKWC	KCC	KEC	KWC	NTEC	NTWC	HA Overall
ENT	1 312	1 023	599	1 549	1 060	3 324	2 030	10 897
GYN	2 222	4 878	3 479	2 282	1 822	4 352	9 025	28 060
MED	26 792	53 687	59 228	47 798	46 917	64 488	36 373	335 283
OPH	4 742	5 542	7 609	6 240	2 178	5 851	4 960	37 122
ORT	4 234	1 097	4 940	1 428	2 102	4 320	2 076	20 197
PAE	591	1 878	15 407	752	3 380	3 548	1 211	26 767
PSY	2	2	13	4	29	22	26	98
SUR	15 463	20 480	17 505	10 742	23 352	25 629	17 279	130 450

2023-24

Specialty	Number of in-patient discharges and deaths							
	HKEC	HKWC	KCC	KEC	KWC	NTEC	NTWC	HA Overall
ENT	673	1 384	1 346	819	1 097	1 458	1 900	8 677
GYN	2 960	2 906	6 830	3 676	4 412	2 835	4 614	28 233
MED	50 902	48 525	96 671	65 324	94 879	87 567	58 100	501 968
OPH	845	522	958	477	1 535	724	984	6 045
ORT	10 825	9 078	19 626	14 074	20 065	19 497	14 336	107 501
PAE	5 659	5 277	20 924	11 409	14 827	14 235	11 127	83 458
PSY	2 107	638	3 385	512	5 176	4 297	3 046	19 161
SUR	18 369	19 724	34 773	21 145	35 252	25 311	26 147	180 721

Specialty	Number of day in-patient discharges and deaths							
	HKEC	HKWC	KCC	KEC	KWC	NTEC	NTWC	HA Overall
ENT	1 385	1 285	821	2 183	1 787	3 755	2 536	13 752
GYN	2 268	4 905	3 633	3 438	2 700	4 560	9 248	30 752
MED	29 224	58 520	67 195	52 285	54 327	72 228	39 069	372 848
OPH	6 322	6 314	8 408	6 493	2 521	6 208	4 628	40 894
ORT	7 539	1 288	4 559	2 015	2 393	4 471	2 730	24 995
PAE	2 798	1 790	16 238	1 172	5 202	4 452	1 150	32 802
PSY	2	1	16	3	50	27	43	142
SUR	17 246	22 228	19 832	12 812	25 380	27 078	20 462	145 038

2024-25 (Up to 31 December 2024)

Specialty	Number of in-patient discharges and deaths							
	HKEC	HKWC	KCC	KEC	KWC	NTEC	NTWC	HA Overall
ENT	483	1 053	1 010	602	858	1 103	1 646	6 755
GYN	2 064	2 346	5 272	2 741	3 183	2 277	3 334	21 217
MED	37 958	35 339	71 057	47 922	67 358	67 559	44 497	371 690
OPH	755	428	688	388	1 060	563	707	4 589
ORT	8 377	7 280	15 516	10 636	15 345	15 385	11 451	83 990
PAE	3 685	3 444	14 581	7 359	9 484	8 854	7 264	54 671
PSY	1 662	551	2 456	462	3 950	3 630	2 588	15 299
SUR	14 313	15 885	27 575	16 661	27 165	20 205	20 096	141 900

Specialty	Number of day in-patient discharges and deaths							
	HKEC	HKWC	KCC	KEC	KWC	NTEC	NTWC	HA Overall
ENT	973	1 141	759	1 704	1 385	3 147	2 391	11 500
GYN	1 847	3 559	2 912	3 092	2 354	3 961	7 248	24 973
MED	24 495	46 464	52 908	42 944	43 364	58 635	31 097	299 907
OPH	5 569	4 889	6 610	5 337	1 685	4 467	3 700	32 257
ORT	5 855	1 179	4 100	1 660	1 883	3 070	2 221	19 968
PAE	2 500	1 354	12 504	883	4 011	3 910	954	26 116
PSY	1	0	27	2	29	15	26	100
SUR	13 789	18 569	15 483	10 105	19 521	20 289	16 487	114 243

Note:

In the HA, day in-patients refer to those who are admitted to hospitals for non-emergency treatment and discharged within the same day. In-patients are those who are admitted to hospitals via Accident & Emergency departments or those who have stayed for more than 1 day.

3.

The tables below set out the number of specialist out-patient new cases triaged as Priority 1 (urgent), Priority 2 (semi-urgent) and Routine (stable) cases and their respective median waiting time (50th percentile) in each hospital cluster of the HA in 2022-23, 2023-24 and 2024-25 (up to 31 December 2024):

Cluster	Specialty	Priority 1		Priority 2		Routine	
		Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)
HKEC	ENT	488	<1	3 502	4	4 910	14
	GYN	695	<1	541	6	3 904	25
	MED	963	1	3 178	5	10 668	48
	OPH	4 482	<1	3 041	5	7 584	52
	ORT	1 311	1	1 293	5	6 688	55
	PAE	76	1	673	4	286	9
	PSY	302	<1	897	3	3 296	19
	SUR	999	1	3 168	7	10 867	46
HKWC	ENT	961	<1	2 085	7	3 605	65
	GYN	1 244	<1	907	6	3 859	34
	MED	1 802	<1	1 793	4	11 414	34
	OPH	2 454	1	1 777	4	6 669	55
	ORT	1 265	1	1 409	4	7 808	20
	PAE	103	<1	361	5	1 122	11
	PSY	363	1	687	4	1 920	41
	SUR	2 441	<1	2 999	4	10 716	26
KCC	ENT	1 985	<1	2 088	4	13 181	37
	GYN	934	<1	2 944	6	7 482	30
	MED	1 210	1	3 593	6	21 992	71
	OPH	6 983	<1	6 604	2	10 388	71
	ORT	1 978	1	1 977	4	11 819	51
	PAE	1 145	<1	1 605	4	2 748	10
	PSY	195	<1	1 318	4	2 347	18
	SUR	2 561	1	5 434	5	27 365	37

Cluster	Specialty	Priority 1		Priority 2		Routine	
		Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)
KEC	ENT	1 611	<1	2 606	6	6 742	86
	GYN	1 574	1	834	4	5 798	57
	MED	1 804	1	4 788	6	19 030	58
	OPH	5 520	<1	5 238	6	10 786	71
	ORT	2 975	<1	2 571	3	9 969	71
	PAE	731	<1	531	4	2 959	10
	PSY	265	1	2 322	3	5 238	52
	SUR	1 814	1	5 204	7	18 083	71
KWC	ENT	2 024	<1	2 303	5	10 662	62
	GYN	222	<1	1 595	6	7 468	46
	MED	1 752	1	5 585	6	15 897	72
	OPH	6 194	<1	5 886	5	9 144	167
	ORT	1 860	<1	3 251	4	12 632	54
	PAE	1 334	<1	1 138	4	2 840	9
	PSY	232	<1	909	4	13 129	29
	SUR	1 874	1	5 953	5	21 840	52
NTEC	ENT	2 469	<1	3 040	4	12 300	50
	GYN	2 216	<1	981	6	7 629	57
	MED	2 407	<1	3 201	6	21 681	48
	OPH	6 635	<1	4 053	4	15 941	52
	ORT	4 524	<1	1 360	4	14 346	45
	PAE	107	<1	407	6	3 701	16
	PSY	828	1	2 427	4	6 342	64
	SUR	2 166	1	2 992	5	26 850	32
NTWC	ENT	3 808	<1	1 380	4	8 828	61
	GYN	1 169	<1	353	6	4 814	62
	MED	1 013	<1	2 404	6	9 591	38
	OPH	10 901	<1	3 449	4	8 243	59
	ORT	1 896	1	1 793	6	9 791	31
	PAE	265	<1	1 059	6	1 951	23
	PSY	377	1	1 459	3	6 027	55
	SUR	1 986	1	5 057	5	18 527	49

Cluster	Specialty	Priority 1		Priority 2		Routine	
		Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)
HA Overall	ENT	13 346	<1	17 004	5	60 228	50
	GYN	8 054	<1	8 155	6	40 954	39
	MED	10 951	1	24 542	6	110 273	54
	OPH	43 169	<1	30 048	4	68 755	55
	ORT	15 809	<1	13 654	4	73 053	48
	PAE	3 761	<1	5 774	4	15 607	12
	PSY	2 562	1	10 019	4	38 299	40
	SUR	13 841	1	30 807	5	134 248	46

2023-24

Cluster	Specialty	Priority 1		Priority 2		Routine	
		Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)
HKEC	ENT	394	<1	3 903	4	5 701	14
	GYN	662	<1	559	6	3 903	25
	MED	699	1	3 412	5	11 750	37
	OPH	4 817	<1	3 799	7	8 817	42
	ORT	1 247	1	1 314	5	6 329	51
	PAE	43	<1	834	6	522	12
	PSY	240	1	766	3	3 655	26
	SUR	878	1	3 078	7	11 116	44
HKWC	ENT	1 154	<1	2 466	7	3 802	26
	GYN	1 431	<1	1 046	5	3 385	27
	MED	1 776	<1	1 946	4	11 123	30
	OPH	2 433	1	1 714	6	6 607	61
	ORT	1 023	1	1 759	4	8 267	20
	PAE	96	1	306	4	1 444	16
	PSY	348	1	811	4	1 914	40
	SUR	2 570	<1	3 218	5	11 190	17

Cluster	Specialty	Priority 1		Priority 2		Routine	
		Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)
KCC	ENT	1 991	<1	2 218	4	13 327	38
	GYN	924	<1	2 885	6	8 097	35
	MED	1 451	1	4 220	6	24 333	57
	OPH	7 328	<1	6 380	2	13 655	85
	ORT	1 307	1	2 378	3	11 901	36
	PAE	1 090	<1	1 930	6	3 480	12
	PSY	271	<1	1 204	3	2 394	20
	SUR	2 369	1	5 907	5	29 556	33
KEC	ENT	1 996	<1	2 959	4	7 932	70
	GYN	1 465	1	905	5	5 447	36
	MED	1 346	1	5 059	5	21 385	56
	OPH	5 764	<1	5 464	6	12 707	84
	ORT	3 233	<1	2 147	4	11 351	57
	PAE	718	<1	545	4	3 544	12
	PSY	272	1	2 066	3	5 455	47
	SUR	1 953	1	5 616	6	19 290	59
KWC	ENT	2 517	<1	2 966	4	12 440	33
	GYN	181	<1	1 696	6	7 475	58
	MED	1 631	1	6 007	6	16 300	62
	OPH	6 357	<1	4 887	5	7 961	74
	ORT	2 086	<1	2 672	3	13 386	50
	PAE	1 259	<1	1 167	6	3 199	11
	PSY	256	<1	795	3	12 947	26
	SUR	1 872	1	5 506	5	23 999	53
NTEC	ENT	2 404	<1	3 104	5	13 897	36
	GYN	2 057	<1	1 028	5	7 687	59
	MED	1 876	1	3 283	6	20 158	40
	OPH	7 005	<1	3 444	4	18 595	78
	ORT	4 632	<1	1 419	5	14 818	58
	PAE	93	<1	394	7	4 759	23
	PSY	829	1	2 310	4	6 701	73
	SUR	2 246	1	3 236	5	27 342	30

Cluster	Specialty	Priority 1		Priority 2		Routine	
		Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)
NTWC	ENT	4 317	<1	1 743	4	10 089	35
	GYN	1 062	<1	314	5	5 030	60
	MED	1 309	<1	2 517	6	10 474	27
	OPH	11 555	<1	6 686	3	8 051	82
	ORT	2 006	1	1 990	6	9 961	36
	PAE	210	1	1 052	6	2 929	21
	PSY	390	1	1 597	3	5 873	34
	SUR	1 947	1	4 625	5	19 741	35
HA Overall	ENT	14 773	<1	19 359	5	67 188	36
	GYN	7 782	<1	8 433	5	41 024	39
	MED	10 088	1	26 444	6	115 523	49
	OPH	45 259	<1	32 374	4	76 393	66
	ORT	15 534	<1	13 679	4	76 013	45
	PAE	3 509	<1	6 228	6	19 877	15
	PSY	2 606	1	9 549	3	38 939	40
	SUR	13 835	1	31 186	5	142 234	40

2024-25 (Up to 31 December 2024)

Cluster	Specialty	Priority 1		Priority 2		Routine	
		Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)
HKEC	ENT	491	<1	2 568	5	4 519	26
	GYN	481	<1	366	7	3 091	25
	MED	586	1	2 496	5	9 484	29
	OPH	3 517	<1	2 718	7	6 270	30
	ORT	926	1	975	5	5 254	30
	PAE	40	<1	679	6	436	15
	PSY	106	1	437	3	3 037	39
	SUR	693	1	2 545	7	8 724	39

Cluster	Specialty	Priority 1		Priority 2		Routine	
		Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)
HKWC	ENT	929	<1	1 907	7	3 148	41
	GYN	1 176	1	899	5	2 627	28
	MED	1 319	<1	1 729	4	8 581	30
	OPH	2 040	1	1 229	6	4 086	61
	ORT	692	1	1 498	4	5 991	23
	PAE	59	1	207	4	1 185	20
	PSY	230	1	569	3	1 522	42
	SUR	1 916	<1	2 641	4	8 889	19
KCC	ENT	1 272	<1	1 388	4	10 035	40
	GYN	713	<1	2 295	6	6 464	31
	MED	1 002	1	3 190	6	18 566	61
	OPH	5 717	<1	4 759	3	10 007	91
	ORT	789	1	1 993	4	8 659	24
	PAE	869	<1	1 742	5	3 468	10
	PSY	212	<1	925	3	1 813	21
	SUR	1 685	1	4 296	5	23 396	37
KEC	ENT	1 472	<1	1 993	4	7 131	80
	GYN	1 000	1	785	5	4 508	31
	MED	922	1	3 331	6	15 866	47
	OPH	4 738	<1	4 216	7	9 079	74
	ORT	2 324	<1	1 494	5	8 781	51
	PAE	498	<1	446	4	2 715	11
	PSY	197	1	1 353	3	4 520	45
	SUR	1 506	1	4 277	6	14 463	58
KWC	ENT	2 523	<1	2 378	4	8 901	39
	GYN	149	<1	1 259	6	5 982	70
	MED	1 039	1	4 351	6	12 486	67
	OPH	4 820	<1	3 807	8	7 815	35
	ORT	1 399	1	2 132	3	10 150	53
	PAE	781	<1	503	6	3 015	17
	PSY	158	<1	395	2	10 266	25
	SUR	1 303	1	3 931	5	19 591	58

Cluster	Specialty	Priority 1		Priority 2		Routine	
		Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)
NTEC	ENT	1 900	<1	2 570	5	10 775	31
	GYN	1 475	<1	689	5	6 066	61
	MED	1 407	1	2 778	6	16 953	49
	OPH	5 556	<1	2 815	6	13 958	74
	ORT	3 581	<1	1 493	5	10 716	29
	PAE	72	<1	293	6	3 502	36
	PSY	482	1	1 858	4	5 531	78
	SUR	2 147	1	2 767	5	20 216	32
NTWC	ENT	3 090	<1	981	5	8 872	52
	GYN	318	<1	273	4	4 224	58
	MED	1 158	<1	2 035	6	8 442	38
	OPH	9 555	<1	3 314	4	6 521	75
	ORT	1 551	1	1 491	6	8 425	33
	PAE	140	<1	892	5	2 016	28
	PSY	291	<1	1 398	2	4 566	39
	SUR	1 302	1	3 290	5	16 606	39
HA Overall	ENT	11 677	<1	13 785	5	53 381	40
	GYN	5 312	<1	6 566	6	32 962	36
	MED	7 433	1	19 910	6	90 378	48
	OPH	35 943	<1	22 858	5	57 736	64
	ORT	11 262	<1	11 076	4	57 976	35
	PAE	2 459	<1	4 762	5	16 337	17
	PSY	1 676	1	6 935	3	31 255	41
	SUR	10 552	1	23 747	6	111 885	40

Note:

With effect from 1 October 2022, integrated clinics have been incorporated with respect to the waiting time for new case booking into Specialist Out-patient Clinics.

Note [Parts 1, 2 and 3]:

In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA has adjusted its services to cope with the epidemic. This factor should be taken into consideration when comparing the service throughput of the HA in the relevant years. With the cessation of various anti-epidemic measures in early 2023, the HA's services have returned to normalcy gradually.

Abbreviations

Cluster

HKEC – Hong Kong East Cluster
HKWC – Hong Kong West Cluster
KCC – Kowloon Central Cluster
KEC – Kowloon East Cluster
KWC – Kowloon West Cluster
NTEC – New Territories East Cluster
NTWC – New Territories West Cluster

Specialty

ENT – Ear, Nose & Throat
MED – Medicine
GYN – Gynaecology
OPH – Ophthalmology
ORT – Orthopaedics & Traumatology
PAE – Paediatrics
PSY – Psychiatry
SUR – Surgery

- End -

CONTROLLING OFFICER'S REPLY

HHB072

(Question Serial No. 1653)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

In December 2019, the Hospital Authority (HA) established the Task Group on Sustainability to review major challenges encountered by the HA, and to formulate relevant strategic directions on manpower, hardware facilities, smart technologies and operation efficiency. Regarding the review on staff retention strategy, will the Government inform this Committee of the following:

1. the respective annual numbers of applications received and approved under the Enhanced Home Loan Interest Subsidy Scheme since its launch;
2. the respective annual numbers of doctors, nurses, allied health professionals and supporting/other grades staff who have been extended employment beyond retirement since the launch of the Extending Employment Beyond Retirement (EER) arrangement;
3. the numbers of HA doctors, nurses and nursing staff who left the service in each of the past 3 years, with a breakdown by length of service and rank;
4. whether other measures will be introduced by the HA to attract, develop and retain healthcare manpower for supporting its overall service needs and development?

Asked by: Hon KOON Ho-ming, Peter Douglas (LegCo internal reference no.: 5)

Reply:

(1)

Since the launch of the Hospital Authority (HA)'s Home Loan Interest Subsidy Scheme (HLISS) in late December 2022, a total of 1 619 applications had been received as at 31 December 2024, of which 1 330 eligible applicants had been granted approval-in-principle to submit a formal loan application to the HA for property purchase or arrangement for property mortgage.

The distribution of staff with approval-in-principle granted is as follows:

Staff Group	Number of Staff with Approval-in-Principle Granted
Doctors	131
Nursing	580
Allied Health Professionals	301
Administration and General Grades Staff	318
Total	1 330

Since the launch of the HLISS till 31 December 2024, a total of 201 staff drew down their loans.

(2)

The number of staff serving on full-time⁽¹⁾/part-time⁽²⁾ terms after retirement as of December in the past 3 years (i.e. from 2022 to 2024) are tabulated below:

Staff Group	December 2022		December 2023		December 2024	
	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time
Doctors	103 ⁽³⁾	1	144 ⁽³⁾	214	181 ⁽³⁾	269
Nursing	263	4	427	378	565	502
Allied Health Professionals ⁽⁴⁾	57	1	86	79	113	104
Supporting/Other Grades Staff	2 868	24	2 964	350	3 020	473
Total	3 291	30	3 621	1021	3 879	1 348

Note:

- (1) The number of staff refers to the number of existing staff on full-time contract/permanent terms with employment extended beyond retirement in each year as at 31 December in various years.
- (2) With effect from 1 December 2022, retired staff who have been employed on a part-time basis under the “Extending Employment Beyond Retirement” (EER) policy will be subject to employment arrangements in accordance with the remuneration and terms of employment under the EER policy. They will also be taken out from the “part-time staff” category and separately grouped under “EER part-time staff” for ease of compilation. The number of staff refers to the number of existing part-time staff with employment extended beyond retirement as at 31 December in various years.
- (3) Including 1 Dental Consultant
- (4) “Allied Health Professionals” group includes radiographers, medical technologists/medical laboratory technicians, occupational therapists, physiotherapists, pharmacists and medical social workers, etc.

(3)

Tables 1 to 4 set out the attrition (wastage) figures and manpower figures of doctors and nursing staff in the HA in the past 3 years.

Table 1: Attrition (wastage) figures of full-time doctors⁽¹⁾⁽²⁾ by year of service and rank in 2022-23, 2023-24 and 2024-25 (rolling 12 months from January to December 2024)

Year of Service	2022-23			2023-24 ⁽³⁾			2024-25 (Rolling 12 Months from January to December 2024) ⁽³⁾		
	CON	SMO/AC	MO/R	CON	SMO/AC	MO/R	CON	SMO/AC	MO/R
< 1 year	0	2	10	5	3	10	6	16	18
1 - < 6 years	14	4	79	9	7	81	8	7	76
6 - < 11 years	3	26	38	1	17	43	1	29	47
11 - < 16 years	6	64	13	4	55	15	6	41	8
16 - < 21 years	11	51	6	11	29	3	13	23	1
21 - < 26 years	9	20	1	8	10	1	7	5	4
26 - < 31 years	39	17	13	11	6	1	14	8	2
31 years or above	6	2	2	6	4	0	4	3	3

Table 2: Number of doctors on full-time equivalent basis⁽²⁾⁽⁴⁾ by rank in 2022-23, 2023-24 and 2024-25 (as at 31 December 2024)

Rank	2022-23 (As at 31 March 2023)	2023-24 (As at 31 March 2024) ⁽⁵⁾	2024-25 (As at 31 December 2024) ⁽⁵⁾
CON	1 222	1 305	1 369
SMO/AC	2 011	1 991	1 946
MO/R	3 308	3 511	3 868
Total	6 541	6 807	7 184

Note:

- (1) Attrition (wastage) includes all types of cessation of service (including retirement) from the HA for permanent and contract staff on headcount basis.
- (2) Doctors exclude Interns and Dental Officers.
- (3) From January 2024 onwards, the number of staff employed under EER has been excluded from attrition (wastage). Relevant figures prior to that month are estimates and for reference only and direct comparison with the data under the revised compilation method is not appropriate.
- (4) The above manpower figures are calculated on full-time equivalent basis including permanent, contract and temporary staff in the HA. Individual figures may not add up to the total due to rounding.

- (5) Starting from January 2024, full-time equivalent for temporary part-time staff is calculated based on their actual working hours. Relevant figures prior to that month are for reference only and cannot be directly compared with the data under the revised compilation method.

Table 3: Attrition (wastage) figures of full-time nursing staff⁽¹⁾ by year of service and rank in 2022-23, 2023-24 and 2024-25 (rolling 12 months from January to December 2024)

Year of Service	2022-23				2023-24 ⁽²⁾				2024-25 (Rolling 12 Months from January to December 2024) ⁽²⁾			
	DOM/ NC/ SNO and above (5)	APN/ NS/ NO/ WM/ ANC (6)	RN	EN/ Others	DOM/ NC/ SNO and above (5)	APN/ NS/ NO/ WM/ ANC (6)	RN	EN/ Others	DOM/ NC/ SNO and above (5)	APN/ NS/ NO/ WM/ ANC (6)	RN	EN/ Others
< 1 year	0	9	196	88	1	13	165	80	2	12	181	68
1 – < 6 years	0	33	940	116	2	20	802	78	0	31	668	65
6 – < 11 years	0	39	438	20	1	35	353	11	0	28	316	15
11 – < 16 years	0	59	120	5	2	43	89	5	2	58	102	3
16 – < 21 years	0	31	27	1	0	34	20	2	1	22	22	1
21 – < 26 years	1	48	72	3	1	21	23	5	1	16	9	1
26 – < 31 years	35	245	214	77	14	84	85	14	12	74	69	8
31 years or above	8	61	38	16	10	80	68	29	19	99	92	36

Table 4: Number of nursing staff on full-time equivalent basis⁽³⁾ by rank in 2022-23, 2023-24 and 2024-25 (as at 31 December 2024)

Rank	2022-23 (As at 31 March 2023)	2023-24 (As at 31 March 2024) ⁽⁴⁾	2024-25 (As at 31 December 2024) ⁽⁴⁾
DOM/NC/ SNO and above ⁽⁵⁾	499	534	539
APN/NS/NO/ WM/ANC ⁽⁶⁾	6 851	7 164	7 325
RN	17 832	17 975	18 867
EN/Others	4 417	3 193	2 807
Total	29 599	28 865	29 538

Note:

- (1) Attrition (wastage) includes all types of cessation of service (including retirement) from the HA for permanent and contract staff on headcount basis.
- (2) From January 2024 onwards, the number of staff employed under EER has been excluded from attrition (wastage). Relevant figures prior to that month are for reference only and cannot be directly compared with the data under the revised compilation method.
- (3) The above manpower figures are calculated on full-time equivalent basis including permanent, contract and temporary staff in the HA. Individual figures may not add up to the total due to rounding.
- (4) Starting from January 2024, full-time equivalent for temporary part-time staff is calculated based on their actual working hours. Relevant figures prior to that month are for reference only and cannot be directly compared with the data under the revised compilation method.
- (5) Since August 2022, the “DMO/SNO and above” rank group has been revised to “DMO/NC/SNO and above”.
- (6) After the creation of the rank of Associate Nurse Consultant, the “APN/NS/NO/WM” rank group was revised to “APN/NS/NO/WM/ANC” in August 2022.

(4)

Over the years, the HA has been closely monitoring its manpower situation and introduced a series of measures to attract, develop and retain talents. The HA has implemented ongoing measures within its overall budget, including increasing the number of Resident Trainee posts to recruit local medical graduates, recruiting non-locally trained doctors to supplement local recruitment, improving promotion prospects to retain staff, hiring part-time healthcare staff (e.g. via recruitment of locum staff), offering flexible work arrangements, extending employment to suitable staff beyond retirement, enhancing the HLISS, and providing better training opportunities for various staff grades by establishing the HA Academy.

The HA established the Task Group on Sustainability in December 2019 to review strategies for retaining staff. In line with the key directions recommended by the Task Group, the HA

gradually rolled out further staff retention measures in 2023-24 and will continue with the relevant work in 2025-26, including:

- (a) creating opportunities for Associate Consultants to be promoted to Consultant rank, so as to retain experienced medical personnel to address the service, manpower and training needs in the HA;
- (b) providing Specialty Nurse Allowance to eligible registered nurses, so as to retain manpower and encourage professional development of nurses through recognising their specialty qualifications;
- (c) providing more career advancement opportunities for its allied health professionals and providing Specialist Allied Health Professionals Allowance for eligible resident physiotherapists, occupational therapists and radiographers, so as to retain manpower and support the demand for and development of specialist services; and
- (d) continuing efforts in implementing EER to attract more retired staff who are willing to stay after retirement.

The HA will continue to closely monitor the manpower situation and make proactive arrangements to attract, develop and retain talents for supporting the overall service demand and development in the HA.

Abbreviations

CON – Consultants

SMO/AC – Senior Medical Officers/Associate Consultants

MO/R – Medical Officers/Residents

DMO/NC/SNO – Department Operations Managers/Nurse Consultants/Senior Nursing Officers

APN/NS/NO/WM/ANC – Advanced Practice Nurses/ Nurse Specialists/Nursing Officers/ Ward Managers/Associate Nurse Consultants

RN – Registered Nurses

EN – Enrolled Nurses

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CONTROLLING OFFICER'S REPLY

HHB073

(Question Serial No. 1654)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Department of Health has set up the Centralised Organ Donation Register (CODR) to make it more convenient for prospective donors to voluntarily register their wish to donate organs after death, and for such wish to be properly recorded. In this connection, please advise this Committee of:

1. the numbers of new registrations, withdrawals of registration and cumulative total registrations recorded in the CODR in each of the past 3 years;
2. the number of patients waiting for organ or tissue transplants, their average waiting time and the number of organ or tissue donations handled by the Hospital Authority in the past 3 years;
3. with nearly 3 000 people in Hong Kong currently waiting for organ transplants every day, whether the Government will increase resources and manpower in the coming year, such as soliciting assistance from the District Services and Community Care Teams to promote organ donation, with a view to raising the awareness and willingness of members of the public to donate organs; if yes, of the estimated expenditure so involved, and if no, of the reasons for that; and
4. the current progress of actively exploring with the relevant authorities of the Mainland to set up a standing organ transplant mutual assistance mechanism, as earlier mentioned by the Government, and whether a specific implementation timetable has been set.

Asked by: Hon KOON Ho-ming, Peter Douglas (LegCo internal reference no.: 6)

Reply:

1)

The numbers of registrations recorded in the Centralised Organ Donation Register (CODR) in the past 3 years are as follows:

	2022	2023	2024
Number of new registrations ¹	13 418	25 968	24 809
Cumulative total number of registrations (as at 31 December of the year)	356 093	367 199	391 187
Number of withdrawals of registration ²	1 068	14 862 ³	821

Note:

1. Number of new registrations refers to:
 - (i) In or before April 2022 – the number of new registrations verified by the Department of Health (DH) minus the number of effective withdrawals during the same period (i.e. net increase in the cumulative number of registrations in the period); and
 - (ii) In or after May 2022 (after enhancement of the CODR System) – the number of new registrations verified by the DH (the number of effective withdrawals during the same period is not deducted in order to indicate more clearly the number of new registrations).
2. Number of withdrawals of registration refers to:
 - (i) In or before April 2022 – the number of applications for withdrawal handled by the DH (without deducting the invalid applications); and
 - (ii) In or after May 2022 (after enhancement of the CODR System) – consists only of the effective withdrawals as verified by the DH.
3. During the period of May and June 2023, the spreading of quite a number of malicious remarks intending to mislead the public had led to an unusual surge in the number of withdrawals of registration from the CODR. Subsequently, with the Government's strengthened publicity efforts, the number of withdrawals of registration has returned to normal, with less than 100 people per month.

2)

The number of patients waiting for organ/tissue transplant, their average waiting time and the number of organ/tissue donation cases handled by the Hospital Authority (HA) in the past 3 years are as follows:

Year (as at December 31)	Organ/ Tissue	Number of Patients Waiting for Transplant	Average Waiting Time (months) ⁴	Number of Donation Cases ⁶
2022	Kidney	2 451	56.8	56 (Cadaveric donation: 45 Living donation: 11)
	Liver	66	38.2	29 (Cadaveric donation: 17 Living donation: 12)

Year (as at December 31)	Organ/ Tissue	Number of Patients Waiting for Transplant	Average Waiting Time (months)⁴	Number of Donation Cases⁶
	Heart	81	23.5	11
	Lung	13	27.6	7
	Cornea (piece)	357	21.2	244
	Skin	N/A ⁵		5
	Bone			0
2023	Kidney	2 429	60	52 (Cadaveric donation: 41 Living donation: 11)
	Liver	81	33.4	30 (Cadaveric donation: 17 Living donation: 13)
	Heart	76	36.8	8
	Lung	21	28.2	2
	Cornea (piece)	474	31.3	253
	Skin	N/A ⁵		2
	Bone			0
2024	Kidney	2 476	61	59 (Cadaveric donation: 41 Living donation: 18)
	Liver	79	33.4	37 (Cadaveric donation: 23 Living donation: 14)
	Heart	77	37.7	4
	Lung	21	32.3	2
	Cornea (piece)	532	31.6	306
	Skin	N/A ⁵		7
	Bone			1

Note:

4. “Average waiting time” is the average of the waiting time for patients on the organ/tissue transplant waiting list as at the end of that year.
5. Cases of skin and bone transplant are sudden and emergency in nature. Substitutes will be used if no suitable skin or bone is identified for transplant.
6. Living donation applies to liver/kidney transplant only.

3)

Since 2023, the Government has stepped up publicity efforts on organ donation and achieved positive results. The total number of registrations in the CODR has reached a record high. The Health Bureau (HHB), the DH and the HA will continue their multi-pronged strategies and strengthen collaboration with different sectors through various channels, including (1) setting up organ donation promotion booths and deploying the organ donation promotion

vehicle to organise promotion activities, with a view to encouraging public registration in the CODR; (2) using various channels, e.g. television, radio, newspapers and the internet for publicity; (3) promoting e-engagement of the public through a dedicated social media page “Organ Donation at HK”; (4) educating the public through health talks; (5) producing publicity materials for distribution in various events and activities; (6) developing an institution-based network by working with signatories of the Organ Donation Promotion Charter and supporters to promote organ donation; and (7) staging large-scale publicity events to support the Organ Donation Day on the second Saturday of November every year.

The expenditure and manpower deployed for work in relation to publicity for organ donation cannot be separately identified as they are absorbed by the HHB’s overall expenditure, the DH’s overall provision for health promotion and the HA’s overall expenditure on provision of healthcare services respectively.

4)

On the basis of the case of the first cross-boundary organ transplant in December 2022, the Government has been making continued efforts to actively take forward the cross-boundary organ transplant mutual assistance mechanism with the relevant authorities of the Mainland. Currently, Hong Kong and the Mainland have established standardised channel and co-operation procedures for handling emergency cross-boundary organ transplant. When a patient in moribund condition is confirmed to be in need of urgent organ transplantation to extend his/her life, subject to the fulfilment of relevant criteria and the consent of his/her family members, the Government will seek assistance from the Country. The current operational procedures for handling emergency cross-boundary organ transplant adopt a second-tier allocation mechanism, which will be activated only when local matching is unsuccessful for a donated cadaveric organ, so as to ensure that the respective organ donation and allocation systems of the two places will not be affected. Each case will be notified to the relevant government departments and an application will be made. The relevant departments will then vet the application and implement the arrangements in accordance with the established mechanism to ensure that the transportation and transplantation processes are in compliance with the laws and regulations of the two places.

Moreover, the HA has formulated and implemented a set of standardised clinical protocols in terms of technical requirements, criteria and procedures for handling emergency cross-boundary organ transplant cases in a consistent approach. This is to ensure that organ donation is conducted in a legal, fair, equitable and safe manner to benefit patients with the greatest need. The Government will continue to seek assistance from the Country for patients in urgent need of organ transplant in accordance with the mechanism, and improve the cross-boundary organ transplant mutual assistance mechanism based on experience gained from handling more successful cases.

- End -

CONTROLLING OFFICER'S REPLY

HHB074

(Question Serial No. 1655)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Since August last year, the Government has implemented the Healthy Mind Pilot Project (the Pilot Project) at 3 District Health Centres or District Health Centre Expresses, providing free preliminary mental health assessment at the community level for the public. Members identified as having mild depressive or anxiety symptoms upon preliminary assessment will be referred to non-governmental organisations (NGOs) for further assessment and follow-up, enabling them to receive appropriate support at an early stage. In this connection, will the Government inform this Committee of the following:

1. What are the total number of people who have undergone preliminary assessment since the implementation of the Pilot Project, and the number of those who need referral and follow-up?
2. It is reported that the Pilot Project has received positive response from the public. Will the Health Bureau (HHB) consider conducting a comprehensive evaluation of the Pilot Project as soon as possible, and allocating additional resources and manpower to extend the coverage of the Pilot Project, so as to provide better mental health support to the public and strengthen primary healthcare services? If yes, what is the estimated expenditure involved; and
3. Currently, the 2 NGOs participating in the Pilot Project, namely, the New Life Psychiatric Rehabilitation Association and Mild Mental Health Hong Kong, have only 13 staff members dedicated to providing related services. According to some psychiatrists and clinical psychologists, it only takes 120 hours to train a mental health officer in general. Will the HHB consider providing additional resources to train more staff? If yes, what are the details? If not, what are the reasons?

Asked by: Hon KOON Ho-ming, Peter Douglas (LegCo internal reference no.: 7)

Reply:

(1)

The Government launched the Healthy Mind Pilot Project (the Pilot Project) in August 2024 at the Tuen Mun District Health Centre (DHC), the Yau Tsim Mong District Health Centre Express (DHCE) and the Eastern DHCE to provide free preliminary mental health assessments for the public on a trial basis at the community level, so as to achieve the objective of early identification and early treatment under the primary care development and enhance the support for people in need. As of 1 March 2025, the aforementioned 3 DHC/DHCEs have conducted preliminary mental health assessments for approximately 17 000 members of the public under the Pilot Project. Around 1 000 (approximately 6% of the total) of them, upon assessments, were advised to visit the collaborating service providers in the same district under the Pilot Project for follow-up services provided by Wellbeing Practitioners (WBPs) who have received mental health training.

(2) and (3)

The Pilot Project is running on a trial basis for 18 months (from August 2024 to January 2026) and has so far been in operation for approximately 7 months. Currently, the 2 collaborating service providers participating in the Pilot Project have arranged a total of 13 WBPs to provide relevant services under the professional supervision of clinical psychologists. The manpower can generally meet the service demand. The Primary Healthcare Commission has established a working group to continuously monitor the implementation and progress of the Pilot Project. The Government will review and evaluate the effectiveness of the Pilot Project in a timely manner and map out the way forward, including examining the feasibility of implementing mental health assessment services in other DHCs/DHCEs, and the arrangements on manpower resources and training.

- End -

CONTROLLING OFFICER'S REPLY

HHB075

(Question Serial No. 1676)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

In respect of implementing measures to promote the mental health of students, the Three-tier School-based Emergency Mechanism will be extended to the end of 2025 to enhance the support for students with suicidal risk and protect students' mental health. In this connection, will the Government inform this Committee of the following:

1. The number of requests from schools for off-campus support and referred to the Hospital Authority (HA) in the past year;
2. Has the Government collected views from schools and stakeholders to monitor the effectiveness and quality of the mechanism? If yes, what are the details? If not, what are the reasons?
3. Since the psychiatric services of the HA are in short supply, there are views that requests from students for support may increase the burden on the healthcare system. Will the Government consider utilising local medical units, such as District Health Centres, for preliminary assessment before determining whether a referral is necessary? If yes, what are the details? If not, what are the reasons?

Asked by: Hon KOON Ho-ming, Peter Douglas (LegCo internal reference no.: 33)

Reply:

(1) & (2)

The Government has implemented a Three-tier School-based Emergency Mechanism in all secondary schools since December 2023 for early identification of and support for students with higher suicidal risk through interdepartmental collaboration of the Education Bureau (EDB), the Health Bureau (HHB) and the Social Welfare Department (SWD). It has been announced in the Chief Executive's 2024 Policy Address that the mechanism will be extended and enhanced until 31 December 2025.

From 1 December 2023 to end-February 2025, the off-campus support network team received a total of 228 cases referred through the second tier of the mechanism. In respect of the third tier of the mechanism, school principals may refer high-risk students to psychiatric specialist out-patient clinics under the Hospital Authority (HA) for services. After triage and

screening, if the student's condition is deemed urgent and requires prompt treatment, the HA will prioritise follow-up care. During the period from 1 December 2023 to 31 January 2025, the psychiatric services of the HA received a total of 379 cases referred by school principals through the mechanism. According to the HA's data as at 31 January 2025, among those cases referred by school principals, about 3% were categorised as Priority 1 (urgent), and about 40% were categorised as Priority 2 (semi-urgent). The remaining cases either fell under the Routine (stable) category or were already being followed up by the HA's psychiatric services.

After undergoing triage and screening, the referred cases which are categorised as urgent and require early treatment will be accorded priority by the HA. The HA has set specific targets in respect of the median waiting time for new cases at its psychiatric specialist out-patient clinics (SOPCs), with the median waiting time for Priority 1 (urgent) cases be kept within 1 week and that for Priority 2 (semi-urgent) be kept within 4 weeks.

The Government closely monitors the operation of the Three-tier School-based Emergency Mechanism and has already engaged consultants to evaluate its effectiveness.

(3)

The HA has implemented a triage system for newly referred cases at the SOPCs to ensure that patients with urgent conditions and requiring early treatment are receiving treatment with priority. Newly referred cases to the HA's psychiatric services are first screened by a nurse followed by review of a specialist doctor for classification into Priority 1 (urgent), Priority 2 (semi-urgent) or Routine (stable) categories. Students with mental health needs will be assessed and provided with appropriate support under the established triage system regardless of the channels through which they are referred to the SOPCs of the HA. After triage and screening, those students in urgent cases will be accorded priority. During the waiting period, if there is any change to the patients' mental condition, they may return to their respective SOPCs for re-assessment to determine whether an earlier consultation period is required, or he/she may be considered for A&E attendance. In addition, the HA has set up a telephone consultation hotline specifically for school principals to provide them with professional advice.

Apart from the mechanism, the then Food and Health Bureau has launched the Student Mental Health Support Scheme (SMHSS) jointly with the EDB, SWD and HA since the 2016/17 school year to provide services based on a medical-educational-social collaboration model. Under the SMHSS, each participating school will set up its own multi-disciplinary team, which comprises a psychiatric nurse of the HA, a designated teacher and a school social worker. It will work closely with the HA's psychiatric team, a school-based educational psychologist, relevant teachers and social workers from a social service unit to provide support services for students with mental health needs in the school setting. The number of primary and secondary schools participating in the SMHSS has increased from 17 in the 2017/18 school year to 210 in the 2023/24 school year.

The HA has earmarked an additional provision of about \$25 million for 2025-26 with a view to further enhancing the nursing manpower and allied health professional support in psychiatric inpatient and out-patient clinic services, strengthening psychiatric services for children and adolescents, as well as improving the Mental Health Direct hotline service.

With an emphasis on preventive work, the District Health Centres (DHCs) provide disease prevention services at the primary healthcare (PHC) level to enhance public awareness of personal health management and disease prevention. Among the three levels of disease prevention, primary prevention provides extensive health educational activities and preventive promotion covering mental health. DHCs also provide basic health risk assessments to identify health risk factors early. If emotional issues are identified in citizens (including children and adolescents), nurses and social workers at DHCs will provide health consultations and counselling services. DHCs act as district PHC hubs, coordinating with other community partners that serve on the PHC level and arranging referral services, including mental health support, for citizens in need. The Government launched the Healthy Mind Pilot Project (Pilot Project) in August 2024 at the Tuen Mun District Health Centre (DHC), the Yau Tsim Mong District Health Centre Express (DHCE) and the Eastern DHCE to provide free preliminary mental health assessments for the public on a trial basis at the community level, so as to achieve the objective of early identification and early treatment under the primary care development and enhance the support for people in need. Trained staff of the DHCs/DHCEs will first conduct health risk assessment and preliminary mental health questionnaire assessments for the public. After assessment, those with mental health needs will be advised to visit service providers in the same district under the Pilot Project for follow-up by Wellbeing Practitioners.

In respect of mental health publicity and public education, the Government earmarks a recurrent funding of \$50 million every year to implement the “Shall We Talk” mental health promotion and public education initiative. Launched in July 2020 with the support of the Advisory Committee on Mental Health, the initiative aims to step up public engagement in promoting mental well-being; to enhance public awareness of mental health with a view to encouraging help-seeking and early intervention; and to reduce stigma towards people with mental health needs. It utilises both traditional channels and emerging social media platforms to reach out to people from all walks of life including secondary and primary school students. Following the launch of touring activities across various districts, primary and secondary schools and tertiary institutions to promote mental health messages, the initiative will continue to encourage the public to take mental health seriously through a diverse range of activities. In addition, the HHB launched the “18111 - Mental Health Support Hotline” in December 2023 to provide one-stop, round-the-clock support for people with mental needs, rendering immediate mental health support and referral services.

The Chief Executive’s 2024 Policy Address put forward the initiative of formulating a stepped-care model, where a multidisciplinary framework with tiers will be adopted to deal with cases ranging from general emotional problems in the frontline to cases requiring follow-up and more serious mental illness cases. The framework will set out the roles of different professionals, such as teaching staff, social workers, healthcare workers, as well as other auxiliary personnel and service providers at each tier, and their division of work in the provision of mental health services for cases in each tier, enabling them to smoothly work together and perform their respective roles systematically in assisting in handling different types of cases with mental health needs.

- End -

CONTROLLING OFFICER'S REPLY

HHB076

(Question Serial No. 1167)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in the Programme that the Hospital Authority (HA) advises the Government on the needs of the public for hospital services and resources required to meet those needs, and provides adequate, efficient and effective public hospital services of the highest standard recognised internationally within the resources available. In this connection, please inform this Committee of the following:

- 1) Please set out in table form, broken down by age group (0-below 5, 5-below 12, 13-below 17) and type of problems (attention deficit/hyperactivity disorder, autism spectrum disorders, depression, bipolar affective disorder, anxiety-related disorders, schizophrenic spectrum disorder and others), the numbers of children and adolescents of the above age groups who received treatment in the HA and were diagnosed as having various types of mental health needs in the past 5 years.
- 2) Following up on the previous question, please set out the specific follow-up services provided by the HA to children and adolescents diagnosed as having various types of mental health needs, the ratio of manpower for providing such services and the relevant expenditure.
- 3) Please set out in table form, broken down by age group (18 or above to 64 or below, 65 or above) and type of problems (attention deficit/hyperactivity disorder, autism spectrum disorders, depression, bipolar affective disorder, anxiety-related disorders, schizophrenic spectrum disorder and others), the numbers of persons aged 18 or above who received treatment in the HA and were diagnosed as having various mental health needs in the past 5 years.
- 4) Following up on the previous question, please set out the specific follow-up services provided by the HA to adults who were diagnosed as having various types of mental health needs, the ratio of manpower for providing such services and the relevant expenditure in the past 5 years.

- 5) What was the Government's expenditure on mental health support for (1) adults and (2) children and adolescents in each of the past 5 years, as well as the planned and estimate expenditure for the coming year?
- 6) Will the HA allocate additional provision to strengthen mental health services in 2025-26; if yes, the details; if not, the reasons for that?

Asked by: Hon KWOK Ling-lai, Lillian (LegCo internal reference no.: 24)

Reply:

(1)

The table below sets out the number of psychiatric patients by type of disorder and age group (aged below 18) in the Hospital Authority (HA) from 2020-21 to 2024-25 (projection as of 31 December 2024).

Year	Age group ²	Number of psychiatric patients aged below 18 ^{1,2,3,5}	Type of disorder					Depression ³
			Anxiety-related disorders ³	Bipolar affective disorder ³	Autism spectrum disorder ³	Attention deficit/hyperactivity disorder ³	Schizophrenic spectrum disorder ³	
2020-21	Aged 0-5	3 490	10	0	1 970	320	0	0
	Aged 6-11	19 230	180	<5	7 510	8 780	10	50
	Aged 12-17	17 390	1 090	130	5 010	7 990	280	1 260
	Total⁴	40 120	1 280	140	14 490	17 090	280	1 310
2021-22	Aged 0-5	3 460	10	0	1 870	290	0	<5
	Aged 6-11	20 320	210	<5	8 090	8 690	10	40
	Aged 12-17	19 490	1 360	160	5 630	8 760	270	1 690
	Total⁴	43 270	1 570	160	15 590	17 730	270	1 730
2022-23	Aged 0-5	3 660	10	0	2 030	280	0	0
	Aged 6-11	20 610	210	<5	8 510	8 690	10	30
	Aged 12-17	20 830	1 540	200	6 160	9 100	280	1 780
	Total⁴	45 100	1 750	200	16 690	18 060	290	1 810
2023-24	Aged 0-5	4 430	10	0	2 490	380	0	0
	Aged 6-11	21 470	270	10	8 860	8 600	10	40

Year	Age group ²	Number of psychiatric patients aged below 18 ^{1,2,3,5}	Type of disorder					
			Anxiety-related disorders ³	Bipolar affective disorder ³	Autism spectrum disorder ³	Attention deficit/hyperactivity disorder ³	Schizophrenic spectrum disorder ³	Depression ³
	Aged 12-17	22 540	1 780	270	6 710	9 380	300	2 030
	Total⁴	48 440	2 070	280	18 050	18 360	310	2 070
2024-25 (projection as of 31 December 2024)	Aged 0-5	3 990	10	0	2 190	290	0	0
	Aged 6-11	21 770	280	10	9 280	8 260	10	30
	Aged 12-17	24 750	1 940	300	7 430	10 000	280	2 060
	Total⁴	50 510	2 220	300	18 890	18 550	290	2 100

Note:

1. Including inpatients, patients at specialist outpatient clinics and those at day hospitals.
2. Referring to the age of the patients as of 30 June of the respective year.
3. Figures are rounded to the nearest ten.
4. Individual figures may not add up to the total due to rounding.
5. As the above table does not cover all types of disorder, the breakdown by type of disorder may not add up to the total number of psychiatric patients.

(2), (4) & (5)

The HA delivers mental health services through an integrated and multi-disciplinary approach involving psychiatric doctors, psychiatric nurses, clinical psychologists, medical social workers and occupational therapists. The adoption of a multi-disciplinary team approach allows flexible deployment of manpower to cope with service needs and operational requirements. As healthcare professionals in the HA usually provide support for a variety of psychiatric services, the manpower and expenditure for supporting individual psychiatric services cannot be separately quantified.

The table below sets out the expenditure for providing mental health services by the HA from 2020-21 to 2025-26.

Year	Expenditure on mental health services (\$ million)
2020-21	5,672
2021-22	5,825
2022-23	6,145
2023-24	6,585
2024-25 (revised estimate)	7,042
2025-26 (estimate)	7,321

The expenditure on mental health services includes direct staff costs (such as doctors, nurses and allied health staff) for providing services to patients; expenditure incurred for various

clinical support services (such as pharmacy); and other operating costs (such as meals for patients, utility expenses and repair and maintenance of medical equipment).

Remark:

In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA adjusted its services to cope with the outbreak. This should be taken into consideration when comparing the service capacity of the HA in the respective years. With the subsiding of local COVID-19 epidemic situation and cessation of anti-epidemic measures in early 2023, the HA has been gradually resuming provision of all of its public healthcare services to tie in with the Government's normalcy measures. As the costing information from 2020-21 to 2022-23 has reflected the impact of the epidemic outbreak on the costs (if any), the costing information for different years may not be directly comparable.

The table below sets out the number of doctors, nurses and allied health professionals working in the psychiatric stream in the HA from 2020-21 to 2024-25 (as of 31 December 2024).

Year	Psychiatric doctors ^{1,2,3}	Psychiatric nurses ^{1,2,4} (including community psychiatric nurses)	Allied health professionals		
			Clinical psychologists ^{1,6}	Medical social workers ⁵	Occupational therapists ^{1,6}
2020-21	384	2 911	103	256	289
2021-22	366	2 953	105	257	298
2022-23	381	3 015	105	257	287
2023-24	399	3 064	108	257	300
2024-25 (as of 31 December 2024)	414	3 147	116	257	338

Note:

1. The manpower figures above are calculated on full-time equivalent basis including permanent, contract and temporary staff in various clusters of the HA, but excluding those in the HA Head Office.
2. Full-time equivalent for temporary part-time staff is calculated based on their actual working hours starting from January 2024. The related figures before January 2024 are for reference only and cannot be directly compared with the revised calculation method.
3. Psychiatry doctors refer to all doctors working for the specialty of psychiatry except interns.
4. Psychiatric nurses include all nurses working in psychiatric hospitals (i.e. Kwai Chung Hospital, Castle Peak Hospital and Siu Lam Hospital), nurses working in psychiatric departments of other non-psychiatric hospitals, as well as all nurses in psychiatric stream.
5. Information on the number of medical social workers supporting psychiatric services in the HA are provided by the SWD.
6. Clinical psychologists and occupational therapists working in psychiatric stream include those working in psychiatric hospitals (i.e. Kwai Chung Hospital, Castle Peak Hospital and Siu Lam Hospital), those working in psychiatric departments of other non-psychiatric hospitals, as well as those engaging in psychiatric-related work.

(3)

The table below sets out the number of psychiatric patients by type of disorder and age group (aged 18 or above) in the HA from 2020-21 to 2024-25 (projection as of 31 December 2024).

Year	Age group ²	Number of psychiatric patients aged 18 or above ^{1,2,3,5}	Type of disorder					
			Anxiety-related disorders ³	Bipolar affective disorder ³	Autism spectrum disorder ³	Attention deficit/hyperactivity disorder ³	Schizophrenic spectrum disorder ³	Depression ³
2020-21	Aged 18-64	164 900	49 000	7 600	4 200	2 700	39 800	43 300
	Aged 65 or above	70 800	19 800	1 300	<50	<50	10 500	16 600
	Total⁴	235 700	68 800	8 900	4 200	2 700	50 300	59 900
2021-22	Aged 18-64	169 600	51 200	7 800	4 800	3 300	39 700	44 800
	Aged 65 or above	76 100	22 100	1 400	<50	<50	11 200	18 200
	Total⁴	245 600	73 200	9 300	4 800	3 300	50 900	63 000
2022-23	Aged 18-64	171 300	52 000	8 000	5 300	3 800	39 200	45 400
	Aged 65 or above	80 500	24 100	1 600	<50	<50	11 700	19 600
	Total⁴	251 800	76 000	9 500	5 300	3 800	50 800	65 000
2023-24	Aged 18-64	174 400	53 300	8 200	6 000	4 500	38 700	46 100
	Aged 65 or above	86 600	26 800	1 700	<50	<50	12 200	21 200
	Total⁴	261 000	80 000	9 900	6 000	4 500	50 900	67 300
2024-25 (projection as of 31 December 2024)	Aged 18-64	176 600	53 700	8 300	6 900	5 500	37 900	46 500
	Aged 65 or above	93 500	29 400	1 900	<50	<50	13 100	22 900
	Total⁴	270 100	83 100	10 200	6 900	5 500	51 000	69 500

Note:

1. Including inpatients, patients at specialist outpatient clinics and those at day hospitals.
2. Referring to the age of the patients as of 30 June of the respective year.
3. Figures are rounded to the nearest ten.
4. Individual figures may not add up to the total due to rounding.
5. As the above table does not cover all types of disorder, the breakdown by type of disorder may not add up to the total number of psychiatric patients.

(6)

The HA has earmarked an additional funding of around \$25 million in 2025-26 to enhance mental health services. Relevant measures include:

- (a) optimising the nursing manpower and allied health support for psychiatric inpatient and outpatient services;
- (b) enhancing mental health services for children and young people; and
- (c) strengthening the “Mental Health Direct” hotline service.

- End -

CONTROLLING OFFICER'S REPLY**HHB077****(Question Serial No. 1177)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): (000) Operational expensesProgramme: (2) HealthControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

It is stated that the aim of this programme is to formulate and oversee implementation of policies to protect and promote public health, to provide comprehensive and lifelong holistic healthcare to each citizen, and to ensure that no one is prevented, through lack of means, from obtaining adequate medical treatment. In this connection, will the Government inform this Committee of the following:

1. a breakdown, by year, of the funding expenditure of District Health Centres (DHCs) in each of the 18 districts in the past 3 years;
2. further to the above question, what are the administrative expenditures involved, outsourced services used and number of beneficiaries; and
3. how will the Government enhance the promotion of DHC services, and what is the related publicity expenditure?

Asked by: Hon KWOK Ling-lai, Lillian (LegCo internal reference no.: 33)Reply:

(1)

The expenditures and revised estimates (including provisions for service contracts, site maintenance and rental cost) of District Health Centres (DHCs)/District Health Centre Expresses (DHCEs) in various districts for 2022-23, 2023-24 and 2024-25 are tabulated as follows:

District	2022-23 Expenditure (\$ million)	2023-24 Expenditure (\$ million)	2024-25 Revised Estimates (\$ million)
DHC			
Kwai Tsing	62	63	62
Sham Shui Po	34	64	63
Tuen Mun	69	80	80
Wong Tai Sin	60	77	69
Southern	52	73	58

Yuen Long	49	69	73
Tsuen Wan	38	65	78
DHCE			
Sai Kung	11	14	14
Kowloon City	10	14	14
Yau Tsim Mong	11	14	14
Wan Chai	11	15	15
North Islands	10	14	14
Kwun Tong	10	13	13
Kwun Tong	10	14	14
Tai Po	11	14	14
Sha Tin	10	14	14
Central and Western	11	15	15
Eastern	11	14	14

Upon the upgrading of the 3 DHCEs to DHCs this year, the 11 existing DHCEs will gradually reduce to 8, while the number of DHCs will increase to 10. The estimated expenditure for DHCs and DHCEs (including provisions for service contracts, site maintenance and rental cost) for 2025-26 are \$1.083 billion and \$213 million respectively.

(2)

The cumulative numbers of members and attendances of DHCs and DHCEs in various districts are set out in the table below:

DHC/DHCE Service Commencement Date	Cumulative Number of Members^{Note 1} (as at 31 December 2024) [Provisional Figures]	Cumulative Number of Attendances^{Note 1, 2, 3, 4} (as at 31 December 2024) [Provisional Figures]
DHC		
Kwai Tsing 24 September 2019	46 100	498 300
Sham Shui Po 30 June 2021	34 300	296 600
Tuen Mun 31 May 2022	38 100	344 100
Wong Tai Sin 30 June 2022	34 700	200 900
Southern 17 October 2022	23 900	175 300
Yuen Long 24 October 2022	42 500	255 000
Tsuen Wan 30 December 2022	26 000	175 700
DHCE		
Sai Kung 1 September 2021	10 600	84 900
Kowloon City	11 300	57 300

DHC/DHCE Service Commencement Date	Cumulative Number of Members ^{Note 1} (as at 31 December 2024) [Provisional Figures]	Cumulative Number of Attendances ^{Note 1, 2, 3, 4} (as at 31 December 2024) [Provisional Figures]
1 October 2021		
Yau Tsim Mong 1 October 2021	9 600	48 500
Wan Chai 4 October 2021	6 800	53 000
North 18 October 2021	8 700	53 700
Islands 18 October 2021	6 400	35 900
Kwun Tong 21 October 2021	10 800	49 300
Tai Po 22 October 2021	7 800	45 000
Sha Tin 30 October 2021	13 300	71 400
Central and Western 30 October 2021	7 900	50 200
Eastern 30 October 2021	10 900	54 700
Total	349 900	2 549 900

Note:

1. Figures are rounded to the nearest hundred.
2. The figures only include service figures captured from the DHC/DHCE information system, and do not include those relating to medical laboratory tests.
3. As different services are provided by the 11 DHCEs, the attendance figures are not directly comparable.
4. The service figures above have included services provided by DHCs/DHCEs for participants of the Chronic Disease Co-care Pilot Scheme which was launched on 13 November 2023.

(3)

The Government promotes primary healthcare services of DHCs/DHCEs through various channels and media, including territory-wide publicity and local outreach activities. DHCs/DHCEs strengthen connection with the local community, especially the hard-to-reach groups, through outreach activities, telephone and other communication technology support, telecare platform, etc. Also, outdoor health exhibitions, health mobile vans and community programmes are regularly organised.

As the operators of DHCs/DHCEs are required under their service contracts to launch targeted promotional activities in their districts, the estimated expenditure has been included in the total price of the contract of each DHC/DHCE, and a breakdown of the relevant expenditure

is thus unavailable. Besides, the Primary Healthcare Commission has also arranged territory-wide activities to promote DHCs/DHCEs. The relevant expenditure is included in the operating expenditure of the Commission, and a breakdown is unavailable.

- End -

CONTROLLING OFFICER'S REPLY

HHB078

(Question Serial No. 1178)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The number of psychiatric outreach attendances for 2025-26 is expected to reach 361 200. In this connection, will the Government inform this Committee of the following:

- 1) Regarding the latest estimated provision for the 361 200 service attendances, how will the Government expand the coverage of the service in the community to cater for the additional number of 600 attendances (compared to 360 600 attendances in 2024-25)? Please provide the list of the service teams.
- 2) How will the Government promote mental health awareness in the community, and what are the estimated expenditure involved and the anticipated number of families to be reached?
- 3) Are psychiatric outreach service teams required to submit outreach service assessment reports? If yes, what are the details? If not, what are the reasons?

Asked by: Hon KWOK Ling-lai, Lillian (LegCo internal reference no.: 34)

Reply:

(1) and (3)

The multi-disciplinary team of the Hospital Authority (HA)'s community psychiatric service, including psychiatric doctors, psychiatric nurses, occupational therapists, medical social workers and peer support workers, provides appropriate community support to persons in mental recovery living in the community. Since 2010-11, the HA has launched the Case Management Programme (the Programme) by phases to provide intensive, continuous and personalised community support services for psychiatric patients. The Programme has been extended to 18 districts in Hong Kong since 2014-15. The case managers under the Programme will assess the needs, risks and clinical conditions of the patients and take appropriate follow-up actions, and maintain close liaison with community partners in providing support to psychiatric patients in the community. The HA further recruited additional case managers in 2024-25 to enhance the community psychiatric services so as to optimise the ratio to no higher than 1:40.

As healthcare professionals in the HA usually provide support for a variety of psychiatric services, the manpower and expenditure for supporting individual psychiatric services cannot be separately quantified.

The multi-disciplinary team of the HA's community psychiatric service provides appropriate community support according to the severity of the condition and clinical needs and risks of the persons in mental recovery living in the community. Community psychiatric services cover 3 levels of services, namely the Intensive Care Team, Case Management Programme and Standard Community Psychiatric Service. Taking into account patients' medical conditions as well as clinical needs and risks, the multi-disciplinary medical team will provide them with appropriate community support. Through regular outreach and home visits, as well as close collaboration with community partners, case managers help persons in mental recovery set goals and draw up recovery plans to facilitate their re-integration into the community, and also offer appropriate support and advice to their carers and families while endeavouring to promote mental health in the community.

Case managers of the community psychiatric service will report the patients' medical conditions to the multi-disciplinary team in a timely manner and conduct case meetings to review and discuss follow-up arrangements for the cases. The HA has an established mechanism to ensure the quality of psychiatric services, including formulating clear clinical guidelines, risk assessment tools and protocols on medical records. Case managers will appropriately assess and record the needs, risks and clinical conditions of the patients as well as the services provided.

(2)

The Government attaches great importance to the mental health of the public, and adopts an integrated approach to promote mental health, providing services that include prevention, early identification, timely intervention, treatment and rehabilitation services for persons in need. Apart from promotion of self-care, primary healthcare and community support, the Government provides specialist and institutionalised services, and also multi-disciplinary and cross-sectoral services to persons with mental health needs through co-ordination and co-operation among the Health Bureau (HHB), the Labour and Welfare Bureau (LWB), the Education Bureau (EDB), the Department of Health, the Social Welfare Department (SWD), the HA, non-governmental organisations (NGOs) and other stakeholders in the community.

The Government set up the Advisory Committee on Mental Health (ACMH) in December 2017, with members comprising professionals from the healthcare sector, social service and education sectors, as well as lay persons with concerns over mental health, to advise the Government on mental health policies and assist the Government in formulating policies, strategies and measures to enhance the mental health services on all fronts.

Over the past 2 years, the HHB and the LWB have introduced or planned to introduce a number of mental health-related policy initiatives, which cover enhancing the manpower for mental health services, strengthening the support for specific groups (including students, ethnic minorities and persons in mental recovery), and enhancing mental health support at district level, etc. The key initiatives and related expenditures are as follows:

- (a) The HA enhanced manpower and further optimised the ratio of case manager under the Case Management Programme to patients to no higher than 1:40 in the fourth quarter of 2023. The HA has earmarked additional funding of around \$127 million in 2024-25 to enhance mental health services. Relevant measures include: (i) enhancing the community psychiatric services by further recruiting additional case managers; (ii) strengthening nursing manpower as well as allied health and peer support for psychiatric inpatient and outpatient services; and (iii) enhancing the use of long-acting injectable antipsychotics in the treatment of mental illness. An additional funding of around \$25 million is earmarked in 2025-26 to further enhance the nursing manpower and allied health support for psychiatric inpatient and outpatient services, enhance psychiatric services for children and adolescents, and strengthen the “Mental Health Direct” hotline service;
- (b) Through cross-departmental collaboration of the HHB, the EDB and the SWD, the Three-Tier School-based Emergency Mechanism was implemented in December 2023 to provide support to students with higher suicidal risk as early as possible. The initiative has been extended to end-2025. A breakdown is not available as the expenditure and manpower involved in the Three-Tier School-based Emergency Mechanism are absorbed by existing resources of the relevant departments;
- (c) The HHB launched the “18111 - Mental Health Support Hotline” in December 2023 to provide one-stop, round-the-clock support for people with mental health needs, rendering immediate mental health support and referral services. The time-limited recurrent expenditure for 2023-24, 2024-25 and 2025-26 is about \$9.9 million;
- (d) The HHB set up a service centre dedicated to emotional support and counselling services for ethnic minorities in December 2023, with a multi-professional team comprising social workers, counsellors and support staff conversant in ethnic minority languages, to provide mental health support and counselling services to ethnic minorities and refers cases to other service platforms for additional support and/or treatment if needed. The time-limited recurrent expenditure for 2023-24, 2024-25 and 2025-26 is about \$8.1 million;
- (e) The HHB launched the Healthy Mind Pilot Project in 3 District Health Centres in August 2024 in collaboration with community organisations to provide mental health assessments for the public and ensure early follow-up referral of high-risk cases, so that the individuals in question can receive support as appropriate in a timely manner. The time-limited recurrent expenditure for 2024-25 and 2025-26 is about \$9.6 million;
- (f) The HHB provided Care Team members with mental health support training (including Mental Health First Aid training) in 2024 to assist in the early referral of persons in need in the local community for support. The time-limited recurrent expenditure for 2024-25 is about \$0.29 million;

- (g) In 2023-24, the SWD increased the manpower of clinical psychologists in 24 Integrated Community Centres for Mental Wellness (ICCMWs) to strengthen professional support and training, and provided additional funding to assist ICCMWs in enhancing the application of information technology in service delivery so as to strengthen the support for persons in mental recovery and their carers. The additional annual recurrent expenditure incurred is about \$23 million;
- (h) The SWD enhanced the services of ICCMWs in 2024-25, including strengthening early identification of persons with mental health needs and early intervention, and scaled up the training of social workers in community mental health service units to raise their capacity in handling complicated cases. The annual expenditure incurred is about \$60 million;
- (i) The SWD strengthened peer support services in 2024-25 by creating additional full-time peer supporter positions, including those of senior level and dedicated to carers. The SWD will also set up 4 additional Parents/Relatives Resource Centres for carers of those in mental recovery in the second quarter of 2025 to support persons in mental recovery and their carers. The annual expenditure incurred in these 2 projects is about \$26 million;
- (j) The SWD plans to strengthen the services of Cyber Youth Support Teams in the second quarter of 2025 by providing an online support platform for the emotional wellness of young people, which offers real-time online counselling services to students or young people facing emotional distress or at immediate risk. The estimated expenditure for 2025-26 is about \$25.88 million; and
- (k) The SWD plans to set up an additional ICCMW in the first quarter of 2026 to provide one-stop and district-based community support services ranging from prevention to risk management. Additionally, the SWD will regularise the Pilot Project on “Transitional Support Service for Persons in Mental Recovery” in the first quarter of 2026 to offer sustained support to persons preparing to be discharged from hospitals while being on the waiting list for halfway house services. The annual expenditure involved in these 2 projects is about \$37 million.

On mental health promotion and public education, the Government has earmarked an annual recurrent funding of \$50 million for the implementation of the “Shall We Talk” mental health promotion and public education initiative (the Initiative). Launched in July 2020 with the support of the ACMH, the Initiative aims to step up public engagement in promoting mental well-being; to enhance public awareness of mental health with a view to encouraging help-seeking and early intervention; and to reduce stigma towards people with mental health needs. The Initiative continues to make use of both offline channels and emerging online platforms to reach out to people from all walks of life, which include: (a) launching a one-stop mental health thematic website (shallwetalk.hk) to provide one-stop information and resources on mental health to the public and broadcasting videos on social media platforms, featuring the sharing of personal experiences and feelings by various stakeholders (including artists and

key opinion leaders) to encourage the public to recognise mental health issues; (b) implementing the “Mental Health Workplace Charter” (the Charter) to promote mental well-being at workplace. Additionally, as announced in the Chief Executive’s 2024 Policy Address, an annual promotional theme will be set for the Charter and recognition will be given to participating organisations for achieving targets; (c) broadcasting promotional videos on the television, radio and other media; and (d) organising tours in different districts, primary schools, secondary schools, and tertiary institutions to promote mental health messages.

At the same time, the LWB collaborates with NGOs in organising public education programmes to enhance the public’s awareness of mental health and disability inclusion, such as the annual “Mental Health Month” programme in support of the “World Mental Health Day”. The SWD also subsidises NGOs to set up mobile vans for publicity across the territory to promote mental health in the community.

- End -

CONTROLLING OFFICER'S REPLY

HHB079

(Question Serial No. 1180)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

In 2025-26, the cost per patient day of mentally ill inpatient services increases to \$3,870 and the cost per psychiatric outreach attendance to \$2,080. In this connection, will the Government inform this Committee of:

- (1) how the Government will control costs and ensure service quality given the cost increase (inpatient services by \$130 and outreach attendance by \$70); and
- (2) whether work reports of outreach attendance need to be submitted; if yes, the details; if no, the reasons?

Asked by: Hon KWOK Ling-lai, Lillian (LegCo internal reference no.: 35)

Reply:

(1)

The Hospital Authority (HA) will continue to review and monitor the services provided as well as their costs, and will deploy and adjust its manpower flexibly according to the operational needs and service demands to meet patients' needs. Moreover, the HA has established key performance indicators to review the quality and efficiency of the relevant services on a regular basis, with a view to providing appropriate services to patients.

(2)

The multi-disciplinary team of the HA's community psychiatric services provides appropriate community support to persons in mental recovery in the community, having regard to their conditions, clinical needs and risks. Community psychiatric services cover 3 levels of services, namely the Intensive Care Team, Case Management Programme and Standard Community Psychiatric Service. The multi-disciplinary team will provide appropriate community support to patients according to their conditions, clinical needs and risks. Through regular outreach or home visits and close collaboration with community partners,

case managers will help persons in mental recovery to develop goals and recovery plans to assist them in reintegrating into the community. They will also provide appropriate support and advice to carers and family members, and strive to promote mental health at the community level.

Case managers of the community psychiatric services will timely report the patients' conditions to the multi-disciplinary team and hold case meetings to review and discuss the follow-up arrangements. The HA has an established mechanism to ensure the quality of psychiatric services, including the formulation of clear clinical guidelines, risk assessment tools and management protocols on medical records. Case managers will evaluate and record patients' needs, risks and clinical conditions, as well as the services provided as appropriate.

- End -

CONTROLLING OFFICER'S REPLY

HHB080

(Question Serial No. 2307)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding Programme (3) Subvention: Hospital Authority, it is noted under Analysis of Financial and Staffing Provision that the provision for 2025-26 is 2.8365 billion (2.9%) higher than the revised estimate for 2024-25. In this connection, please advise this Committee on the following:

- (a) What proportion of the estimated additional provision will be used for pay adjustments for newly created posts or existing posts? Please provide a detailed breakdown of the relevant allocation by grade or rank.
- (b) Does the estimated additional provision involve any new policies or ongoing projects? If yes, please elaborate on the specific details, objectives and expected outcomes of these policies or projects.

Asked by: Hon KWOK Wai-keung (LegCo internal reference no.: 30)

Reply:

In 2025-26, the Government provides a recurrent provision of \$99 billion for the Hospital Authority (HA), an increase of 3.7% as compared to the 2024-25 revised estimate (\$95.4 billion). The HA will implement the following key initiatives:

- (a) pursuing reform on governance and management, with a view to enhancing the quality of public healthcare services and sustainable development to strengthen support to patients;
- (b) pressing ahead with driving forward the fees and charges reform for public healthcare to guide the public to make optimal use of healthcare resources, reduce wastage and abuse, and enhance healthcare protection for “poor, acute, serious, critical” patients on all fronts, thereby enhancing the sustainability of the healthcare system;
- (c) fully dovetailing with the Government’s policy and development direction, continuing to enhance the capacity and quality of public healthcare services to cope with the

demand by, inter alia, providing around 330 additional hospital beds as well as additional operating theatres and endoscopy sessions, and increasing service capacity for cataract surgeries; enhancing clinical services such as oncology, ophthalmology, psychiatry, radiology, nuclear medicine and pathology, genetic and genomic services, as well as non-clinical support services; rolling out measures to reduce the waiting time for specialist out-patient services; enhancing the role of general out-patient clinics as primary healthcare service providers for the underprivileged by introducing chronic disease screening services and strengthening nurse clinic services; and integrating paediatric services at the Hong Kong Children's Hospital;

- (d) further expanding the integrated Chinese-Western medicine services, progressively extending the cancer care programme to all hospital clusters, and launching pilot programmes for the treatment of other disease areas where Chinese medicine has an advantage;
- (e) strengthening centralised procurement of drugs and medical devices to boost cost-effectiveness and ensure optimal use of healthcare resources;
- (f) developing smart hospital initiatives, with the aim of enhancing patient experience and improving operational workflow and efficiency with the use of advanced technologies;
- (g) continuing the review and planning of Second Hospital Development Plan projects;
- (h) augmenting the workforce by attracting and retaining staff; recruiting healthcare professionals to work in Hong Kong through Mainland and global healthcare talent visiting programmes, with a view to establishing a regional talent hub of healthcare professionals in the long run to meet future public demand for healthcare services; and
- (i) continuing the Preceptorship Programme under which clinical preceptors are recruited to provide guidance for newly-recruited and junior nurses and to familiarise them with ward procedures and environment.

The HA will deploy existing staff and recruit additional manpower to implement the above measures. The HA estimates that the number of doctors, nurses and allied health professionals in 2025-26 will increase by 290, 1 040 and 250 (in terms of full-time equivalent staff) respectively as compared with 2024-25.

When the Government adjusts civil service pay, the HA, in general, will review and adjust its salary pay accordingly. While there is no specified rule, the HA has all along made reference to the civil service pay adjustment in determining the actual adjustment rate to the HA's salary pay.

- End -

CONTROLLING OFFICER'S REPLY

HHB081

(Question Serial No. 0604)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Starting from 2023-24, the Government of the Hong Kong Special Administrative Region has enhanced the functions of the Chinese Medicine Unit (CMU) under the Health Bureau to further promote the development of Chinese medicine. In this connection, would the Government inform this Committee of:

- (1) the manpower establishments, salary expenditures and total expenditures of the CMU for the past 3 financial years;
- (2) the forecast manpower establishment, estimated salary expenditure and total estimated expenditure of the CMU for 2025-26;
- (3) the number of posts of different ranks (e.g. Assistant Commissioner for Chinese Medicine Development, Chinese Medicine Officers of different ranks, Executive Officers of different ranks, etc.) in the CMU for the past 3 financial years; and
- (4) given that the Government indicated last year that it had started recruiting more non-directorate supporting staff with professional backgrounds in Chinese medicine for the CMU, details of the recruitment of such supporting staff over the past 3 years?

Asked by: Hon LAI Tung-kwok (LegCo internal reference no.: 13)

Reply:

(1) to (4)

To implement the work on enhancing the functions of the Chinese Medicine Unit (CMU) of the Health Bureau (HHB) as set out in the Chief Executive's 2022 Policy Address, the Government has created the post of Commissioner for Chinese Medicine Development (C for CMD) since 2023-2024, and increased the number of non-directorate supporting staff of the CMU which includes recruiting personnel from the market with professional background in the areas of Chinese medicine (CM) practice, CMs, public education and publicity, professional education and academic research on non-civil service contract (NCSC) terms. The Government will continue to review the scope of work and manpower requirements of the CMU to ensure that there are sufficient and appropriate manpower to support the coordination and oversight of the development of CM.

The numbers of posts and the salary expenditures of the CMU in the past 3 financial years and in 2025-26 are tabulated below.

Year	Number of establishment posts	Number of NCSC positions [Number of positions for personnel with CM professional background]	Salary Expenditure
2022-2023 (Note 1)	6	3 [1]	About \$8,537,000
2023-2024	9 (Note 2)	19 [15] (Note 3)	About \$13,355,000
2024-2025	9 (Note 4)	19 [15] (Note 5)	About \$24,887,000
2025-2026 (Estimates)	9 (Note 4)	18 [15] (Note 6)	About \$28,340,000

Note:

1. The CMU of the HHB was under Team 7/Chinese Medicine Unit in the organisational structure before 1 April 2023. The numbers of posts listed above include Principal Assistant Secretary for Health 7/Head (Chinese Medicine Unit) and other posts responsible for the work of the CMU.
2. The creation of the post of C for CMD was approved in 2023-24 and the appointee assumed office in May 2024.
3. Of the 15 NCSC positions created for personnel with CM professional background, 6 were filled in 2024-2025.
4. The figure includes 1 C for CMD, 1 Senior Administrative Officer (time-limited post until 2025-26), 1 Chief Executive Officer (CEO), 2 Senior Executive Officers (SEO), 1 Executive Officer I (EO I), 1 Executive Officer II (EO II), 1 Personal Secretary I and 1 Assistant Clerical Officer.
5. The figure includes 15 positions created for personnel with CM professional background, namely 1 Consultant Chinese Medicine Practitioner (CEO-equivalent), 1 Consultant Chinese Medicine Officer (CEO-equivalent), 5 Senior Chinese Medicine Officers (SEO-equivalent), 5 Chinese Medicine Officers (EO I-equivalent) and 3 Assistant Chinese Medicine Officers (EO II-equivalent); and 4 executive positions, namely 1 Senior Executive Manager (SEO-equivalent), 2 Executive Managers (EO I-equivalent) and 1 Assistant Executive Manager (EO II-equivalent).
6. The figure includes 15 positions created for personnel with CM professional background (see Note 5) and 3 executive positions (namely 2 Executive Managers (EO I-equivalent) and 1 Assistant Executive Manager (EO II-equivalent)).

- End -

CONTROLLING OFFICER'S REPLY

HHB082

(Question Serial No. 0607)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The first Hong Kong Chinese Medicine Culture Festival was kicked off at the end of last year. During the three-month period, an array of promotional activities for Chinese medicine (CM) culture have been held across Hong Kong by the Health Bureau in conjunction with the CM sector and various sectors of the community. In this connection, would the Government inform this Committee of the following:

- (1) the number of participants in the festival and the expenditure involved;
- (2) the community organisations that have partnered with the Government in the Festival, as well as the activities in which they have participated; and
- (3) how does the Government plan to continually promote and pass on CM culture and knowledge to the community in the future?

Asked by: Hon LAI Tung-kwok (LegCo internal reference no.: 16)

Reply:

(1) and (2)

Partnering with the local Chinese medicine (CM) sector and various community organisations, the Health Bureau (HHB) organised the first Hong Kong Chinese Medicine Culture Festival (Culture Festival) from December 2024 to February 2025 to promote in diversified ways cultural inheritance and knowledge of CM to the general public. The kick-off event of the Culture Festival was held at the Central Market on 7 and 8 December 2024, staging exhibitions, interactive booths and a number of CM thematic talks for members of the public and various sectors. The estimated number of participants was about 17 000.

The Culture Festival was also supported by over 80 organisations including the Department of Health, the Hospital Authority, The Chinese Medicine Hospital of Hong Kong, the Schools of CM of three local universities, the CM sector and community partners, to feature over 200 supporting activities in various forms, ranging from free consultation sessions, free health consultation, exhibitions, visits, online and physical thematic talks, exchange forums and seminars, to CM-related workshops, experiential activities and carnivals, etc. First-hand experience through these activities enabled citizens to enhance their interest in and

understanding of the traditional wisdom and concepts of CM, thereby fostering CM inheritance and development. The estimated number of participants for these supporting activities was about 35 000.

A thematic website for the Culture Festival (<https://www.hkcmfest.gov.hk/>) has been established, with promotion made through other means, including promotional posters, roadside and lamppost advertisements, bus body and building exterior advertisements, online and radio advertisements, as well as interviews and advertorials in magazines and on websites, reaching an estimated total of over 1.83 million people.

The overall expenditure involved in the Culture Festival is estimated to be about 2.52 million (provisional figure).

(3)

The Government has been committed to fostering cultural inheritance, education and promotion of CM, with the aim of promoting CM culture and the high-quality development of CM on all fronts.

The Chinese Medicine Promotion Funding Scheme (the Scheme) under the Chinese Medicine Development Fund (CMDF) provides funding for eligible organisations to take forward CM publicity and public education projects, with a view to enhancing public understanding of CM and showcasing the latest developments of the CM sector. To enhance the scale and effectiveness of the projects, the funding ceiling of the Scheme has been raised from \$0.75 to \$2 million with effect from March 2024, with priority given to themes such as enhancing health with CM, cultural dissemination, talent and technology exchange, and promotion of the industry. As at the end of February 2025, the CMDF has supported more than 1 100 CM publicity and public education activities of various forms, targeting audiences such as kindergarten, primary and secondary school students, and elderly persons.

The Strategic Theme Commissioned Project Funding Programme has been established under the CMDF for commissioning organisations to conduct large-scale training, publicity and research projects on specific strategically priority themes, among which organisations were invited in May 2024 to submit applications for the development of diverse, flexible and practical teaching and learning resource kits on CM, in conjunction with the application in teaching, classroom learning or extra-curricular enrichment activities, thereby enhancing primary and secondary school students' understanding of CM culture and knowledge. Upon completion of the development of the teaching and learning resource kits, the CMDF will further consider promoting their wider application in schools across the territory.

Starting from the second quarter of 2025, the Government will subsidise and encourage more large-scale international and regional CM conferences, exhibitions and events to be held in Hong Kong through the CMDF in order to further popularise the CM culture, promote CM professional development, strengthen international ties, attract high-level CM academic and research development, and showcase the latest sector development, thereby creating a favourable environment for business and technological innovation.

Furthermore, the Government is formulating the Chinese Medicine Development Blueprint in collaboration with the CM sector to map out the future developmental directions of CM in

Hong Kong. The main strategic directions include fostering cultural inheritance, education and promotion of CM extensively.

- End -

CONTROLLING OFFICER'S REPLY

HHB083

(Question Serial No. 0610)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

To reserve Chinese medicine (CM) talents for Hong Kong, the Government co-organises high-quality CM talent training programmes with the National Administration of Traditional Chinese Medicine. Since 2023, 2 rounds of the Hong Kong Chinese Medicine Talent Short-term Training Programme (Short-term TP) and 1 round of the Hong Kong Chinese Medicine Talent Medium-term Training Programme (Medium-term TP) have been completed. In this connection, would the Government inform this Committee of the following:

- (1) the respective training topics covered and numbers of participants in the completed Short-term and Medium-term TPs;
- (2) are figures on the expenditure involved in the TPs kept? If yes, what are the details? If not, what are the reasons?
- (3) the number of target participants planned for CM talent training programmes in the future.

Asked by: Hon LAI Tung-kwok (LegCo internal reference no.: 19)

Reply:

(1) to (3)

The Government has been committed to promoting the development of the Chinese medicine (CM) talent pool in Hong Kong to meet future development needs. The National Administration of Traditional Chinese Medicine (NATCM) and the Health Bureau (HHB) have jointly launched the Hong Kong Chinese Medicine Talent Training Programme since 2023, with funding support from the Chinese Medicine Development Fund. Hong Kong Chinese medicine practitioners (CMPs) and Chinese medicines (CMs) professionals are arranged to receive high-quality advanced training at training institutions under the China Academy of Chinese Medical Sciences, focusing on specific clinical areas of CM or specialised CMs techniques. Two editions of short-term training programme (with duration of around one week) and one edition of medium-term training programme (with duration of around one month) have been completed so far, with a total of 85 participants involving an

expenditure of approximately \$2.3 million. The training topics and numbers of participants of the training programmes are tabulated below:

Training Programme	Training Topic	Number of Participants
Hong Kong Chinese Medicine Talent Short-term Training Programme (1 st Edition)	Application of special techniques of acupuncture and moxibustion (Class A)	11
	Application of special techniques of acupuncture and moxibustion (Class B)	10
	Chinese medicines compounding and processing techniques	9
Hong Kong Chinese Medicine Talent Short-term Training Programme (2 nd Edition)	Diagnosis and treatment of common in-patient diseases by acupuncture	10
	Applications on dangerous acupuncture points and special acupuncture techniques	10
	Application of Chinese medicine special therapies for external treatment	10
	Chinese medicines compounding and processing techniques	10
Hong Kong Chinese Medicine Talent Medium-term Training Programme (1 st Edition)	Clinical management of emergency and critical diseases in Chinese medicine hospital setting	5
	Clinical management of gynaecological diseases in Chinese medicine hospital setting	5
	Clinical management of orthopaedics and traumatology in Chinese medicine hospital setting	5
Total		85

The NATCM and the HHB will organise two editions of short-term training programme and one edition of medium-term training programme in mid-2025, expecting to enrol 110 CMPs and CMs professionals, with the enrolment currently underway. To meet the future service development needs of The Chinese Medicine Hospital of Hong Kong, topics such as Theory and Clinical Application of CM Classics, CM Paediatrics, CM Tui-na, and Research and Development of CMs, will be added to the aforementioned training programmes. The HHB will continue to consult with the NATCM and consider further expanding the Hong Kong Chinese Medicine Talent Training Programme in the future as needed.

In addition, the Hospital Authority (HA) has all along been providing various types of CM training for CM professionals of various ranks in the 18 Chinese Medicine Clinics cum Training and Research Centres, including CMP trainee programme, scholarships at junior and advanced levels, training on the knowledge and practice of scientific research and commissioned training in Western medicine, with a view to nurturing more local CM talents. The HA also offers related training for CMs professionals, including programmes on CMs professional training and fundamental knowledge on Western medicine, as well as online training platforms, so as to enhance the expertise of CMs professionals. To foster the cultivation of local CM talents, the HA launched the Greater Bay Area (GBA) CM Visiting Scholars Programme and the CM Enhanced In-patient Training Programme with GBA in

November 2022 and April 2024 respectively, with the aim to enhance the clinical competency of local CMPs in providing CM in-patient services on all fronts.

- End -

CONTROLLING OFFICER'S REPLY

HHB084

(Question Serial No. 1012)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Government plans to establish the Real-World Study and Application Centre by the end of this year and integrate the data from the “special measure of using Hong Kong registered drugs and medical devices used in Hong Kong public hospitals in the Greater Bay Area” to accelerate approval for registration of new drugs in Hong Kong, the Mainland, and overseas through co-operation with other cities in the Greater Bay Area. Would the Government inform this Committee of the following:

1. What are the manpower and additional expenditure involved in establishing the Real-World Study and Application Centre?
2. What are the functions and work details of the Real-World Study and Application Centre?
3. What are the expected benefits to be brought to Hong Kong by the Real-World Study and Application Centre?

Asked by: Hon LAM Kin-fung, Jeffrey (LegCo internal reference no.: 24)

Reply:

The Chief Executive proposed in the 2024 Policy Address the establishment of the Real-World Study and Application Centre (Application Centre) to foster collaboration between Hong Kong and Shenzhen by integrating the data generated from the “special measure of using Hong Kong-registered drugs and medical devices used in Hong Kong public hospitals in the Greater Bay Area (GBA)”, and promote the conduct of real-world studies by leveraging this data, thereby expediting the approval for market launch of new drugs in Hong Kong, the Mainland and overseas.

By analysing real-world data such as electronic medical records, real-world studies make up for the limitations of traditional randomised controlled trials (such as long durations, high costs, and insufficient samples for rare disease) by providing the necessary scientific evidence for the evaluation of new drugs. The Application Centre will capitalize on Hong Kong's advantage in medical data and promote the opening up of extensive and standardised local medical databases (including the integrated electronic medical record system of the Hospital

Authority which encompasses an accumulated total of more than 11 million medical records over the years, and data from the Hong Kong Genome Project) to support clinical diagnosis and treatment, new drug development and public health research. At the same time, the “GBA Clinical Trial Collaboration Platform” will connect healthcare institutions across the GBA to integrate real-world data generated from the “special measure of using Hong Kong-registered drugs and medical devices used in Hong Kong public hospitals in the GBA”, which will facilitate the application of real-world studies in drug and medical device approvals, new drug development and other areas.

The establishment of the Application Centre is one of key initiatives by the Hong Kong Special Administrative Region Government to provide support on all fronts for research and development, clinical trials and application of advanced biomedical technology (including advanced therapy products) in Hong Kong. Through a series of measures such as deepening reform of the approval mechanism for drugs and medical devices, opening access to local medical databases, establishing highly efficient collaboration mechanisms across bureaux and departments, and strengthening medical collaboration within the GBA, the Government aims to improve the ecosystem for supporting the development of advanced biomedical technologies in Hong Kong, with a view to attracting world-leading innovative enterprises and research institutions to establish their presence in Hong Kong.

The Health Bureau (HHB) has earmarked approximately \$12 million in 2025-26 as the start-up resources for the first-phase work of establishing the Application Centre. The HHB is currently consulting key stakeholders as planned to formulate the detailed construction plans and estimates for the Application Centre, including the staffing for professional and supporting personnel, and other operational expenses. The Application Centre is expected to be established by the end of 2025.

- End -

CONTROLLING OFFICER'S REPLY

HHB085

(Question Serial No. 1742)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

As put forward in the 2024 Policy Address, the Hong Kong Children's Hospital (HKCH) will fully integrate the paediatric services of various clusters and develop more advanced healthcare services to make the best use of the HKCH and strengthen the paediatric care system. Regarding the estimate of subvention to the Hospital Authority under Programme (3), what is the expenditure on integrating the paediatric services at HKCH? Will additional healthcare resources such as paediatric beds be allocated? If so, what is the specific expenditure involved?

Asked by: Hon LAM Lam, Nixie (LegCo internal reference no.: 1)

Reply:

The Hospital Authority (HA) operates its paediatric services under a hub-and-spoke model. As a tertiary referral centre for severe, complex and uncommon paediatric cases requiring multi-disciplinary management, the Hong Kong Children's Hospital (HKCH) provides diagnosis, treatment and rehabilitation services for patients from the whole territory from birth to 18 years of age with relevant clinical needs. As for the paediatric departments in public hospitals in different regions, they are mainly responsible for secondary, emergency and community care services. Under this hub-and-spoke model, the HKCH and regional hospitals work together as a co-ordinated and coherent paediatric service network.

As announced in the Chief Executive's 2024 Policy Address, the HKCH will fully integrate the paediatric services of various clusters and develop more advanced healthcare services to best fulfil its function as a "Centre of Excellence in Paediatrics". In this connection, the HA is exploring the expansion of paediatric services at the HKCH, including expanding the scope of newborn screening; collaborating with foetal medicine teams to perform magnetic resonance imaging of the brain and spine of foetuses and newborns; developing advanced and complex neurosurgical procedures; establishing an evidence-based therapeutic centre targeting patients with rare neurological diseases, introducing advanced gene therapy and maintaining case directories of neuromuscular disorders. Additionally, the HA is exploring more service models including private services to meet public expectation, while providing

support to other healthcare organisations in the region on the management of complex cases that the latter find difficult to handle.

The HA is actively integrating paediatric services in various clusters with HKCH as the core of paediatric services, and has set up various paediatric sub-specialty working groups comprising staff of paediatric departments from HKCH and district hospitals to discuss the specific arrangements for integrating the governance and management of paediatric services in HKCH. These include aligning the operation of paediatric facilities in accordance with the hub-and-spoke model and defining the service model with HKCH as the core and regional hospitals as the nodes. This aims to expedite the centralisation of treating complex paediatric cases in the HKCH in the near future, so that patients can receive appropriate treatment and the resources of the HKCH can be better utilised.

Besides, as announced in the Chief Executive's 2024 Policy Address, to enhance the health of the people of Hong Kong, improve healthcare protection and quality, and capitalise on our healthcare professions' strengths, the Government is conducting a comprehensive review on the positioning and objectives of the healthcare system. The review covers a reform of the functions and division of work among the HA, the Department of Health (DH) and the Primary Healthcare Commission. In this connection, the DH is discussing with the HA the detailed arrangements for the integration of the Child Assessment Service into HKCH under the HA, with a view to enhancing inter-specialty collaboration and streamlining the service flow through the integration of public paediatric services, so that children suspected with developmental or behavioural problems can receive the necessary integrated multi-disciplinary assessment, treatment and rehabilitation services in a timely manner, and that the referral arrangements and services to patients can also be optimised. The HA and the DH expect to complete the transfer of the entire service within 2026 and will announce the relevant details in a timely manner.

Currently, the HA does not have a breakdown of the estimated expenditure for the integration of paediatric services.

- End -

CONTROLLING OFFICER'S REPLY

HHB086

(Question Serial No. 1743)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: Not Specified

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

To further support assisted reproduction, the Hospital Authority will gradually increase the number of places for public assisted reproduction services to 1 800, enhance the training of the relevant medical professionals, and refine the medical consultation procedures, with a view to shortening the waiting time for patients. Besides, the Hong Kong Chinese Medicine Hospital, commissioned at the end of this year, will introduce “Infertility, pre-natal and postnatal care” as one of the special disease programmes in the Department of Gynecology in Chinese Medicine. What are the details of the expenditure relating to the implementation of the above initiatives in support of assisted reproduction?

Asked by: Hon LAM Lam, Nixie (LegCo internal reference no.: 2)

Reply:

To further support couples facing fertility difficulties, the Chief Executive's 2023 Policy Address announced that the Hospital Authority (HA) would increase the relevant public service quota on assisted reproductive services for in-vitro fertilisation (IVF). The HA increased the assisted reproductive service quota for IVF treatment by 100 in 2024-2025 and will further increase the quota by 300 in 2025-2026. The estimated expenditure for 2025-26 is about \$12.6 million. The number of quota will increase by 100 each in 2026-27, 2027-28 and 2028-29. The relevant service quota will reach 1 800 in 2028-29.

Reproductive Medicine (RM) is a subspecialty of Obstetrics and Gynaecology (O&G). Upon completion of specialist training in O&G, doctors are required to undergo subspecialty training in the training hospitals (i.e. Queen Mary Hospital – Kwong Wah Hospital Joint Training Centre and Prince of Wales Hospital) for 2 to 3 years, during which they need to complete a specified number of procedures and assessments before they can apply for certification as a specialist in RM under the Specialist Register. Based on the current caseload, the HA can train 4 doctors to obtain specialist qualifications in RM every 2 to 3 years. This structured training programme can ensure that the trainees are equipped with necessary skills and experience, so that patients will benefit from the higher-quality and evidence-based care.

The subspecialty training of RM specialists is conducted during their daily services in hospitals and is part of their on-going clinical duties. Also, as the training process is tailored to the specific conditions of each trainee and hinges on the applicability of the cases, relevant training costs cannot be separately quantified. Besides, the HA has set up nurse-led infertility clinics to provide talks on subfertility and laboratory tests, and expedite referrals for patients for further medical assessment and follow-up as appropriate according to clinical needs, thereby reducing patients' waiting time. The manpower and expenditure of infertility clinics have been absorbed under the overall expenditure of the O&G departments of relevant hospitals.

Chinese medicine (CM) enjoys a competitive edge in regulating body functions and assisting reproduction. At present, the HA, non-governmental organisations and local universities operate the Chinese Medicine Clinics cum Training and Research Centres (CMCTRs) in 18 districts under a tripartite collaboration model to provide the public with Government-subsidised and non-Government-subsidised CM out-patient services at the district level. Members of the public who need treatment of infertility and subfertility or prenatal and postnatal care may make appointments for out-patient services at the 18 CMCTRs. In addition, The Chinese Medicine Hospital of Hong Kong (CMHHK), which is expected to commence services in phases by the end of 2025, will provide a range of CM clinical services including Gynecology in CM as one of the 6 specialised CM services. The main treatment scope includes diseases related to menstruation, leucorrhoea, pregnancy, postnatal and other gynecological disorders (including infertility), etc. A special disease programme named "Infertility, pre-natal and postnatal care" under Gynecology in CM will also be launched. Talents and experts of Gynecology in CM in Hong Kong will provide CM treatment options to women having plans or difficulties in pregnancy. This will further promote the development of CM services related to AR. As the CMHHK has not yet commenced services, the expenditure related to the special disease programme is not available.

- End -

CONTROLLING OFFICER'S REPLY

HHB087

(Question Serial No. 1744)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Hospital Authority will continue to take forward and implement the five-year plan of eHealth+ to transform eHealth from a health record sharing system into a comprehensive healthcare information infrastructure that integrates multiple functions of healthcare data sharing, service delivery and care journey management. Under the estimate for Programme (2), what is the expenditure for the eHealth five-year plan? Please provide a breakdown of the annual expenditure for the five-year plan. What measures have been put in place to encourage more private healthcare service providers to upload medical records to eHealth? What is the expenditure for carrying out such measures (for example, what is the expenditure for implementing the eHealth Adoption Sponsorship Pilot Scheme)?

Asked by: Hon LAM Lam, Nixie (LegCo internal reference no.: 3)

Reply:

eHealth is a territory-wide electronic health record sharing system launched by the Government in 2016 that enables citizens to authorise healthcare providers (HCPs) in the public and private sectors to view and share their electronic health records (eHRs) for healthcare purposes. Building on the strengths of the existing infrastructure of eHealth, the Government announced in the 2023 Policy Address the initiative to roll out a five-year development plan of eHealth+ to transform eHealth into a comprehensive healthcare information infrastructure that integrates multiple functions of data sharing, service delivery and care journey management. eHealth+ aims to facilitate care coordination, cross-sector collaboration, as well as active health management and surveillance, thereby better serving our citizens in obtaining optimal healthcare services, and supporting the healthcare reform and various healthcare policies more effectively, such as primary healthcare and cross-boundary healthcare services. In July 2024, the Finance Committee of the Legislative Council approved a capital funding of \$1,395.8 million to support the eHealth+ development. The Government is taking forward the eHealth+ development in phases in accordance with the patient-centric principle and four strategic directions, namely, “One Health Record”, “One Care Journey”, “One Digital Front Door to Empowering Tool” and “One Health Data Repository”. The itemised budget from 2024-25 to 2028-29 is listed in the Enclosure 4 of

Under the strategic development direction of “One Health Record”, we seek to consolidate the longitudinal eHRs of citizens spread across a multitude of healthcare processes into their personal eHealth accounts. A comprehensive and complete eHR profile enables the HCPs authorised by citizens to respond to their health needs more effectively, thus enhancing clinical outcomes and saving costs of the care process. Nevertheless, while private HCPs have been actively using eHealth in supporting clinical processes as evidenced by the fact that nearly 60% of eHR access by HCPs as of end-February 2025 were by private HCPs, more than 99% of some 4.5 billion eHRs shared on eHealth are from public HCPs.

The Government has been taking a multi-pronged approach to incentivise and facilitate the provision of citizens’ eHRs into eHealth by private HCPs, thereby assisting citizens in accessing, managing and using their own eHRs during the healthcare process more conveniently. Last year, the Government launched a platform enabling self-service data compliance testing to simplify the technical testing procedures, and provided dedicated technical support to healthcare institutions. When taking forward various public-private partnership programmes, the Government will require HCPs to deposit the related medical records of the participating citizens into eHealth. The Government also rolled out the eHealth Adoption Sponsorship Pilot Scheme (the Pilot Scheme) by partnering with electronic medical record (eMR) solutions vendors and medical groups to co-fund system enhancements in achieving seamless eHR sharing between eHealth and eMR systems in the market. From July 2023 to February 2025, about 80 private HCPs (involving around 480 private doctors and 200 service locations) connected to eHealth and provided more than 1.12 million eHRs under the Pilot Scheme. The expenditure of the Pilot Scheme incurred from 2023-24 to 2025-26 is tabulated as follows:

Financial Year	Expenditure of the Pilot Scheme (\$ million)
2023-24 (actual)	1.0
2024-25 (revised estimate)	2.4
2025-26 (estimate)	6.9

With the Government’s endeavours, the eHRs provided by private HCPs in a year increased from 2.19 million in 2023 to 3.67 million in 2024. The Government will continue to collaborate with the private healthcare sector to enhance the connectivity between eHealth and their eMR solutions. In particular, given the positive impacts of the Pilot Scheme, we have progressively expanded the scheme to include more eMR solution vendors, medical groups and other sectors, including Chinese medicine. We will also launch the eHealth+ accreditation scheme in 2025 to enable citizens to easily identify if an HCP has the capability to deposit health records into their personal eHealth accounts and the extent of data involved. Citizens can make reference to such information in choosing a suitable HCP, to ensure that their medical records will be deposited in their personal eHealth accounts.

Besides, the Government introduced the Electronic Health Record Sharing System (Amendment) Bill 2025 (the Amendment Bill) into the Legislative Council this year to provide a legal framework to assist citizens in building a more comprehensive eHR profile. Among other things, the Amendment Bill will streamline the consent mechanism such that

once citizens agree to join eHealth, their HCPs will be able to deposit health data into their personal eHealth accounts. Meanwhile, citizens will continue to retain full control over their personal data and can grant individual HCPs access to their eHealth records at their own will. The Amendment Bill will also empower the Secretary for Health to require specified HCPs to provide specified important health data into the personal eHealth accounts of citizens registered with eHealth and with their consents, in order to facilitate citizens' easy access and control of their key health information.

The Government will continue to provide support and collaborate with the private healthcare sector to enable the majority of private HCPs to seamlessly connect with eHealth; and will consider providing additional assistance to healthcare institutions and professionals that are less prepared for digitalisation.

- End -

CONTROLLING OFFICER'S REPLY

HHB088

(Question Serial No. 1745)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

- (1) To strengthen primary healthcare, what are the specific measures for taking forward the development of District Health Centres (DHCs) and DHC Expresses (DHCEs) across the territory, and what is the expenditure involved?
- (2) How long will it take to integrate the services of Woman Health Centres (WHCs) and Elderly Health Centres (EHCs) into DHC Network, and will it be carried out in phases? What are the expenditures for such service integration in respect of WHCs and EHCs respectively? In January this year, the Health Bureau awarded the operation of 3 Women Wellness Satellites (WWSs) to Tung Wah Group of Hospitals for providing women health services. What is the expenditure for each of the WWSs?
- (3) What measures will be taken to enhance publicity for the primary healthcare services of DHCs and WWSs, and what are the publicity expenses involved?

Asked by: Hon LAM Lam, Nixie (LegCo internal reference no.: 4)

Reply:

(1)

The Government set up District Health Centres (DHCs) and smaller interim District Health Centre Expresses (DHCEs) across the territory by the end of 2022, thereby attaining the interim goal of covering all 18 districts to establish personalised health plans for the public according to their age, gender and lifestyle, etc. The Primary Healthcare Commission (PHCC) continues to take forward the plan of establishing DHCs in all districts, including the preparation for upgrading the three DHCEs in the Central and Western District, Yau Tsim Mong District and Eastern District to DHCs within 2025. By then, 10 out of the 18 Districts in Hong Kong will have DHCs in place to serve members of the public. Each DHC will set up several satellite centres/service points and DHCEs will set up service points to expand public reach.

Upon the upgrading of the 3 DHCEs to DHCs this year, the 11 existing DHCEs will gradually reduce to 8, while the number of DHCs will increase to 10. The estimated expenditure for

DHCs and DHCEs (including provisions for service contracts, site maintenance and rental cost) for 2025-26 are \$1.083 billion and \$213 million respectively.

(2)

Integration of women and elderly health services under the Department of Health (DH) into the district health network of the PHCC aims to utilise resources more effectively, strengthening the prevention-oriented, district-based, and family-centric primary healthcare network.

The PHCC will commence the integration of women health services within this year in an orderly manner. The services, operated by non-governmental organisations engaged by open tender, will be rendered through three service points named Women Wellness Satellites (WWSs) to provide women primary healthcare services. The 3 WWSs in Chai Wan, Lam Tin and Tuen Mun will progressively start service in 2025 to replace the Woman Health Centres of the DH. The Chai Wan WWS will commence operation in the second quarter while the Lam Tin and Tuen Mun WWSs are expected to be open in the third quarter. DHCs and DHCEs across all 18 districts will enhance promotion and education on women's health, and provide new dedicated nurse clinics for women's health services to encourage and support members of the public to manage their own health. DHCs and DHCEs will also identify women in need through basic health assessments and individual consultations, and refer them to WWSs or General Out-patient Clinics of the Hospital Authority to receive women's health services.

Specifically, DHCs and DHCEs provide basic women health services, conduct initial assessments and arrange referrals to WWSs for services as necessary. WWSs will provide more personalised primary healthcare services for women. In addition to the existing services such as health assessments, breast cancer and cervical cancer screenings, WWSs will devise personalised preventive care or specific consultation services according to individual health risks and needs for members' selection to enhance prevention-oriented women's health services.

Upon open tendering, the Health Bureau awarded a 3-year service contract with a total value of approximately \$531.7 million for the Central and Western DHC and 3 WWSs. The operational expenses (including renovation costs) borne by the operator have been included in the total price of the service contract. A separate breakdown of the expenses is therefore not available.

To further expand the multidisciplinary primary healthcare service network, the PHCC plans to start the preparation for the integration of the services of Elderly Health Centres under the DH into the district health network in phases from 2025-26, with a view to enhancing service synergy and minimising service duplication. The detailed transitional arrangements will be announced after discussion with the DH.

The above work is carried out by the PHCC as part of its overall functions, and there is no separate staff establishment. Therefore, information on the expenditure and staff establishment involved in the related work is not available.

(3)

The Government carries out various territory-wide promotion of the primary healthcare services of DHCs and WWSs through various means and media. For district-level promotion, DHCs strengthen connection with the local community, especially the hard-to-reach groups, through outreach activities, telephone and other communication technology support, telecare platform, etc. Also, outdoor health exhibitions, health mobile vans and community programmes are regularly organised. As the operators of DHCs and WWSs are required under their service contracts to launch targeted promotional activities in their districts, the estimated expenditure is included in the total price of the contract of each DHC. Therefore, a separate breakdown of the relevant expenses is unavailable. Besides, the PHCC arranges territory-wide activities to promote DHCs. These expenses are included in its operating expenditure and a separate breakdown is unavailable.

- End -

CONTROLLING OFFICER'S REPLY**HHB089****(Question Serial No. 0430)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: Not SpecifiedControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

In the past 3 years, did the Health Bureau engage external lawyers for consultancy services in accordance with the Stores and Procurement Regulations of the Government without first seeking assistance from the Department of Justice? If so, what were the nature of such services and the expenditures incurred?

Asked by: Hon LAM San-keung (LegCo internal reference no.: 9)Reply:

In the past 3 years, the Health Bureau engaged lawyers in accordance with the Stores and Procurement Regulations to provide the following services:

	Year	Nature of Services	Expenditures (HK\$)
1.	2022-23 2023-24 2024-25	Providing assistance to the Voluntary Health Insurance Scheme Office in examining and approving applications for product certification and re-certification, as well as interpreting and making recommendations on the provisions of the Scheme	Approximately \$1.92 million (for each financial year)
2.	2023-24 2024-25	Providing legal services on matters relating to the development and operation of The Chinese Medicine Hospital of Hong Kong project, including trademark registration	Approximately \$0.44 million (the total amount for the two years)
3.	2023-24	Providing incorporation and business registration services for the establishment of the Greater Bay Area International Clinical Trial Institute	Approximately \$85 000

	Year	Nature of Services	Expenditures (HK\$)
4.	2023-24	Providing company secretarial services for the Greater Bay Area International Clinical Trial Institute	Approximately \$65 000
5.	2024-25	Providing services to review tender document and letter of conditional acceptance for the Greater Bay Area International Clinical Trial Institute	Approximately \$70 000

- End -

CONTROLLING OFFICER'S REPLY

HHB090

(Question Serial No. 0299)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (1) Director of Bureau's Office

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in paragraph 206 of the Budget Speech that to develop primary healthcare, the Government will upgrade the District Health Centre Expresses in Central and Western District, Eastern District and Yau Tsim Mong District into District Health Centres (DHCs) this year, with a view to strengthening the community healthcare system. In this connection, will the Government inform this Committee of:

- (1) the expenditure for the 3 DHCs mentioned above;
- (2) the number and age distribution of DHC members in 18 districts across the territory; and
- (3) the expenditure for promoting DHCs?

Asked by: Hon LAM Shun-chiu, Dennis (LegCo internal reference no.: 16)

Reply:

(1)

In April 2024, the Health Bureau (HHB) launched a tender exercise for the operation of the Central and Western District Health Centre (DHC) and 3 women's health service points named Women Wellness Satellites located in Chai Wan, Lam Tin and Tuen Mun. A three-year operation service contract with a total value of approximately \$531.7 million was subsequently awarded in January 2025. The Central and Western DHC is expected to commence operation in the third quarter of this year.

In addition, the HHB conducted another tender exercise for the operation of the Eastern and Yau Tsim Mong DHCs in July 2024. The service contracts for these 2 DHCs are expected to be awarded this year.

Upon the upgrading of the 3 District Health Centre Expresses (DHCEs) to DHCs this year, the 11 existing DHCEs will gradually reduce to 8, while the number of DHCs will increase to 10. The estimated expenditure for DHCs and DHCEs (including provisions for service contracts, site maintenance and rental cost) for 2025-26 are \$1.083 billion and \$213 million respectively.

(2)

As at 31 December 2024 (provisional figures), the cumulative number of members of the 18 DHCs and DHCEs across Hong Kong is about 349 900. As for age distribution, about 90% of the members are aged^{Note1} 45 or above.

The cumulative numbers of members of each DHC and DHCE are set out in the table below:

DHC/DHCE Service Commencement Date	Cumulative Number of Members (as at 31 December 2024) ^{Note 2} [Provisional Figures]
<i>DHC</i>	
Kwai Tsing 24 September 2019	46 100
Sham Shui Po 30 June 2021	34 300
Tuen Mun 31 May 2022	38 100
Wong Tai Sin 30 June 2022	34 700
Southern 17 October 2022	23 900
Yuen Long 24 October 2022	42 500
Tsuen Wan 30 December 2022	26 000
<i>DHCE</i>	
Sai Kung 1 September 2021	10 600
Kowloon City 1 October 2021	11 300
Yau Tsim Mong 1 October 2021	9 600
Wan Chai 4 October 2021	6 800
North 18 October 2021	8 700
Islands 18 October 2021	6 400
Kwun Tong 21 October 2021	10 800
Tai Po 22 October 2021	7 800
Sha Tin 30 October 2021	13 300
Central and Western 30 October 2021	7 900
Eastern 30 October 2021	10 900

DHC/DHCE Service Commencement Date	Cumulative Number of Members (as at 31 December 2024) ^{Note 2} [Provisional Figures]
Total	349 900

Note:

1. Age refers to a member's age at the time of registration as a DHC member.
2. Figures are rounded to the nearest hundred.

(3)

As the operators of DHCs are required under their operation contracts to launch targeted promotional activities in their districts, the estimated expenditure has been included in the total price of the contract of each DHC, and a breakdown of the relevant expenditure is thus unavailable. Besides, the Primary Healthcare Commission also arranges territory-wide activities to promote DHCs. The relevant expenditure is included in the operating expenditure of the Commission, and a breakdown is unavailable.

- End -

CONTROLLING OFFICER'S REPLY

HHB091

(Question Serial No. 0300)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (1) Director of Bureau's Office

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Government has been promoting the "HA Go" mobile application to help patients and carers manage medical appointments and healthcare arrangement in an easy and effective manner. In this connection, please advise this Committee on:

1. the number of downloads of the "HA Go" mobile application in the past 3 years;
2. the annual expenditure on the "HA Go" mobile application;
3. the number of patients having arranged for delivery of their medications to their homes or other specified addresses using "HA Go"; and
4. the numbers of electronic sick leave certificates, medical certificates and attendance certificates issued through "HA Go" in the past year.

Asked by: Hon LAM Shun-chiu, Dennis (LegCo internal reference no.: 17)

Reply:

The Government announced in the 2023 Policy Address the initiative to roll out a five-year development plan of eHealth+ to transform eHealth into a comprehensive healthcare information infrastructure that integrates multiple functions of healthcare data sharing, service delivery and care journey management. The Government is taking forward the eHealth+ plan in phases in accordance with the patient-centric principle and four strategic directions, namely, "One Health Record", "One Care Journey", "One Digital Front Door to Empowering Tool" and "One Health Data Repository". The Hospital Authority (HA) introduced its mobile application "HA Go" in December 2019, with a view to enhancing patients' healthcare experience in public hospitals. With "HA Go", users can check the appointments made in HA hospitals or clinics, pay HA bills and drug charges, book appointments for general outpatient services and new cases of specialist outpatient services, arrange medication delivery service and perform rehabilitation exercises as prescribed, etc. The five-year plan of eHealth+ include rationalising the roles of eHealth, "HA Go" and other major healthcare

platforms, in order to prevent overlapping of functions and enable eHealth to give full play to its role in the system under the four strategic directions.

Our reply to the questions raised by the Hon LAM is as follows:

- (1) The numbers of downloads of “HA Go” mobile application in the past 3 years are tabulated below:

<u>Financial year</u>	<u>Number of downloads of “HA Go” mobile application (million)</u>
2022-23	1.0
2023-24	0.8
2024-25 (as at 28 February 2025)	0.8

- (2) The expenditures on software development of “HA Go” mobile application in the past 3 years are tabulated below:

<u>Financial year</u>	<u>Annual expenditure (\$ million)</u> ^(Note)
2022-23 (Actual)	9
2023-24 (Actual)	31
2024-25 (Revised estimate)	31

Note:

The first-phase development of “HA Go” mobile application was completed in 2022-23, providing patients with basic functions such as appointment booking for outpatient services, mobile registration and bill payment, and payment of drug charges. The HA took forward the second-phase development work of “HA Go” in 2023-24 and rolled out dozens of new functions, making it more convenient for patients to manage the public hospital services for themselves and their family members, including the medication delivery service, “Family Touch” for checking the operation status of family members, electronic platform for patient assessment questionnaires, and supporting carers in joining tele-consultations with patients through “HA Go”, etc.

- (3) Since the launch of the HA’s medication delivery service in March 2023, patients attending specialist out-patient clinics, general out-patient clinics, discharged from hospitals, and receiving accident and emergency services can arrange delivery of their medications to their homes or other specified addresses through “HA Go”. Starting from September 2024, patients can also choose to collect HA-dispensed medications at community collection points stationed with pharmacists without the need to return to or wait at the pharmacy departments

of hospitals or clinics after attending consultations. The numbers of patients using the HA's medication delivery service in 2023-24 and 2024-25 are tabulated below:

<u>Financial year</u>	<u>Number of patients using the HA's medication delivery service</u>
2023-24	12 008
2024-25 (as at February 2025)	27 848

(4) Since March 2023, all medical certificates (i.e. sick leave certificates) issued by the HA have adopted digital signature with electronic version. Patients can view their electronic medical certificates through "HA Go". In 2024-25 (as at February 2025), the HA issued a total of 1 862 974 electronic medical certificates and 1 331 268 electronic attendance certificates.

Electronic medical documents can reduce the risk of losing paper documents and facilitate convenient access and use of the documents by citizens. Under the eHealth+ development, we plan to introduce the eMedical Certificate function for the public to manage their personal medical documents (such as medical certificates, prescriptions, healthcare referrals and advance medical directives (AMDs)) in a centralised manner through the one-stop eHealth App. We expect to roll out the first phase of the eMedical Certificate function in 2025-26, covering medical certificates issued by the HA and the Department of Health. A verification function will be incorporated to enable users to verify electronic medical documents by scanning the QR codes, to prevent forgery and alteration of documents, and enable users to confirm the authenticity and validity of documents at anytime and anywhere. We will also consider expanding the eMedical Certificate function to cover more private healthcare providers and other types of medical documents, such as the development of an "electronic AMD" function (including the electronic storage of paper AMDs and the electronic making of AMDs directly through eHealth). To tie in with these developments, the Government has submitted the Electronic Health Record Sharing System (Amendment) Bill 2025 to the Legislative Council, proposing to provide a clear legal framework for governing electronic medical documents issued or authenticated through eHealth, and to enable the Government to designate eHealth as the only platform for issuing certain medical documents under appropriate circumstances, in order to facilitate the centralised management and support of the usage of these documents.

- End -

CONTROLLING OFFICER'S REPLY

HHB092

(Question Serial No. 0301)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (1) Director of Bureau's Office

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Preparatory Office for the Hong Kong Centre for Medical Products Regulation (CMPR) will put forward the timetable for establishing the CMPR and the roadmap towards adoption of "primary evaluation" in the first half of this year, with a view to restructuring and strengthening the current regulatory and approval regimes for drugs, medical devices and medical technologies. In this connection, would the Government inform this Committee of:

- (1) the progress and expenditure of the project; and
- (2) the operating expenditure of the CMPR?

Asked by: Hon LAM Shun-chiu, Dennis (LegCo internal reference no.: 18)

Reply:

(1)

As mentioned in the Chief Executive's 2023 Policy Address and the Chief Executive's 2024 Policy Address, the Government of the Hong Kong Special Administrative Region (HKSAR Government) would enhance the approval and registration mechanism for drugs and establish an internationally renowned regulatory authority of drugs and medical devices (medical products). To this end, the HKSAR Government has set up the Preparatory Office for the Hong Kong Centre for Medical Products Regulation (CMPR) under the Department of Health (DH) in June 2024. The Preparatory Office is proactively reviewing the regulatory functions on Chinese and Western medicines and medical devices under the DH, and studying the potential restructuring and strengthening of the current regulatory and approval regimes for medical products and medical technologies. The Preparatory Office will also put forward proposals and steps for the establishment of the CMPR which will be a step towards the transition to the "primary evaluation" approach in approving applications for registration of new medical products. This will help accelerate the clinical application of new medical products, and foster the development of emerging industries relating to the research and development (R&D) and testing of medical products. The Preparatory Office is drawing up the timetable for establishing the CMPR and the roadmap towards adoption of "primary evaluation", which will be announced in the first half of 2025 as planned. The revised estimated expenditure of the Preparatory Office in 2024-25 is \$8 million.

(2)

The Legislative Council has approved the creation of 4 permanent directorate posts/non civil-service positions (including Controller, Deputy Controller and 2 Assistant Controllers) in the CMPR of the DH in 2025-26 to provide dedicated support for embarking on the various tasks, and formulating and implementing the enhanced medical products regulation and approval regime under the “primary evaluation” approach. The DH will delete 4 existing permanent Consultant posts upon the creation of the above posts.

In addition, the current functions in relation to the regulation of Western medicines, Chinese medicines and medical devices of these services will be consolidated and re-organised by the DH to be put under the purview of the CMPR, which makes fuller use of the existing highly efficient regulatory regime to achieve greater benefits and synergies. This also centralises relevant expertise and optimises resource allocation, with the aim of supporting the approval of innovative medical products, promoting the scientific advancement of medical products and medical technologies, and expediting their clinical application, thereby driving the development of industries relating to the R&D as well as testing of medical products. The above re-organisation will involve redeployment of 7 permanent directorate officers (including 2 Assistant Directors of Health, 3 Chief Pharmacists and 2 Principal Medical and Health Officers) and about 420 non-directorate officers.

In 2025-26, the financial provision for the CMPR is \$41.63 million. The DH will continue to review the consolidation of various functions of the CMPR as well as the manpower and resources required.

- End -

CONTROLLING OFFICER'S REPLY

HHB093

(Question Serial No. 0302)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (1) Director of Bureau's Office

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in paragraph 208 of the Budget Speech that the Government and the Hospital Authority are reviewing the structure and levels of subsidisation for public healthcare, with a view to strengthening the financial sustainability of public healthcare services. In this connection, will the Government inform this Committee of:

- (1) the respective number of attendances, average waiting time of patients and staffing establishment of the accident and emergency departments of the 18 public hospitals under the Hospital Authority in 2025-26; and
- (2) the distribution of healthcare expenditures in 2025-26?

Asked by: Hon LAM Shun-chiu, Dennis (LegCo internal reference no.: 19)

Reply:

Hong Kong's public hospitals have long been one of the most efficient healthcare systems in the world. The Hospital Authority (HA) will continue to pursue the reform efforts to enhance the service standards of public hospitals. The Government announced on 25 March this year the fees and charges reform for public healthcare that aims to guide the public to make optimal use of healthcare resources, reduce wastage and abuse, and enhance healthcare protection for "poor, acute, serious, critical" patients on all fronts, thereby enhancing the sustainability of the healthcare system.

The fees and charges reform for public healthcare covers the following three major areas:

1. Reforming the subsidisation structure: Reforming the subsidisation structure from a systemic perspective by setting the levels of government subsidisation and the proportion of co-payments by members of the public for various public healthcare services to rationalise the relative demands for in-patient, accident and emergency, as well as different tiers of out-patient services.
2. Reducing waste and abuse: Introducing a co-payment model for non-urgent diagnostic radiology and pathology services, adjusting the charges for and quantities of standard drugs,

making use of the fees and charges to drive changes to the public's behaviour in seeking medical treatment to guide the optimal use of resources.

3. Enhancing healthcare protection: Strengthening protection for “poor, serious, critical” patients on all fronts by enhancing the fee waiver mechanism, introducing an annual cap on fees and charges at \$10,000, and increasing subsidies on drugs and medical devices for the critically ill, with a view to preventing “patients with serious conditions falling into poverty”.

The HA will continue to pursue reform and strives to provide high-quality and safe healthcare services for its patients.

At present, there are 18 public hospitals under the HA providing Accident and Emergency (A&E) services for the critically ill or seriously injured people and victims of disasters. To ensure that citizens with urgent needs can receive timely services, A&E departments implement a patient triage system under which patients are classified into five categories, namely Critical, Emergency, Urgent, Semi-urgent and Non-urgent based on their clinical conditions, and will receive treatment as prioritised by their urgency category. The HA’s service target specifies that critical patients (i.e. 100%) will receive immediate treatment while those categorised as Emergency and Urgent will also be given priority for receiving treatment upon arrival at A&E departments. The target is that most of the Emergency (95%) and Urgent (90%) patients will be treated within 15 and 30 minutes respectively. A&E departments are not General Out-patient Clinics. If there are a large number of Semi-urgent or Non-urgent patients in the A&E departments, this may affect treatment of the Emergency and Urgent patients. The HA has met its service targets for both Critical and Emergency patients, but the target achievement rate for Urgent cases is 76.6%, indicating that some urgent patients could not be treated within 30 minutes.

The table below sets out the number of attendances under various triage categories at each A&E department under the HA in 2024-25 (up to 31 December 2024).

Hospital Cluster	Hospital	No. of A&E attendances				
		Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
HKEC	PYNEH	930	3 266	31 313	44 427	1 196
	RH	1 197	550	16 237	28 146	2 093
	SJH	49	81	1 526	4 686	140
HKWC	QMH	915	2 677	34 815	44 200	1 538
KCC	KWH	1 367	2 926	45 150	46 903	1 633
	QEH	3 259	2 826	70 054	58 383	4 644
KEC	TKOH	859	2 124	36 130	45 847	2 429
	UCH	2 090	3 463	52 802	47 553	3 916
KWC	CMC	779	2 155	34 252	36 115	1 546
	NLTH	268	800	14 615	43 511	842
	PMH	1 112	2 295	47 822	31 171	438
	YCH	1 348	1 667	33 656	49 578	170
NTEC	AHNH	445	1 568	20 511	46 262	1 621

Hospital Cluster	Hospital	No. of A&E attendances				
		Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
	NDH	1 193	2 004	31 097	33 863	955
	PWH	1 319	5 250	36 030	73 604	1 002
	POH	610	2 294	21 532	39 389	3 920
NTWC	TMH	898	4 081	51 503	63 936	1 586
	TSWH	432	1 561	18 195	57 987	2 689
HA Overall		19 070	41 588	597 240	795 561	32 358

Note:

The above attendances for A&E services under various triage categories in each hospital under the HA exclude (i) first-time visits without triage categories, and (ii) follow-up visits to the A&E departments.

The table below sets out the average waiting time under various triage categories at each A&E department under the HA in 2024-25 (up to 31 December 2024).

Hospital Cluster	Hospital	Average waiting time (in minutes) for A&E services				
		Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
HKEC	PYNEH	0	5	33	185	216
	RH	0	9	24	139	210
	SJH	0	9	15	26	32
HKWC	QMH	0	9	29	132	175
KCC	KWH	0	6	33	204	217
	QEH	0	7	11	91	133
KEC	TKOH	0	7	26	166	216
	UCH	0	12	24	199	228
KWC	CMC	0	4	25	175	164
	NLTH	0	7	20	98	113
	PMH	0	9	29	221	219
	YCH	0	4	25	140	176
NTEC	AHNH	0	9	28	142	135
	NDH	0	9	29	212	254
	PWH	0	11	34	200	212
NTWC	POH	0	7	20	155	193
	TMH	0	6	21	194	228
	TSWH	0	5	15	172	209
HA Overall		0	8	25	164	190

The table below sets out the full-time equivalent strength of doctors and nursing staff in A&E departments under the HA by cluster in 2024-25 (up to 31 December 2024) ^{(1) (4)}.

Cluster	2024-25 (up to 31 December 2023)	
	Doctors ⁽²⁾	Nursing Staff ⁽³⁾
HKEC	71	142
HKWC	34	60
KCC	94	201
KEC	78	164
KWC	132	327
NTEC	94	243
NTWC	92	235

Note:

1. The manpower figures above are calculated on full-time equivalent basis, including permanent, contract and temporary staff of the HA.
2. The manpower figures of doctors above exclude those of Interns and Dental Officers.
3. The manpower figures of nurses above include Senior Nursing Officers, Department Operations Managers, Nurse Consultants, Associate Nurse Consultants, Ward Managers, Nursing Officers, Advanced Practice Nurses, Registered Nurses, Enrolled Nurses, Nursing Trainees, etc.
4. Starting from January 2024, the full-time equivalent strength for temporary part-time staff is calculated based on their actual working hours. The figures before January 2024 are for reference only and direct comparison with the revised calculation method is not appropriate.

(2)

The recurrent expenditure of \$115.3 billion on Policy Area Group (PAG): Health covers a wide range of recurrent expenditure items. Programme details related to Policy Area 15: Health could be found in the Controlling Officer's Report of the respective Heads including Head 140, 37, 48 and 155.

The table below sets out the breakdown of the estimated recurrent expenditure allocated to the 4 health-related Heads of Expenditure in 2025-26.

Head of Expenditure	2025-26 Estimate (\$million)
Head 140 – Government Secretariat: Health Bureau	102,706.8
Head 37 – Department of Health	12,316.7
Head 48 – Government Laboratory	88.8
Head 155 – Government Secretariat: Innovation and Technology Commission	4.4
Total:	(Note) 115,116.6

Note:

1. Breakdown may not add up to the total due to rounding.
2. The total recurrent expenditure for PAG: Health amounts to \$115.3 billion as per Appendix B of the Budget Speech. It has included \$214.5 million of Additional Commitments under Head 106 – Miscellaneous Services apportioned to PAG: Health to meet funding for initiatives under planning and any unavoidable recurrent expenditure that may arise during the year in excess of the amounts provided under other heads and subheads of the Estimates.

Abbreviations

Cluster

HKEC – Hong Kong East Cluster
HKWC – Hong Kong West Cluster
KCC – Kowloon Central Cluster
KEC – Kowloon East Cluster
KWC – Kowloon West Cluster
NTEC – New Territories East Cluster
NTWC – New Territories West Cluster

Hospital

PYNEH – Pamela Youde Nethersole Eastern Hospital
RH – Ruttonjee Hospital
SJH – St. John Hospital
QMH – Queen Mary Hospital
KWH – Kwong Wah Hospital
QEH – Queen Elizabeth Hospital
TKOH – Tseung Kwan O Hospital
UCH – United Christian Hospital
CMC – Caritas Medical Centre
NLTH – North Lantau Hospital
PMH – Princess Margaret Hospital
YCH – Yan Chai Hospital
AHNH – Alice Ho Miu Ling Nethersole Hospital
NDH – North District Hospital
PWH – Prince of Wales Hospital
POH – Pok Oi Hospital
TMH – Tuen Mun Hospital
TSWH – Tin Shui Wai Hospital

- End -

CONTROLLING OFFICER'S REPLY

HHB094

(Question Serial No. 0303)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: ()

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Medical Registration Ordinance was amended in 2021 to create a new pathway for non-locally trained doctors to practise in Hong Kong. In this connection, will the Government inform this Committee of the following:

1. the annual number of non-locally trained doctors admitted in the past 3 years; and
2. the publicity expenses incurred by the Government on the admission of non-locally trained doctors in the past 3 years?

Asked by: Hon LAM Shun-chiu, Dennis (LegCo internal reference no.: 20)

Reply:

The Government has adopted a multipronged strategy to tackle the shortage of doctors in the public healthcare system. On the admission of qualified non-locally trained doctors, the Government created a new pathway (i.e. special registration (SR)) under the existing Medical Registration Ordinance (MRO) (Cap. 161) in 2021 to allow more qualified non-locally trained doctors to practise in our public healthcare system of Hong Kong so as to increase the supply of doctors in Hong Kong.

1.

According to the information provided by the Medical Council of Hong Kong (MCHK), the figures of SR and limited registration (LR) in relation to the number of applications, employing institutions, countries/places where doctors under LR or SR obtained medical qualifications and the number of applicants who have acquired specialist qualifications as at 31 December 2024 are as follows:

	SR			LR
	Holding recognised medical qualifications	Bridging from LR	Total	
Number of applications				
- Number of applicants ^{Note(1)}	108	13	121	436
- Number of approved applicants ^{Note(1)}	106	13	119 ^{Note(2)}	436
- Number of applicants with registration in effect	93 ^{Note(3)}	13	106	315 ^{Note(4)}
Employing institutions				
- The University of Hong Kong	4	5	9	27
- The Chinese University of Hong Kong	2	7	9	51
- Hospital Authority (HA)	79	1	80	200
- Department of Health	8	0	8	16
- Clinics exempted from the provisions of section 7 of the Medical Clinics Ordinance	Not applicable			7
- Public or private hospitals/medical institutions which are registered with the health administrative departments of the local people’s government in the Mainland/the Health Bureau of the Macao Special Administrative Region (SAR)	Not applicable			14 ^{Note(5)}
Total	93	13	106	315
Countries/regions from where medical qualifications were obtained				
- China (Except Hong Kong) ^{Note(6)}	9	1	10	128
- United Kingdom	63	6	69	72
- Australia	15	0	15	15
- New Zealand	0	0	0	2
- Canada	2	2	4	5
- United States	2	2	4	8
- Singapore	0	0	0	2

	SR			LR
	Holding recognised medical qualifications	Bridging from LR	Total	
- South Africa	2	1	3	3
- India	0	0	0	7
- Others	Not applicable	1 ^{Note(7)}	1	73 ^{Note(8)}
Total	93	13	106	315
Specialist qualifications acquired ^{Note(9)}				
- Anesthesiology	4	0	4	1
- Clinical Oncology	1	0	1	0
- Emergency Medicine	0	1	1	0
- Family Medicine	1	0	1	0
- Gastroenterology & Hepatology	1	2	3	0
- General Surgery	0	0	0	1
- Geriatric Medicine	0	1	1	0
- Intensive Care	0	0	0	1
- Medical Oncology	0	1	1	0
- Neurosurgery	1	0	1	0
- Obstetrics & Gynaecology	0	0	0	1
- Ophthalmology	0	1	1	2
- Otorhinolaryngology	0	1	1	0
- Paediatrics	0	1	1	2
- Pathology	0	0	0	1
- Public Health Medicine	0	2	2	0
- Radiology	1	3	4	1
- Rheumatology	0	0	0	1
- Urology	1	0	1	0
Total	10	13	23	11

Note:

- (1) The numbers of applicants and approved applicants include the numbers from 1 January 2022 to 31 December 2024, excluding renewal applications.
- (2) Among the 121 SR applications, 1 application was not approved, and 1 application was approved in January 2025.
- (3) Among the 106 approved SR doctors holding recognised medical qualifications, the SR of 9 applicants came into effect only after 31 December 2024, 3 applicants had their SR terminated before 31 December 2024 and 1 applicant passed the MCHK's licensing examination and became a doctor with full registration in February 2024. The number of applicants with SR in effect includes renewed applications.
- (4) Among the 436 doctors approved for LR, 20 had their LR came into effect only after 31 December 2024; 101 had their LR terminated on or before 31 December 2024 due to expiry of registration or resignation. The number of doctors with LR in effect includes renewed applications.

- (5) It refers to doctors attending to the medical needs of the patient(s) during direct point-to-point cross-boundary ambulance transfer service between Hong Kong Special Administrative Region and the Mainland/Macao Special Administrative Region according to Promulgation No. 13 on LR under the MRO (Cap. 161).
- (6) Including the Mainland China, the Macao SAR and the Taiwan Region.
- (7) The doctor with SR obtained his medical qualification in the Czech Republic.
- (8) Regarding the 73 doctors with LR, the countries/regions involved are: the Czech Republic (2), the Philippines (13), Sri Lanka (2), Ireland (13), France (1), Italy (1), the Netherlands (2), Argentina (1), Malaysia (15), Thailand (3), Saudi Arabia (2), Russia (3), Japan (1), Turkey (3), Poland (2), Germany (2), Myanmar (1), Indonesia (2), Pakistan (1), Colombia (1), Hungary (1) and Nigeria (1).
- (9) It refers to the number of specialists whose names are included in the Specialist Register of the MCHK as at 31 December 2024 and their relevant specialties.

2.

The HA established the Hospital Authority Global Healthcare Professional Recruitment Centre in December 2023 to co-ordinate the recruitment and exchange programmes for non-locally trained healthcare professionals and attract allied health professionals from around the world. The publicity expenses on attracting non-locally trained doctors are absorbed by the existing provisions of the HA and there is no separate breakdown available.

- End -

CONTROLLING OFFICER'S REPLY

HHB095

(Question Serial No. 0304)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (1) Director of Bureau's Office

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in paragraph 158 of the Budget Speech that the Hospital Authority, through various talent exchange programmes, invites healthcare professionals, including those from the Mainland especially the Greater Bay Area (GBA), for professional and clinical exchange with local healthcare personnel. In this connection, will the Government inform this Committee of:

1. the detailed figures and incurred expenditures of the aforesaid talent exchange programmes in the past 3 years; and
2. the respective numbers of healthcare personnel from Hong Kong and the GBA participating in the aforesaid talent exchange programmes in the past 3 years?

Asked by: Hon LAM Shun-chiu, Dennis (LegCo internal reference no.: 21)

Reply:

1. and 2.:

The Hospital Authority (HA) has all along been actively promoting the exchange with Mainland healthcare talents. In the fourth quarter of 2022, the HA rolled out the Greater Bay Area (GBA) Healthcare Talents Visiting Programmes which cover various healthcare professions including doctors, nurses, allied health staff and Chinese medicine (CM) practitioners. Subsequently, the Government announced in the 2023 Policy Address the strengthening of two-way training and exchange of healthcare talents between Hong Kong and the Mainland. The Government also mentioned in the 2025-26 Budget that the HA, through various talent exchange programmes, brings in healthcare professionals including those from the Mainland especially the GBA for professional and clinical exchange with local healthcare professionals with a view to fostering mutual professional enhancement and establishing a regional healthcare talent pool in the long run.

The following table sets out the numbers of healthcare talents who visited Hong Kong under the healthcare talent exchange programmes launched by the HA and different regions/municipalities in the Mainland from 2022-23 to 2024-25 (up to 31 December 2024):

Discipline group ^{Note (1)}	2022-23	2023-24	2024-25 (up to 31 December 2024)
Doctor (Doctors from the GBA)	-	13 (12)	48 (38)
Nurse	-	70	99
Allied health staff	-	5	35
CM practitioner ^{Note (2)}	3	13	18

Note:

- (1) The nurses, allied health staff and CM practitioners who participated in the exchange programmes mentioned above were all from the GBA cities.
- (2) The figures refer to the cumulative numbers of CM experts in the CM expert pool. The HA will arrange those CM experts, who have joined the expert pool, to offer clinical training in Hong Kong from time to time according to the training plans.

The following table sets out the numbers of staff from various healthcare professions arranged by the HA to visit the Mainland for two-way exchange from 2022-23 to 2024-25 (up to 31 December 2024):

Discipline group	2022-23	2023-24	2024-25 (up to 31 December 2024)
Doctor	Not applicable	-	8
Nurse		26	21
Allied health staff		19	41
CM practitioner ^{Note (3)}		-	16

Note:

- (3) All the participating CM practitioners (non-HA staff) who receive training under the CM Enhanced In-patient Training Programme with the GBA launched in April 2024 come from the Chinese Medicine Clinics cum Training and Research Centres in the 18 districts. They will visit the Mainland to receive clinical training by batches according to the training plans.

Since the target groups and objectives of exchanges under various programmes are different, the modes of exchange may not be the same. The healthcare talents visiting Hong Kong will also be arranged to conduct exchanges with the HA's healthcare professionals in relevant clinical departments of different hospital clusters. It is therefore difficult to separately quantify the expenditures involved in the exchanges.

- End -

CONTROLLING OFFICER'S REPLY

HHB096

(Question Serial No. 0305)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operating expenses

Programme: (1) Director of Bureau's Office

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It was mentioned in paragraph 207 of the Budget Speech that the Government was progressively implementing and completing the 16 works projects, which entailed a total of about \$190 billion, under the First Hospital Development Plan. In this connection, please inform this Committee of:

1. the progress and expenditure of each of the 16 works projects under the First Hospital Development Plan;
2. the numbers of additional beds and operating theatre suites provided to the public medical system under the First Hospital Development Plan as at 2024; and
3. the anticipated total numbers of additional beds and operating theatre suites to be provided to the public medical system upon completion of the First Hospital Development Plan.

Asked by: Hon LAM Shun-chiu, Dennis (LegCo internal reference no.: 22)

Reply:

In 2016, the Government and the Hospital Authority commenced the implementation of the First Hospital Development Plan (HDP) which encompasses a total of 16 projects, covering the redevelopment and expansion of 11 hospitals, the construction of a new acute hospital, 3 community health centres and 1 supporting services centre. It is aimed that upon completion of the First HDP, a total of 6 557 additional bed spaces (Note) and 94 operating theatres will be provided, along with the creation of more room for increasing service quotas of specialist and general out-patient clinics.

Up till now, 15 out of those 16 projects under the First HDP have been upgraded to Category A. The completed or substantially completed projects include the expansion of Haven of Hope Hospital, the extension of Operating Theatre Block for Tuen Mun Hospital (New Block), the redevelopment of Kwong Wah Hospital (Phase 1), the North District Community Health Centre, the Hospital Authority Supporting Services Centre, and the redevelopment of Queen Mary Hospital (Phase 1). Other projects the main work of which

are currently underway include the redevelopment of Kwai Chung Hospital (Phases 2 and 3), the construction of a new acute hospital at Kai Tak Development Area, the redevelopment of Grantham Hospital (Phase 1), the redevelopment of Our Lady of Maryknoll Hospital, the expansion of Lai King Building in Princess Margaret Hospital, the redevelopment of Prince of Wales Hospital, Phase 2 (Stage 1), the expansion of United Christian Hospital, the redevelopment of Kwong Wah Hospital (Phase 2), and the expansion of North District Hospital. As for the redevelopment of Shek Kip Mei Health Centre, which has recently been upgraded to a Category A project, the construction works are expected to commence in the second quarter of 2025. The remaining Category B project, namely the development of a community health centre building at On Sau Road, Kwun Tong, is currently in the planning stage.

As of 31 December 2024, apart from the redevelopment of Kwong Wah Hospital (its Phase 1 already in operation) where works are still ongoing and the redevelopment of Queen Mary Hospital (Phase 1) where medical equipment installation and commissioning preparations are underway, other projects completed and commissioned under the First HDP have collectively provided an additional 174 hospital beds and 9 operating theatres to the public healthcare system.

Note: The figures include the additional beds at Kai Tak New Acute Hospital, which are provided for the relocation of the services from Queen Elizabeth Hospital (QEH). Currently, QEH has around 1 940 beds and the reprovisioning of these beds will depend on the reallocation or redevelopment plan of its vacated buildings after its service relocation.

- End -

CONTROLLING OFFICER'S REPLY**HHB097****(Question Serial No. 0753)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (3) Subvention: Hospital AuthorityControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

According to a study released by the Faculty of Medicine, the University of Hong Kong in November 2024, the mortality risk for patients with treatment-resistant depression (TRD) in Hong Kong is 1.5 times higher, and the psychiatric and non-psychiatric care costs 1.8 times higher. In this connection, will the Government inform this Committee of the following:

1. Please set out in table form the number and age distribution of patients diagnosed with and having been treated for mental illnesses, namely depression (with a breakdown of TRD patients), anxiety disorder, bipolar affective disorder and severe mental illness, in the Hospital Authority (HA) over the past 5 financial years:

	Depression (TRD)	Anxiety disorder	Bipolar affective disorder	Severe mental illness
Aged 0-17				
Aged 18-64				
Aged 65 or above				
Total				

2. What treatment options are currently adopted by the HA for TRD patients not achieving remission after 2 trials of antidepressants?

3. Currently, there are various medication and treatment options available in the market for treating or alleviating TRD. Please set out in table form the number of patients and the expenditure incurred for receiving the following types of treatment by hospital cluster over the past 5 financial years:

Financial Year	Prescription medication Esketamine (expenditure)	Prescription medication Olanzapine (expenditure)	Prescription medication Aripiprazole/ Abilify (expenditure)	Prescription medication Quetiapine (expenditure)	Electro-convulsive therapy (ECT) (expenditure)	Repetitive Transcranial Magnetic Stimulation (rTMS) (expenditure)
2024-25						
2023-24						
2022-23						
2021-22						
2020-21						

4. Among the aforementioned medication and treatment options, Esketamine, ECT and rTMS are the relatively new and targeted options for TRD. Will the HA allocate additional resources in the coming financial year to provide more patients with these new options? If yes, what are the details and the estimates concerned? If no, what are the reasons?

Asked by: Hon LAM So-wai (LegCo internal reference no.: 9)

Reply:

(1)

A breakdown of the numbers of psychiatric patients receiving treatment under the Hospital Authority (HA) and diagnosed with anxiety-related disorders, bipolar affective disorder, schizophrenic spectrum disorder or depression by disease group and age group from 2020-21 to 2024-25 (the projections as of 31 December 2024) is tabulated below:

2020-2021

Age Group ³	No. of Psychiatric Patients of HA ^{1,2,6}	Disease Group			
		Anxiety-related Disorders ²	Bipolar Affective Disorder ²	Schizophrenic Spectrum Disorder ^{2,5}	Depression ²
0-17	40 100	1 300	100	300	1 300
18-64	164 900	49 000	7 600	39 800	43 300
65 or above	70 800	19 800	1 300	10 500	16 600
Total⁴	275 800	70 100	9 100	50 600	61 300

2021-2022

Age Group ³	No. of Psychiatric Patients of HA ^{1,2,6}	Disease Group			
		Anxiety-related Disorders ²	Bipolar Affective Disorder ²	Schizophrenic Spectrum Disorder ^{2,5}	Depression ²
0-17	43 300	1 600	200	300	1 700
18-64	169 600	51 200	7 800	39 700	44 800
65 or above	76 100	22 100	1 400	11 200	18 200
Total⁴	288 900	74 800	9 400	51 200	64 700

2022-2023

Age Group ³	No. of Psychiatric Patients of HA ^{1,2,6}	Disease Group			
		Anxiety-related Disorders ²	Bipolar Affective Disorder ²	Schizophrenic Spectrum Disorder ^{2,5}	Depression ²
0-17	45 100	1 800	200	300	1 800
18-64	171 300	52 000	8 000	39 200	45 400
65 or above	80 500	24 100	1 600	11 700	19 600
Total⁴	296 900	77 800	9 700	51 100	66 800

2023-2024

Age Group ³	No. of Psychiatric Patients of HA ^{1,2,6}	Disease Group			
		Anxiety-related Disorders ²	Bipolar Affective Disorder ²	Schizophrenic Spectrum Disorder ^{2,5}	Depression ²
0-17	48 400	2 100	300	300	2 100
18-64	174 400	53 300	8 200	38 700	46 100
65 or above	86 600	26 800	1 700	12 200	21 200
Total⁴	309 400	82 100	10 200	51 200	69 400

2024-2025 (the projections as of 31 December 2024)

Age Group ³	No. of Psychiatric Patients of HA ^{1,2,6}	Disease Group			
		Anxiety-related Disorders ²	Bipolar Affective Disorder ²	Schizophrenic Spectrum Disorder ^{2,5}	Depression ²
0-17	50 500	2 200	300	300	2 100
18-64	176 600	53 700	8 300	37 900	46 500
65 or above	93 500	29 400	1 900	13 100	22 900
Total⁴	320 600	85 300	10 500	51 300	71 600

Note:

1. Including inpatients, patients at specialist outpatient clinics and those at day hospitals.
2. Figures are rounded to the nearest hundred.
3. Patients are grouped by their age as of 30 June of the respective year.
4. Individual figures may not add up to the total due to rounding and the inclusion of patients of unknown age.
5. As far as the HA is concerned, patients with severe mental illness generally refer to psychiatric patients with schizophrenic spectrum disorder and do not include severely mentally ill patients diagnosed with other disorders.
6. The breakdown by disease group may not add up to the total number of psychiatric patients due to incomplete coverage of disease groups in the above tables.

The HA does not maintain statistics on the number of patients with treatment-resistant depression.

(2)

As medical conditions vary among patients, the HA's multi-professional teams provide them with appropriate treatment in the light of their individual needs, clinical conditions, complexity of medical conditions and risks.

(3)

The numbers of HA patients prescribed with Esketamine, Olanzapine, Aripiprazole/Abilify and Quetiapine, which are listed on the HA Drug Formulary (HADF), from 2020-21 to 2024-25 (the projections as of 31 December 2024) are tabulated below:

2020-21

Hospital Cluster¹	No. of Patients³			
	Esketamine²	Olanzapine	Aripiprazole/ Abilify	Quetiapine
HKEC	0	2 110	1 740	5 980
HKWC	0	1 290	1 290	4 630
KCC	0	2 260	1 740	5 830
KEC	0	2 570	1 750	7 460
KWC	0	5 430	3 780	11 520
NTEC	0	3 580	3 520	8 560
NTWC	0	3 790	2 380	6 940
Total⁴	0	19 670	15 310	47 580

2021-22

Hospital Cluster¹	No. of Patients³			
	Esketamine²	Olanzapine	Aripiprazole/ Abilify	Quetiapine
HKEC	0	1 890	1 610	5 130
HKWC	0	1 140	1 120	4 010
KCC	0	1 910	1 550	5 060
KEC	0	2 320	1 760	6 430
KWC	0	4 910	3 560	10 160
NTEC	0	3 070	3 130	7 260
NTWC	0	3 490	2 260	6 270
Total⁴	0	17 900	14 360	42 080

2022-23

Hospital Cluster¹	No. of Patients³			
	Esketamine²	Olanzapine	Aripiprazole/ Abilify	Quetiapine
HKEC	0	2 300	2 150	6 320
HKWC	0	1 400	1 590	5 230

KCC	0	2 430	2 020	6 510
KEC	0	2 920	2 420	7 950
KWC	0	6 090	4 860	13 290
NTEC	0	3 640	4 520	8 970
NTWC	0	4 130	2 900	7 430
Total⁴	0	21 120	19 050	51 110

2023-24

Hospital Cluster ¹	No. of Patients ³			
	Esketamine ²	Olanzapine	Aripiprazole/ Abilify	Quetiapine
HKEC	0	2 330	2 380	6 460
HKWC	0	1 400	1 700	5 480
KCC	<5	2 640	2 580	7 070
KEC	<5	3 130	2 810	8 330
KWC	0	6 240	5 400	12 970
NTEC	20	3 720	5 350	9 070
NTWC	0	4 210	3 270	7 430
Total⁴	20	22 000	21 910	52 610

2024-25 (the projections as of 31 December 2024)

Hospital Cluster ¹	No. of Patients ³			
	Esketamine ²	Olanzapine	Aripiprazole/ Abilify	Quetiapine
HKEC	0	2 990	3 150	8 100
HKWC	<5	1 810	2 350	7 120
KCC	0	3 260	3 510	8 700
KEC	0	4 110	3 840	10 880
KWC	0	8 160	7 260	16 570
NTEC	20	4 820	7 180	11 680
NTWC	<5	5 530	4 490	9 570
Total⁴	20	28 910	29 850	68 140

The drug consumption expenditures involved in prescribing the above drugs in the past 5 years (i.e. from 2020-21 to 2024-25) are tabulated below:

Year	Drug Consumption Expenditure Involved (\$ million)			
	Esketamine ²	Olanzapine	Aripiprazole/ Abilify	Quetiapine
2020-21	0	4.4	103.7	32.8
2021-22	0	4.7	118.0	27.1
2022-23	0	4.5	132.7	21.2
2023-24	0.5	4.5	151.0	21.2
2024-25 (the projections as of 31 December 2024)	1.1	4.7	165.0	21.9

Note:

1. Patients may be treated in more than one hospital cluster.
2. No relevant information is available from 2020-21 to 2022-23 as Esketamine has only been listed on the HADF since July 2023.
3. Figures are rounded to the nearest ten.
4. Individual figures may not add up to the total due to rounding.

The HA does not maintain statistics on the number of patients receiving Electroconvulsive Therapy and Transcranial Magnetic Stimulation and the expenditure so incurred.

(4)

The HA adopts an integrated and multi-disciplinary approach in providing mental health services. Psychiatrists, psychiatric nurses, clinical psychologists, occupational therapists and medical social workers provide comprehensive medical services such as in-patient services, out-patient services, day rehabilitation training and community support services to patients with mental health needs (including patients with depression) according to their medical conditions and clinical needs.

The HA expands the coverage of the HADF under an established mechanism to provide long-term sustainable, affordable and appropriate support to patients with mental health needs. Apart from drug treatment, the HA provides Electroconvulsive Therapy and Transcranial Magnetic Stimulation for the treatment of depression. Healthcare professionals will refer patients with depression to receive appropriate treatment according to their medical conditions and clinical needs.

The HA will continue to review its mental health services and treatment options (including the prescription of newer drugs) to provide appropriate support to patients in need.

Remark:

In view of the COVID-19 epidemic in Hong Kong in early 2020, the HA adjusted its services in response to the epidemic. This should be taken into account when comparing the throughput of services provided by the HA across the years. With the subsiding of local COVID-19 epidemic situation and cessation of anti-epidemic measures in early 2023, the HA has been gradually resuming provision of all of its public healthcare services to tie in with the Government's normalcy measures.

Abbreviations:

HKEC – Hong Kong East Cluster
HKWC – Hong Kong West Cluster
KCC – Kowloon Central Cluster
KEC – Kowloon East Cluster
KWC – Kowloon West Cluster
NTEC – New Territories East Cluster
NTWC – New Territories West Cluster

- End -

CONTROLLING OFFICER'S REPLY**HHB098****(Question Serial No. 0322)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): (514) Hospital AuthorityProgramme: (3) Subvention: Hospital AuthorityControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

The authorities allocate tens of billions of dollars annually to the Hospital Authority (HA) for the provision of public healthcare services. While the amount of public funding has doubled from 49.8 billion in 2014/15 to approximately 100.1 billion in 2025/26, data on the unit costs of various surgeries and treatments are lacking during this period. In contrast, for the private sector, the authorities, together with the Hong Kong Private Hospitals Association, launched a pilot programme in 2016 to enhance price transparency for private hospitals. Currently, all private hospitals in Hong Kong have participated in the pilot programme, voluntarily publishing fee schedules for major chargeable items and providing estimated service charges and historical bill sizes statistics for 30 common treatments or procedures. In this connection, will the Government inform this Committee of the following:

- 1) the average unit costs of the 30 common treatments or procedures provided by the public healthcare system (with a breakdown according to the American Society of Anesthesiologists (ASA) classification), as well as the average unit costs for the treatment of stroke, acute myocardial infarction, and pneumonia in the table below.

Treatments/ procedures	ASA classification	Clinical staff costs	Drug costs	Consumable costs	Facility costs	Special device costs	Other costs	Total costs
Breast lump excision								
Bronchoscopy								
Caesarean section	I/II							
Caesarean section	III/IV							
Carpal tunnel release								
Cholecystectomy	I/II							
Cholecystectomy	III/IV							
Circumcision								
Colectomy (Laparoscopic)	I/II							
Colectomy (Laparoscopic)	III/IV							

Colonoscopy								
Colonoscopy with polypectomy								
Colposcopy								
Cystoscopy								
Dilation and curettage								
Direct laryngoscopy								
Gastroscopy								
Gastroscopy with polypectomy								
Haemorrhoidectomy								
Hernia repair								
Hernia repair (Laparoscopic)								
Herniotomy								
Hysterectomy (Laparoscopic)	I/II							
Hysterectomy (Laparoscopic)	III/IV							
Knee arthroscopy								
Laminectomy								
LASIK								
Micro-laryngoscopy								
Open reduction and internal fixation of various fractures								
Ovarian cystectomy (Laparoscopic)								
Phacoemulsification and intraocular lens implantation								
Spine fusion								
Thyroidectomy								
Tonsillectomy								
Trigger finger release								
Vaginal delivery	I/II							
Vaginal delivery	III/IV							
Stroke								
Acute myocardial infarction								
Pneumonia								

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 1)

Reply:

With a view to enhancing the price transparency of private healthcare facilities, the Government and the Hong Kong Private Hospitals Association rolled out a pilot programme in 2016. Currently, all 14 private hospitals in Hong Kong voluntarily participate in the pilot programme, with three price transparency measures implemented, namely (a) publicising the fee schedules of major chargeable items; (b) providing budget estimates for patients receiving 30 common treatments/procedures; and (c) publicising historical billing statistics for 30 common treatments/procedures.

Under the pilot programme, the Government has set up a designated website (<https://apps.orphf.gov.hk/Public/Enquiry/Main.aspx>) to facilitate public access to the historical billing statistics published by private hospitals for common treatments/procedures, including the annual discharge numbers for specified treatments/procedures, the average length of stay, and the actual billing data for the 50th and 90th percentiles of each specified treatment/procedure. The billing data are further separated into doctors' and hospitals' fees, but the basis of calculation of the fees is not standardised and is different from the cost structure of public hospitals, making direct comparison with the costs/charges of public hospitals difficult.

The prevailing fee schedule for private services provided by the Hospital Authority (HA) has been effective since 19 June 2018. To enhance the price transparency of its private services, apart from publishing the categories and ranges of fees for private surgeries through the Government Gazette, the HA has also uploaded reference prices of detailed operation items at its website (<https://www3.ha.org.hk/fnc/Operations.aspx?lang=CHIB5>) for the public's perusal.

The HA's website lists out different private surgery items and the respective ranges of fees. Fees for various categories of surgeries may vary depending on the complexity of the medical conditions, as well as the nature and scope of the actual treatment. Following the increasing public demand for transparency of healthcare costs and fees as well as the progressive implementation of the HA's various reforms to enhance its governance and effectiveness, the Government will roll out relevant measures to enhance the price transparency of private healthcare while requiring the HA to collate and publish the costs of relevant medical procedures. This would enable the public to access comprehensive information including the costs and fees of both public and private healthcare services for their reference in order to choose suitable healthcare services.

- End -

CONTROLLING OFFICER'S REPLY

HHB099

(Question Serial No. 0323)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (514) Hospital Authority

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Hospital Authority announced that from 24 March onwards, the dispensing of drugs will be limited to an amount of no more than 24 weeks. In this connection, will the Government inform this Committee of the estimated amount of reduction in drug wastage as a result of the new measure and the amount of savings in expenditure?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 2)

Reply:

The Government heavily subsidises the healthcare services provided at public hospitals under the Hospital Authority (HA), with a view to ensuring that citizens are not denied adequate medical services due to lack of means. As the major provider of publicly-funded public healthcare services, the HA allocates a substantial amount of resources annually to the provision of healthcare services and drugs in order to provide patients with optimal treatments. In recent years, the expenditure on drugs has continued to escalate. In 2023-24, the HA's total expenditure on drugs reached \$13.1 billion. With the rapidly ageing population and increasing prevalence of chronic diseases, the healthcare system faces long-term demand pressure. Additionally, expanding the drug formulary and introducing new drugs with better efficacy also involve higher costs.

The HA has been monitoring drug utilisation and expenditure through an established mechanism to ensure prudent and effective use of limited public healthcare resources. To further optimise the current drug dispensing mechanism in public hospitals and reduce drug wastage, the HA has introduced a new measure starting from 24 March 2025. Under the new measure, the target dispensing period for drugs prescribed to patients attending special out-patient clinics and general out-patient clinics, as well as discharged in-patients, will not exceed 24 weeks per visit. If a patient is prescribed with medications for more than 24 weeks, arrangement will be made for the patient to collect the medications by batches through medication refills. In addition, the HA will adjust the dispensing quantity of "As Needed" medications as necessary and enhance the services of pharmacist clinics, so as to improve treatment outcomes and drug compliance of patients. Meanwhile, the HA will also boost efforts in patient empowerment to prevent patients from accumulating excess drugs, thereby

minimising the risk of misuse of drugs and reduce wastage due to excessive drugs. It is expected that upon implementing the aforementioned measures, patients will collect “As Needed” medications from public hospitals based on their clinical needs, while some patients will no longer need to refill their long-term drugs due to changes in their medical conditions. It is estimated that these measures can reduce drug wastage by about \$70 million to \$80 million each year.

The HA will continue to engage and liaise with the relevant departments, patient groups, healthcare professional bodies and various stakeholders to continuously optimise the drug dispensing system and reduce drug wastage by patients through education, publicity and administrative measures.

Besides, the Government and the HA will press ahead with the implementation of the fees and charges reform for public healthcare announced recently, which aims to guide the public to make optimal use of healthcare resources through 3 aspects, namely reforming the subsidisation structure, reducing wastage and abuse, and enhancing healthcare protection. It also seeks to strengthen the healthcare protection on all fronts for patients who are “poor, acute, serious or critical”, with a view to ensuring that the limited healthcare resources can be directed in a more targeted manner to assist those patients most in need, thereby enhancing the sustainability of the healthcare system so as to cope with the challenges posed by an ageing population, inflation of healthcare cost, etc., and serve as a safety net for all.

- End -

CONTROLLING OFFICER'S REPLY

HHB100

(Question Serial No. 0324)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (514) Hospital Authority

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is learnt that inpatients in public acute hospitals need to extend their stay due to various non-medical reasons. In this connection, will the Government inform this Committee of the number of patients whose hospital stay was extended for various non-medical reasons (such as waiting for admission to elderly homes or residential care institutions, lacking care and assistance at home, waiting for admission to rehabilitation hospitals and to residential homes for children due to abuse, etc.), the total number of days involved in the extended hospital stay, and the relevant expenditures over the past 3 years in tabular form?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 3)

Reply:

The Hospital Authority (HA) has all along considered patients' suitability for discharge through the exercise of professional judgment by multi-disciplinary teams comprising healthcare staff and medical social workers, and planned for their discharge and provided appropriate support having regard to the individual circumstances of patients.

The HA does not systematically collect statistics on extended hospital stays for non-medical reasons. The relevant statistics and expenditures are thus unavailable. Under the fees and charges reform for public healthcare currently promoted by the Government, the levels of government subsidisation and the proportion of co-payments by members of the public for various public healthcare system will be adjusted. This would rationalise the relativity of in-patient as well as different tiers of out-patient services, so that resources can be directed in a more targeted manner and waste and abuse can be reduced. The fees and charges reform, when implemented, will help the HA address situations where patients extend their hospital stay due to non-medical reasons.

- End -

CONTROLLING OFFICER'S REPLY

HHB101

(Question Serial No. 0325)

Head: (140) Government Secretariat: Health Bureau
Subhead (No. & title): (514) Hospital Authority
Programme: (3) Subvention: Hospital Authority
Controlling Officer: Permanent Secretary for Health (Thomas CHAN)
Director of Bureau: Secretary for Health

Question:

Regarding the reduction in expenditure in the Budget, would the Government inform this Committee of the following:

- 1) Whether public healthcare institutions (the Hospital Authority (HA) and the Department of Health) have plans to reduce manpower. If so, the respective numbers of health and non-clinical staff to be reduced;
- 2) Whether there will be sufficient vacancies to employ all newly graduated doctors (granted with full registration after internship), registered nurses, physiotherapists (excluding the places with tuition sponsorship provided by the Social Welfare Department for social welfare organisations) and occupational therapists (excluding the places with tuition sponsorship provided by the Social Welfare Department for social welfare organisations) in Hong Kong over the next 3 years;
- 3) Whether the HA's Special Retired and Rehire Scheme for healthcare professionals will continue, and whether its scale will be reduced;
- 4) Will the HA's clinical preceptor programme be curtailed?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 4)

Reply:

1)

As announced in the Chief Executive's 2024 Policy Address, to enhance the health of the people of Hong Kong, improve healthcare protection and quality, and capitalise on our healthcare professions' strengths, the Government is conducting a comprehensive review on the positioning and objectives of the healthcare system. The review covers a reform of the functions and division of work among the Hospital Authority (HA), the Department of Health (DH) and the Primary Healthcare Commission (PHCC), which includes a reform of the HA's governance and efficiency, with a view to improving the standards and efficiency of its specialist and in-patient services. Meanwhile, the PHCC and the DH will enhance their work on health promotion and disease prevention, continuing to shift the emphasis of the healthcare system from treatment-oriented to prevention-focused, so as to address the existing

problem of system imbalance. The DH will also strengthen its roles as the Government's public health adviser and the regulatory authority by focusing on its public health functions. To this end, the DH is gradually transferring its specialist clinical and primary healthcare services to the HA and the PHCC respectively, including the following:

- (i) Transfer of the clinical genetic service to the HA was completed in early 2024;
- (ii) Woman health services will be integrated into the district health network, to be named as Women Wellness Satellites, of the PHCC under the Health Bureau within 2025, forming a network with District Health Centres/District Health Centre Expresses in all 18 districts across Hong Kong to provide eligible women with prevention-based and more personalised primary healthcare services. In addition, to further develop the multi-disciplinary primary healthcare service network, the PHCC plans to prepare for the integration of services of the Elderly Health Centres under the DH into the district health network in phases, starting from 2025-26, with a view to enhancing service synergy and minimising service duplication. Details of the transitional arrangements will be announced upon discussion with the DH; and
- (iii) In 2025-26, hospital dental services will be integrated into those under the HA and there is a plan to gradually transfer services such as child assessment service and tuberculosis and chest service to the HA.

Additionally, in order to further enhance manpower utilisation while containing public operating expenditure, the civil service establishment will be reduced by two per cent each in 2026-27 and 2027-28 by the Government, based on the establishment of the previous financial year respectively. In order to further streamline the civil service establishment while continuing to implement various current services, new policies and measures of the Government, various bureaux/departments (including the DH) will continue to enhance efficiency and optimise the manpower utilisation by reviewing work priorities, reallocating internal resources, streamlining procedures and leveraging technology through the adoption of management measures and digitalisation.

Meanwhile, the HA is facing various challenges including ageing population, increasing prevalence of chronic diseases and the risk of outbreak of major infectious diseases, which would increase its service pressure. To provide necessary healthcare services to the public, the Government provides a recurrent subvention of \$99 billion for the HA in 2025-26, representing an increase of 3.7 % over the revised estimate for 2024-25 (\$95.4 billion). The HA estimates that the total manpower in 2025-26 (in terms of full-time equivalent staff) will increase by 2 550 as compared with 2024-25, including 290 doctors, 1 040 nurses and 250 allied health professionals.

2)

The number of healthcare staff to be recruited by the HA each year is determined having regard to factors such as service demand, development needs of specialist services, staff turnover and manpower supply in the market. With the increase in the number of local medical graduates, the HA has increased the number of Resident Trainee posts as appropriate, with a view to recruiting all qualified local medical graduates. The HA

will continue to review the manpower situation and implement various measures to recruit qualified local graduates of healthcare professions as necessary and provide them with training opportunities, so as to meet service demand and enhance its service standards continuously.

3)

The HA has closely monitored its manpower situation over the years. In view of manpower wastage earlier, the HA has introduced a series of measures to attract, train and retain talents, including increasing the number of Resident Trainee posts to recruit local medical graduates, recruitment of non-locally trained healthcare personnel to supplement local recruitment, improving promotion prospects to retain staff, hiring part-time healthcare staff (e.g. via recruitment of locum staff), offering flexible work arrangements for full-time jobs, extending employment to suitable staff beyond retirement, enhancing Home Loan Interest Subsidy Scheme and provision of better training opportunities for various staff grades by establishing HA Academy. Specifically, to retain experienced staff to cope with the increasing service demand in the future, the HA Board endorsed the policy of Extending Employment Beyond Retirement (EER) at its meeting in September 2021 to retain suitable retired staff, with a view to alleviating manpower shortage and succession gaps in the HA.

Since the implementation of the relevant measures, the overall turnover rate of the HA has shown improvement. The overall wastage rates in 2021-22 and 2022-23 are 12 % and 12.8% respectively while that in 2024-25 (as at 31 December 2024) is 9.5%. The HA will continue to closely monitor the operational needs and manpower situation, and review various measures on attracting, training and retaining talents, including the policy of EER, to support the HA's overall service demand and development.

4)

The Preceptorship Programme is one of the HA's key initiatives to retain nursing talents. The HA will continue to recruit advanced practice nurses as clinical preceptors to coach newly recruited and junior nurses as necessary, thereby familiarising them with ward procedures and environment.

- End -

CONTROLLING OFFICER'S REPLY

HHB102

(Question Serial No. 0327)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: ()

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the recruitment of non-local healthcare professionals to work in Hong Kong, will the Government inform this Committee of the following:

1. Since the passage of the Medical Registration (Amendment) Bill 2021, what are the annual numbers of applications received and approvals for special registration and limited registration of doctors, the number of doctors hired by employing institutions and the number of those holding specialist qualifications at the time of their first application (please provide a breakdown by the specialty involved)?
2. Since the passage of the Nurses Registration (Amendment) Bill 2023, what are the annual numbers of applications received and approvals for special registration and limited registration of nurses, the number of nurses hired by employing institutions and the distribution of nurses with special registration or limited registration hired by the Hospital Authority across departments (please provide a breakdown by the specialty involved)?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 6)

Reply:

1.

According to the information provided by the Medical Council of Hong Kong (MCHK), the figures of special registration (SR) and limited registration (LR) in relation to the number of applications, employing institutions, the countries/places where the medical qualifications were obtained and the number of applicants who have acquired specialist qualifications as at 31 December 2024 are as follows:

	SR			LR
	Holding recognised medical qualifications	Bridging from LR	Total	
Number of applications				
- Number of applicants ^{Note(1)}	108	13	121	436
- Number of approved applicants ^{Note(1)}	106	13	119 ^{Note(2)}	436
- Number of applicants with registration in effect	93 ^{Note(3)}	13	106	315^{Note(4)}
Employing institutions				
- The University of Hong Kong	4	5	9	27
- The Chinese University of Hong Kong	2	7	9	51
- Hospital Authority (HA)	79	1	80	200
- Department of Health	8	0	8	16
- Clinics exempted under section 7 of the Medical Clinics Ordinance	Not applicable			7
- Public or private hospitals/medical institutions which are registered with the health administrative departments of the local people's government in the Mainland/the Health Bureau of the Macao Special Administrative Region (SAR)	Not applicable			14 ^{Note(5)}
Total	93	13	106	315
Countries/places where the medical qualifications were obtained				
- China (Except Hong Kong) ^{Note(6)}	9	1	10	128
- United Kingdom	63	6	69	72
- Australia	15	0	15	15
- New Zealand	0	0	0	2
- Canada	2	2	4	5

	SR			LR
	Holding recognised medical qualifications	Bridging from LR	Total	
- United States	2	2	4	8
- Singapore	0	0	0	2
- South Africa	2	1	3	3
- India	0	0	0	7
- Others	Not applicable	1 ^{Note(7)}	1	73 ^{Note(8)}
Total	93	13	106	315
Specialist qualifications acquired ^{Note(9)}				
- Anesthesiology	4	0	4	1
- Clinical Oncology	1	0	1	0
- Emergency Medicine	0	1	1	0
- Family Medicine	1	0	1	0
- Gastroenterology & Hepatology	1	2	3	0
- General Surgery	0	0	0	1
- Geriatric Medicine	0	1	1	0
- Intensive Care	0	0	0	1
- Medical Oncology	0	1	1	0
- Neurosurgery	1	0	1	0
- Obstetrics & Gynaecology	0	0	0	1
- Ophthalmology	0	1	1	2
- Otorhinolaryngology	0	1	1	0
- Paediatrics	0	1	1	2
- Pathology	0	0	0	1
- Public Health Medicine	0	2	2	0
- Radiology	1	3	4	1
- Rheumatology	0	0	0	1
- Urology	1	0	1	0
Total	10	13	23	11

Note:

- (1) The numbers of applicants and approved applicants include the numbers from 1 January 2022 to 31 December 2024, excluding renewal applications.
- (2) Among the 121 SR applications, 1 application was not approved, and 1 application was approved in January 2025.
- (3) Among the 106 approved SR doctors holding recognised medical qualifications, the SR of 9 applicants came into effect only after 31 December 2024, 3 applicants had their SR terminated before 31 December 2024 and 1 passed the MCHK's licensing examination and became a doctor with full registration in February 2024. The number of applicants with SR in effect includes renewed applications.

- (4) Among the 436 doctors approved for LR, 20 had their LR come into effect only after 31 December 2024; 101 doctors had their LR terminated on or before 31 December 2024 due to expiry of registration or resignation. The number of doctors with LR in effect includes renewed applications.
- (5) It refers to doctors attending to the medical needs of patients(s) during the direct point-to-point cross-boundary ambulance transfer service between Hong Kong SAR and the Mainland/Macao SAR according to Promulgation No. 13 on LR under the Medical Registration Ordinance (Cap. 161).
- (6) Including the Mainland China, the Macao SAR and the Taiwan Region.
- (7) The doctor with SR obtained his/her medical qualification in the Czech Republic.
- (8) Regarding the 73 doctors with LR, the countries/regions involved are: the Czech Republic (2), the Philippines (13), Sri Lanka (2), Ireland (13), France (1), Italy (1), the Netherlands (2), Argentina (1), Malaysia (15), Thailand (3), Saudi Arabia (2), Russia (3), Japan (1), Turkey (3), Poland (2), Germany (2), Myanmar (1), Indonesia (2), Pakistan (1), Colombia (1), Hungary (1) and Nigeria (1).
- (9) It refers to the number of specialists whose names are included in the Specialist Register of the MCHK as at 31 December 2024 and their relevant specialties.

2.

Since the passage of the amendments to the Nurses Registration Ordinance by the Legislative Council (LegCo) in July 2024, the HA has been actively carrying out various publicity and recruitment work. As at 31 December 2024, the HA has issued offers to 79 non-locally trained nurses, and the applicants have been gradually submitting applications for LR and SR to the Nursing Council of Hong Kong (NCHK) for vetting. The HA will continue to follow up on the applications and assist the applicants in applying for employment visas from the Immigration Department, so that they can serve in the HA as soon as possible.

According to the information provided by the NCHK, the number of applications for SR/special enrolment (SE) and LR/limited enrolment (LE) of nurses as at 31 December 2024 are as follows:

	SR	SE	LR	LE	Total
Number of applications ^{Note (1)}					
- Number of applicants	3	0	1	1	5 ^{Note (2)}
- Number of approved applicants	3	0	1	1	5 ^{Note (3)}
- Number of applicants with registration/enrolment effected	0	0	0	0	0

Note:

- (1) The number of applicants and approved applicants are figures as at 31 December 2024 after the passage of the amendments to the Nurses Registration Ordinance by the LegCo in July 2024.
- (2) It refers to applications received with complete information. At the same time, the NCHK has been further following up with the applicants on the 54 applications requiring supplementary/verification of information. The NCHK will include these cases to the formal application figures upon receipt of complete application information.
- (3) The 5 approved applications took effect only after 31 December 2024. Among them, 3 SR and 1 LR nurses are employed by the HA, while the remaining 1 LE nurse is employed by a residential care home for the elderly.

- End -

CONTROLLING OFFICER'S REPLY**HHB103****(Question Serial No. 0328)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: Not SpecifiedControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

Regarding local training of healthcare manpower, will the Government inform this Committee of the numbers of training places for local healthcare professionals (with a breakdown by discipline including medicine, dentistry, nursing for registered nurse and enrolled nurse, medical laboratory science, occupational therapy, physiotherapy, radiography and Chinese medicine) over the past 3 years?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 7)Reply:

All along, the Government has been striving to enhance the training of local healthcare professionals so as to cater for the needs of the society. The number of government-funded intake places in designated degree programmes related to healthcare professions subject to statutory registration in the past 3 years is tabulated as follows: ⁽¹⁾

Programme	Academic Year		
	2022/23	2023/24	2024/25
Medicine	590	590	590
Dentistry	90	90	90
Nursing ⁽²⁾	2 070	2 370	2 385
Medical Laboratory Science	105	165	165
Occupational Therapy	160	160	160
Physiotherapy	300	320	320
Radiography	135	135	135
Chinese Medicine	84	84	84

Note:

- (1) Includes designated student intake places of the University Grants Committee-funded manpower-planned healthcare-related programmes, as well as subsidised places of the designated undergraduate programmes in the healthcare discipline under the Study Subsidy Scheme for Designated Professions/Sectors (SSSDP) launched by the Education Bureau, which are related to healthcare professions subject to statutory registration.
- (2) Refers to registered nurse (RN) degree programmes. In addition to RN degree programmes, a total of 1 070 places are available across 8 enrolled nurse (general) non-degree programmes offered by various institutions in the 2024-25 academic year. Among them, 605 places are subsidised through the Social Welfare Department's "Enrolled Nurse Training Programme for the Welfare Sector" or the SSSDP, etc., and 100 places are offered by the Enrolled Nurse Training Programme organised by the Hospital Authority (HA), with full subsidy provided by HA on the tuition fee of each student.

- End -

CONTROLLING OFFICER'S REPLY

HHB104

(Question Serial No. 0331)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (514) Hospital Authority

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding healthcare manpower, will the Government inform this Committee of: the numbers of practising (i) medical practitioners, (ii) registered nurses, (iii) enrolled nurses, (iv) registered Chinese medicine practitioners, (v) listed Chinese medicine practitioners, (vi) registered midwives, (vii) chiropractors, (viii) medical laboratory technologists, (ix) physiotherapists, (x) pharmacists, (xi) dentists, (xii) dental hygienists, (xiii) radiographers, (xiv) optometrists, and (xv) occupational therapists in Hong Kong and the changes in manpower; and the numbers of those who are newly registered/enrolled (as a percentage of the total numbers of the respective professions, and the percentages of those who are non-locally trained) in the past 3 years?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 10)

Reply:

The total numbers of registrants, practising certificate holders, and new registration/enrolment of medical practitioners, dentists, dental hygienists, nurses, registered midwives, Chinese medicine practitioners (CMPs), pharmacists, occupational therapists, physiotherapists, medical laboratory technologists, optometrists, radiographers and chiropractors in Hong Kong over the past 3 years are set out at Annex.

2022

Healthcare professions (a)		Total no. of registrants (b) [as at 31 December 2022]	No. of practising certificate holders (c)	No. of new registration/enrolment				
				Locally-trained (d)	Non-locally trained (e)	Total (f)	As a percentage of the total no. of registrants (g) =(f)/(b)x100%	Percentage of those who are non-locally trained (h) =(e)/(f)x100%
Doctors		15 954	15 954	430	66 ^{Note(1)}	496	3.1%	13.3%
Dentists		2 786	2 786	75	17	92	3.3%	18.5%
Dental hygienists		558	558	27	0	27	4.8%	0%
Nurses	Registered nurses	50 650	50 650	2 306	2	2 308	4.6%	0.1%
	Enrolled nurses	15 842	15 842	653	4	657	4.1%	0.6%
Registered midwives		4 538	4 538	102	0	102	2.2%	0%
CMPs	Registered CMPs	8 296	7 079	105	181	287 ^{Note(2)}	3.5%	63.1%
	Listed CMPs	2 436	/	/	/	/	/	/
Pharmacists		3 259	3 259	60	45	105	3.2%	42.9%
Occupational therapists		2 966	2 966	146	55	201	6.8%	27.4%
Physiotherapists		4 170	4 170	176	70	246	5.9%	28.5%
Medical laboratory technologists		4 326	4 326	104	44	148	3.4%	29.7%
Optometrists		2 283	2 283	39	3	42	1.8%	7.1%
Radiographers (Diagnostic radiographers and Radiation therapists)		2 790	2 790	127	9	136	4.9%	6.6%

Chiropractors	304	304	0	19	19	6.3%	100%

Note

(1): Including 53 doctors with limited registration and 10 doctors with special registration.

(2): Including 1 former listed CMP who has obtained the qualification for registration.

2023

Healthcare professions (a)	Total no. of registrants (b) [as at 31 December 2023]	No. of practising certificate holders (c)	No. of new registration/enrolment				
			Locally-trained (d)	Non-locally trained (e)	Total (f)	As a percentage of the total no. of registrants (g) =(f)/(b)x100%	Percentage of those who are non-locally trained (h) =(e)/(f)x100%
Doctors	16 406	16 406	465	193 ^{Note(3)}	658	4.0%	29.3%
Dentists	2 876	2 876	80	22	102	3.5%	21.6%
Dental hygienists	612	612	54	0	54	8.8%	0%
Nurses	Registered nurses	52 327	2 327	11	2 338	4.5%	0.5%
	Enrolled nurses	16 425	703	7	710	4.3%	1.0%
Registered midwives	4 618	4 618	94	0	94	2.0%	0%
CMPs	Registered CMPs	8 423	73	159	232	2.8%	68.5%
	Listed CMPs	2 137	/	/	/	/	/
Pharmacists	3 317	3 317	52	21	73	2.2%	28.8%
Occupational therapists	3 205	3 205	187	78	265	8.3%	29.4%
Physiotherapists	4 589	4 589	245	202	447	9.7%	45.2%
Medical laboratory technologists	4 658	4 658	292	81	373	8.0%	21.7%
Optometrists	2 306	2 306	45	14	59	2.6%	23.7%
Radiographers (Diagnostic radiographers and Radiation therapists)	2 907	2 907	132	13	145	5.0%	9.0%
Chiropractors	338	338	0	39	39	11.5%	100%

Note

(3): Including 128 doctors with limited registration and 32 doctors with special registration.

2024

Healthcare professions (a)	Total no. of registrants (b) [as at 31 December 2024]	No. of practising certificate holders (c)	No. of new registration/enrolment				
			Locally-trained (d)	Non-locally trained (e)	Total (f)	As a percentage of the total no. of registrants (g) =(f)/(b)x100%	Percentage of those who are non-locally trained (h) =(e)/(f)x100%
Doctors	16 954	16 954	471	363 ^{Note(4)}	834	4.9%	43.5%
Dentists	2 942	2 942	74	31 ^{Note(5)}	105	3.6%	29.5%
Dental hygienists	647	647	32	3	35	5.4%	8.6%
Nurses	Registered nurses	54 759	2 481	15 ^{Note(6)}	2 496	4.6%	0.6%
	Enrolled nurses	17 122	832	5 ^{Note(6)}	837	4.9%	0.6%
Registered midwives	4 368	4 368	78	0	78	1.8%	0%
CMPs	Registered CMPs	8 575	91	202	293	3.4%	68.9%
	Listed CMPs	2 079	/	/	/	/	/
Pharmacists	3 386	3 386	67	35	102	3.0%	34.3%
Occupational therapists	3 429	3 429	190	83	273	8.0%	30.4%
Physiotherapists	4 977	4 977	286	153	439	8.8%	34.9%
Medical laboratory technologists	4 733	4 733	157	41	198	4.2%	20.7%
Optometrists	2 283	2 283	44	6	50	2.2%	12.0%
Radiographers (Diagnostic radiographers and Radiation therapists)	2 972	2 972	114	12	126	4.2%	9.5%
Chiropractors	338	338	0	18	18	5.3%	100%

Note

- (4): Including 235 doctors with limited registration and 68 doctors with special registration.
- (5): The relevant provisions for special registration and limited registration under the Dentists Registration Ordinance came into effect on 1 January 2025. The figure does not include the number of special registration and limited registration.
- (6): As at 31 December 2024, applications for special registration of 3 nurses, limited registration of 1 nurse, and limited enrolment of 1 nurse have been approved. Their registration/enrolment took effect only after 31 December 2024, and is therefore not included.

- End -

CONTROLLING OFFICER'S REPLY

HHB105

(Question Serial No. 0335)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the development of Chinese medicine, will the Government inform this Committee of:

- (1) the number of funding schemes rolled out under the Chinese Medicine Development Fund (CMDF) in the past 3 financial years (please set out the expenditure and concrete outcomes of each funding scheme); and
- (2) the amounts of financial support to the Chinese medicine sector through the CMDF and the outcomes in 2024-25, with a breakdown by project?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 14)

Reply:

(1) & (2)

As the first dedicated fund set up to support Chinese medicine (CM) development, the Chinese Medicine Development Fund (CMDF) has been injected with a total of \$1 billion since its official launch in June 2019. The CMDF aims to enhance the overall standards of the CM sector to promote the high-quality development of CM in Hong Kong on all fronts. Having regard to the diverse needs of stakeholders, the CMDF has launched various support programmes covering different areas to benefit CM personnel and organisations of different segments of the sector. As of end of February 2025, the CMDF has approved an accumulative total of about 8 900 funding applications, involving a total funding of about \$403 million (provisional figure) for the approved projects and benefiting more than 3 million members of the sector and the general public, with major achievements listed below:

- (a) Talent nurturing: Close to 3 500 Chinese medicine practitioners (CMPs) and CMs personnel have received subsidies to attend CM professional training programmes for continuously upskilling their professional knowledge and ability. The CMDF has supported programme providers to design and organise innovative training projects, benefitting over 41 300 practitioners. The CMDF has supported 85 CMPs and CMs personnel to participate in the Hong Kong Chinese Medicine Talent Training Programme co-organised by the National Administration of Traditional Chinese Medicine and Health Bureau (HHB) to cater for the need of establishing a talent pool;

- (b) Quality enhancement: The CMDF has supported more than 560 CM clinics and 220 Chinese herbal medicine retailers/wholesalers to upgrade their facilities and equipment, with a view to enhancing service quality and the safety and quality control of CMs. The CMDF has also supported nearly 180 proprietary Chinese medicines (pCm) manufacturers/wholesalers to engage consultancy services or technical support for over 760 pCm products, thereby levelling up the quality of Hong Kong-registered pCm products;
- (c) Market development: The CMDF has provided subsidies for 12 Hong Kong-registered pCm products for external use to be registered and sold on the Mainland through streamlined approval procedures to promote industry development;
- (d) Research and applied studies: The CMDF has supported the commencement of 72 CM research and applied studies projects which are instrumental in driving academic and clinical research as well as the professional and industry development of CM in Hong Kong; and
- (e) Publicity and promotion: The CMDF has supported more than 1 100 CM publicity and public education activities of various forms, targeting audiences such as kindergarten, primary and secondary school students, and elderly persons.

Following an additional injection of funds in the 2023-24 Budget, the CMDF has rolled out various new and enhanced initiatives to cater for the needs of the CM sector and align with its latest development. For example:

- (a) To facilitate Hong Kong pCms to explore the Mainland market and promote industry development, the CMDF launched the Greater Bay Area pCm Industry Development Support Scheme in February 2024 to provide subsidies for Hong Kong-registered pCms for external use to apply for registration in the Mainland through the streamlined approval procedures;
- (b) To dovetail with the phased service commencement of The Chinese Medicine Hospital of Hong Kong at the end of 2025, the CMDF invited organisations to submit applications for 6 talent training programmes relating to cross-disciplinary collaboration, healthcare administration and management under the Strategic Theme Commissioned Project Funding Programme from mid-2024. The approval process for the relevant commissioned training programmes was completed and the programmes are expected to commence in phases starting from mid-2025; and
- (c) To further fostering cultural inheritance and promotion of CM, the CMDF raised the funding ceiling of CM public promotion projects to \$2 million from April 2024 to enhance the scale and effectiveness of public education and promotion projects designed and implemented by the CM sector. The CMDF also invited organisations to submit applications under the Strategic Theme Commissioned Project Funding Programme for the development of CM teaching and learning resource kits for secondary and primary schools in mid-2024. The approval

process for the relevant commissioned projects was completed and the projects is expected to commence in phases starting from mid-2025.

The HHB will continue to closely monitor the implementation of the CMDF in consultation with the Advisory Committee on CMDF, work with the CMDF's implementation agent (the Hong Kong Productivity Council) to maintain close liaison with the CM sector and relevant stakeholders, and introduce more enhancement measures as and when necessary.

The details and vetting criteria of the funding schemes as well as the amount of subsidy, progress and achievements of the approved projects have been uploaded to the CMDF website (www.cmdevfund.hk).

- End -

CONTROLLING OFFICER'S REPLY

HHB106

(Question Serial No. 0336)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Chinese medicine (CM) is a treasure of Chinese civilisation, and plays an important role in promoting health for all. In this connection, will the Government inform this Committee of: whether it will consider earmarking specific expenditure for supporting primary and secondary schools in compiling course contents about CM-related knowledge, and encouraging primary and secondary students to gain a basic understanding of CM, as part of the efforts to promote Chinese culture?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 15)

Reply:

The Government has been committed to fostering cultural inheritance, education and promotion of Chinese medicine (CM), with the aim of promoting CM culture and the high-quality development of CM on all fronts.

The Chinese Medicine Promotion Funding Scheme (the Scheme) under the Chinese Medicine Development Fund (CMDf) provides funding for eligible organisations to take forward CM publicity and public education projects, with a view to enhancing public understanding of CM and showcasing the latest developments of the CM sector. To enhance the scale and effectiveness of the subsidised projects, the funding ceiling of the Scheme has been raised from \$0.75 to \$2 million with effect from March 2024, with priority given to themes such as enhancing health with CM, cultural dissemination, talent and technology exchange, and promotion of the industry. As at the end of February 2025, the CMDf has supported more than 1 100 CM publicity and public education activities of various forms, targeting audiences such as kindergarten, primary and secondary school students, and elderly persons.

The Strategic Theme Commissioned Project Funding Programme has been established under the CMDf for commissioning organisations to conduct large-scale training, publicity and research projects on specific strategically priority themes, among which organisations were invited in May 2024 to submit applications for the development of diverse, flexible and practical teaching and learning resource kits on CM, in conjunction with the application in teaching, classroom learning or extra-curricular enrichment activities, thereby enhancing primary and secondary school students' understanding of CM culture and knowledge. Upon

completion of the development of the teaching and learning resource kits, the CMDF will further consider promoting their wider application in schools across the territory.

Starting from the second quarter of 2025, the Government will subsidise and encourage more large-scale international and regional CM conferences, exhibitions and events to be held in Hong Kong through the CMDF in order to further popularise the CM culture, promote CM professional development, strengthen international ties, attract high-level CM academic and research development, and showcase the latest sector development, thereby creating a favourable environment for business and technological innovation.

Furthermore, the Government is formulating the Chinese Medicine Development Blueprint in collaboration with the CM sector to map out the future developmental directions of CM in Hong Kong. The main strategic directions include fostering cultural inheritance, education and promotion of CM extensively.

- End -

CONTROLLING OFFICER'S REPLY**HHB107****(Question Serial No. 0339)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (2) HealthControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

Regarding the Voluntary Health Insurance Scheme (VHIS), will the Government inform this Committee of:

- 1) the number of persons who joined the VHIS in the past 5 years, and the respective shares of new policies and policies transferred from other medical policies;
- 2) the total number of persons who have medical expense reimbursement insurance by age group and the number of them who are holders of VHIS policies; and
- 3) the change in the share of medical expenses covered by private and company/group medical expense reimbursement insurance (including VHIS) in the total health expenditure in the past 5 years?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 18)

Reply:

- 1) The Government launched the Voluntary Health Insurance Scheme (VHIS) in 2019, aiming to regulate individual indemnity hospital insurance products and enhance the transparency and coverage of medical insurances, thereby encouraging the public to purchase suitable medical insurance to get financially prepared for their healthcare needs. Relevant figures in the past 5 years broken down by financial year are as follows:

	Number of policies	Percentage of new policies (%)	Percentage of policies transferred from other insurances to VHIS (%)
As at 31 March 2020	522 000	20	80
As at 31 March 2021	791 000	29	71
As at 31 March 2022	1 045 000	38	62
As at 31 March 2023	1 220 000	44	56
As at 31 March 2024	1 341 000	50	50

As a person may have more than one VHIS policy, the Health Bureau (HHB) is unable to provide the exact number of persons participating in the VHIS.

- 2) As at 31 March 2024, the breakdown by the age of insured person for VHIS is as follows:

Age of insured person	Number of VHIS policies*
0-9	129 000
10-19	122 000
20-29	179 000
30-39	278 000
40-49	263 000
50-59	212 000
60 or above	157 000
Total	1 341 000

* Breakdown may not add up to the total due to rounding.

As non-VHIS medical insurances are not regulated by HHB, the number of persons in Hong Kong with medical insurance on a reimbursement basis is not available.

- 3) As estimated from the latest data collected for Hong Kong's Domestic Health Accounts, the expenditure on insurance schemes and its percentage share of Current Health Expenditure in the past 5 years are as follows:

Financial year	(a) Expenditure on privately purchased insurance schemes (HK\$ million)	As percentage of Current Health Expenditure (%)	(b) Expenditure on employer-based insurance schemes (HK\$ million)	As percentage of Current Health Expenditure (%)	(a)+(b) Total# (HK\$ million)	As percentage of Current Health Expenditure (%)	Current Health Expenditure (HK\$ million)
2018-19	16,828	9.2	12,200	6.7	29,028	15.8	183,438 [^]
2019-20	18,489	9.5	13,534	7.0	32,023	16.5	193,991*
2020-21	20,555	10.3	13,796	6.9	34,351	17.2	199,939*
2021-22	22,367	10.5	13,891	6.5	36,258	17.1	212,650*
2022-23	23,598	10.4	14,366	6.3	37,964	16.8	226,311*

Source: Hong Kong's Domestic Health Accounts. The figures may be different from those provided previously due to data update by the Insurance Authority.

[^] There was no identified COVID-19 expenditure in 2018-19.

* Excluding identified COVID-19 expenditure.

Breakdown may not add up to the total due to rounding.

- End -

CONTROLLING OFFICER'S REPLY

HHB108

(Question Serial No. 0340)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (514) Hospital Authority

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the support for patients with rare diseases, will the Government inform this Committee of the following:

- 1) Based on the database on rare diseases developed in phases by the Hospital Authority (HA) which will, in the long term, cover data on 207 uncommon disorders, which categories of rare diseases have been covered by such a database and what are the recorded numbers of patients?
- 2) Over the past 3 years, what has been the number of cases in which the HA provided support to those eligible patients with lysosomal storage disorders including Pompe disease, Gaucher disease, Fabry disease, Mucopolysaccharidosis (MPS) Type I, MPS Type II, MPS Type IV and MPS Type VI through enzyme replacement therapy, and what has been the expenditure for such support? Please provide a breakdown by years, numbers of patients and expenditures involved for each of these diseases.
- 3) Over the past 3 years, what has been the number of patients receiving support from the HA through the “Subsidy for Eligible Patients to Purchase Ultra-expensive Drugs (Including Those for Treating Uncommon Disorders)”, and what has been the expenditure for such support? Please provide a breakdown by years, numbers of patients and expenditures involved for each of the ultra-expensive drugs and clinical indication categories)?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 19)

Reply:

(1)

The Government and the Hospital Authority (HA) attach high importance to providing optimal care for all patients, including those with rare diseases, based on available medical evidence while ensuring optimal and rational use of public resources.

There is no common definition of rare diseases available worldwide. Nevertheless, the HA is progressively building up a database on rare diseases. Doctors will tag the relevant patients in the consultation records in the HA's Clinical Management System (CMS) to provide relevant reference data to facilitate healthcare service planning as well as clinical

diagnosis and treatment. As at 31 December 2024, the CMS of the HA maintained records of about 59 810 cases in total, encompassing 178 of the rare diseases listed in the national catalogue of rare disease.

At present, undiagnosed disorders, hereditary cancers, as well as cases related to genomics and precision medicine, are also covered by the Hong Kong Genome Project. Eligible patients and their family members are recruited at HA hospitals to participate in the project on a voluntary basis with informed consent, and the sequencing analysis results obtained will allow patients to benefit from more precise diagnosis and appropriate treatment.

Besides, the Government and the HA will press ahead with the implementation of the fees and charges reform for public healthcare announced recently, which aims to guide the public to make optimal use of healthcare resources through 3 aspects, namely reforming the subsidisation structure, reducing wastage and abuse, and enhancing healthcare protection. It also seeks to strengthen the healthcare protection on all fronts for patients who are “poor, acute, serious or critical”. Such measures include enhancing the protection in terms of drugs and medical devices for critically ill patients (including rare disease patients) through accelerating the introduction of more effective innovative drugs and devices to the HA Drug Formulary and the coverage of the safety net, with a view to ensuring that the limited healthcare resources can be directed in a more targeted manner to assist those patients most in need. This will thereby enhance the sustainability of the healthcare system so as to cope with the challenges posed by an ageing population, inflation of healthcare cost, etc., and serve as a safety net for all.

(2)

The HA currently makes use of designated government funding to provide a special drug programme for the treatment of eligible patients with specific lysosomal storage disorders (LSDs), including Pompe, Gaucher, Fabry, Mucopolysaccharidosis (MPS) Type I, MPS Type II, MPS Type IV and MPS Type VI, through enzyme replacement therapy. On the other hand, the HA keeps in view the clinical and scientific research evidence regarding medications and introduces appropriate drug treatments in a timely manner to enhance the support for LSD patients. The table below sets out the number of LSD patients receiving drug treatment under the HA over the past 3 years, namely 2022-23, 2023-24 and 2024-25 (up to 31 December 2024):

LSD	No. of patients receiving drug treatment under HA		
	2022-23	2023-24	2024-25 (up to 31 December 2024)
a) Pompe	10	11	11
b) Gaucher	4	4	4
c) Fabry	30	40	43
d) MPS Type I	2	2	2
e) MPS Type II	0	0	0
f) MPS Type IV	3	3	3
g) MPS Type VI	1	2	2
Total	50	62	65

The table below sets out the HA's drug expenditure for the treatment of LSDs over the past 3 years, namely 2022-23, 2023-24 and 2024-25 (up to 31 December 2024):

2022-23 (\$ million)	2023-24 (\$ million)	2024-25 (up to 31 December 2024) (\$ million)
99.7	115.9	103.0

(3)

The statistics on drug-related subsidies granted under the Community Care Fund Medical Assistance Programme, "Subsidy for Eligible Patients to Purchase Ultra-expensive Drugs (Including Those for Treating Uncommon Disorders)", over the past 3 years, namely 2022-23, 2023-24 and 2024-25 (up to 31 December 2024), are tabulated in detail below:

Drug item (Clinical indication)	2022-23		2023-24		2024-25 (up to 31 December 2024)	
	No. of subsidised case	Amount of subsidy granted (\$ million)	No. of subsidised case	Amount of subsidy granted (\$ million)	No. of subsidised case	Amount of subsidy granted (\$ million)
Burosumab (for X-linked Hypophosphataemia)	-	-	1	2.85	3	4.46
Dinutuximab beta (for Neuroblastoma)	4	5.76	3	3.78	5	10.12
Eculizumab (for Atypical Haemolytic Uraemic Syndrome)	1	5.18	-	-	2	2.95
Nusinersen (for Spinal Muscular Atrophy)	18	37.60	13	24.24	10	19.92
Onasemnogene Abeparvovec (for Spinal Muscular Atrophy)	-	-	-	-	1	12.87
Ravulizumab (for Paroxysmal Nocturnal Haemoglobinuria)	-	-	11	35.74	8	26.43
Ravulizumab (for Atypical Haemolytic Uraemic Syndrome)	-	-	1	3.42	-	-

Drug item <i>(Clinical indication)</i>	2022-23		2023-24		2024-25 (up to 31 December 2024)	
	No. of subsidised case	Amount of subsidy granted (\$ million)	No. of subsidised case	Amount of subsidy granted (\$ million)	No. of subsidised case	Amount of subsidy granted (\$ million)
Risdiplam <i>(for Spinal Muscular Atrophy)</i>	18	29.10	29	45.09	11	16.42
Tafamidis <i>(for Hereditary Transthyretin Amyloidosis in Adult Patients with Cardiomyopathy)</i>	3	2.53	4	3.55	7	6.27
Tisagenlecleucel <i>(for B-cell Acute Lymphoblastic Leukaemia)</i>	3	7.83	3	7.37	1	2.70
Tisagenlecleucel <i>(for Diffuse Large B-cell Lymphoma)</i>	17	43.99	35	76.78	18	44.41
Tisagenlecleucel <i>(for follicular lymphoma)</i>	-	-	-	-	1	2.79
Total	64	131.99	100	202.82	67	149.34

- End -

CONTROLLING OFFICER'S REPLY

HHB109

(Question Serial No. 0343)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Vision problems including refractive error are very common among young children. Early detection and correction will lessen the impact on their development and learning. There is sufficient medical evidence proving that timely intervention can retard myopia progression. In this connection, will the Government inform this Committee whether vision examination for children will be included as a component of the life-course healthcare plan in primary care; if yes, of the details; if not, the reasons for that?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 22)

Reply:

The Maternal and Child Health Centres of the Department of Health (DH) provides Pre-School Vision Screening (PSVS) for children aged 4 to 5 in order to detect as early as possible any visual abnormality (such as amblyopia, squint, and significant refractive errors) among children so that they can be referred to ophthalmologists for further visual assessment and treatment, with a view to protecting their vision and visual development. In 2024, there were 23 650 new cases of PSVS (around 50% of the target number of children), of which 15% were referred to ophthalmologists for follow-up.

Furthermore, the Student Health Service (SHS) of DH provides visual acuity tests including refractive errors for all primary school and secondary school students during their annual health checks. Such tests aim to detect as early as possible visual acuity problems among the students and to assess whether the problems so detected have already been corrected as appropriate by, for example, wearing suitable glasses. Those who fail the visual acuity tests will be referred to optometrists through the health assessment services under the SHS for further visual assessment. If other visual problems such as amblyopia are detected, the students will be referred as appropriate as well. In 2023/24 school year, there were 430 000 primary and secondary school students (about 66% of such students across Hong Kong) who received annual health checks under the SHS. Among them, 9.7% needed to be referred to optometrists under the SHS for further visual assessment (including those who failed the visual acuity tests).

Meanwhile, the Primary Healthcare Commission is actively promoting the Life Course Preventive Care Plan at the District Health Centres and District Health Centre Expresses (collectively referred to as DHCs) in all 18 districts across Hong Kong, to formulate personalised life course preventive care plans for members of the public, including children, at different stages of their lives through health risk assessment and family doctor pairing. The DHCs and family doctors consider personal factors such as age, gender and family history to provide health education (e.g. eye care) as well as advice and services on disease prevention. This includes guidance on healthy lifestyles (e.g. limiting screen time and regular visual acuity test) to promote the healthy growth and development of children. In addition to providing health assessments and organising health promotion activities, the DHCs also serve as a primary healthcare resource hub, connecting different healthcare professionals in the community (including optometrists), co-ordinating and making referrals for persons in need.

- End -

CONTROLLING OFFICER'S REPLY

HHB110

(Question Serial No. 0344)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Three-Tier School-based Emergency Mechanism implemented by the Government in all secondary schools in Hong Kong in December 2023 has been operated for a year. The first tier is in-school support provided by school personnel with enhanced training; the second tier is external support provided through off-campus support network at the district level; and the third tier is the psychiatric specialist outpatient services of the Hospital Authority (HA). In this connection, would the Government inform this Committee of:

- 1) the number of school personnel who have received training, the content of training, the assessment on the effectiveness of training and the assessment results since the implementation of the Mechanism;
- 2) the number of cases in which the second tier off-campus support network was contacted and the effectiveness of support at the district level;
- 3) the respective numbers of cases referred to the psychiatric specialist services of the HA by schools and the off-campus support network;
- 4) whether the training for school personnel will be further strengthened; if yes, the details; if not, the reasons; and
- 5) whether the systems of stationing school social workers and visiting psychologists will be enhanced and the ways to enhance the systems?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.:)

Reply:

(1) and (4)

To enhance teachers' professional capabilities in catering for the needs of students with special educational needs (SEN), the Education Bureau (EDB) provides in-service teachers with structured programmes pitched at three levels, i.e. Basic, Advanced and Thematic Courses (BAT Courses). Among them, the Thematic Courses include a 60-hour course focusing on students with mental illness, enhancing the professional capabilities of teachers to cater for students with mental health needs and to identify students with mental health needs at an early stage. To further strengthen training, the EDB provided approximately 40 additional thematic training workshops for teachers in the 2023/24 and 2024/25 school years,

including topics on supports for students with mental health needs, crisis management and basic counselling skills. The contents cover depression, anxiety disorders, psychosis, suicide risks, counselling skills in regulating emotions, Cognitive Behavioural Therapy, etc., with a more intense focus on enhancing their knowledge and skills in supporting students with mental health needs. As at the end of February 2025, about 3 500 school personnel participated in the relevant training workshops. The participants generally believe that the training workshops help enhance their knowledge and skills in early identification of and supporting students with mental health needs. Moreover, the EDB has organised the “Mental Health@School” Teacher Professional Network, assisting them in promoting student mental health within schools by regularly sharing the latest information and relevant resources.

(2)

Under the second-tier mechanism, schools may directly contact the off-campus support network in their respective regions, which will match students or their families with other community support services and refer them to the services as needed. As at the end of February 2025, the off-campus support network has received a total of 228 cases referred through the second-tier mechanism.

(3)

As regards the third-tier mechanism, school principals may refer students with higher risks to the psychiatric specialist outpatient services of the Hospital Authority (HA) to receive relevant services. After triage and screening assessment, the HA will prioritise the follow-up of students with urgent conditions that necessitate prompt treatment. During the period from 1 December 2023 to 31 January 2025, the HA’s psychiatric services received a total of 379 cases referred by school principals through the Three-Tier Emergency Mechanism. According to the HA’s data as at 31 January 2025, among those cases referred by school principals, about 3% were categorised as Priority 1 (urgent), and about 40% were categorised as Priority 2 (semi-urgent). The remaining cases either fell under the Routine (stable) category or were already being followed up by the HA’s psychiatric services.

(5)

To enhance the mental health of adolescents and strengthen their resilience to stresses, the Social Welfare Department (SWD) has implemented the measure of “2 school social workers for each school” in more than 460 secondary schools in Hong Kong since the 2019/20 school year, with the addition of about 370 school social workers (i.e. increasing the number of school social workers for each secondary school from 1.2 to 2). At the same time, about 46 Social Work Officer posts have been increased to enhance supervisory support in handling complicated cases. To enable school social workers to provide students in need with in-depth counselling and group services/activities, the SWD has also strengthened the supporting manpower for school social work service in secondary schools across the territory since the 2021/22 school year, so as to assist school social workers in handling administrative tasks and implementing activities. Moreover, the “School-based Educational Psychology Service (SBEPS)” provided by the EDB has covered all public sector ordinary primary and secondary schools in Hong Kong. The Government has also provided the Enhanced SBEPS to public sector ordinary primary and secondary schools admitting a greater number of students with

special educational needs by enhancing the educational psychologists to schools ratio to 1:4, in order to strengthen the preventive and development work of such schools.

- End -

CONTROLLING OFFICER'S REPLY**HHB111****(Question Serial No. 0345)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (2) HealthControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

Regarding the promotion of organ donation and the cross-boundary mutual assistance mechanism, will the Government inform this Committee of the following:

- 1) the total number of registrations in the Centralised Organ Donation Register in each of the past 5 financial years;
- 2) the number of patients waiting for organ transplants, the average waiting time, the longest waiting time, the number of organ transplant operations completed in public hospitals, as well as the number of patients who passed away while waiting for organ transplants in each of the past 5 financial years, broken down by type of organ; and
- 3) whether the Government has any specific work plan and implementation timetable for setting up a cross-boundary mutual assistance mechanism on organ donation?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 26)Reply:

1)

The numbers of registrations recorded in the Centralised Organ Donation Register in the past 5 years are as follows:

	2020	2021	2022	2023	2024
Cumulative total number of registrations (as at 31 December of the year)	330 764	343 593	356 093	367 199	391 187

2)

The number of patients waiting for organ/tissue transplant, their average waiting time, the number of patients who passed away while waiting for transplant and the number of organ/tissue donation cases handled by the Hospital Authority (HA) in the past 5 years are as follows:

Year (as at December 31)	Organ/ Tissue	Number of Patients Waiting for Transplant	Average Waiting Time (months) ¹	Number of Patients who Passed Away while Waiting for Transplant	Number of Donation Cases ⁵
2020	Kidney	2 302	55	N/A ²	65 (Cadaveric donation : 55 Living donation : 10)
	Liver	72	37.1	11	50 (Cadaveric donation : 27 Living donation : 23)
	Heart	78	24.4	4	10
	Lung	29	18.1	7	8
	Cornea (piece)	280	14.5	N/A ³	267
	Skin	N/A ⁴			1
	Bone				0
2021	Kidney	2 360	56	N/A ²	72 (Cadaveric donation : 57 Living donation : 15)
	Liver	69	38.2	10	53 (Cadaveric donation : 33 Living donation : 20)
	Heart	78	27.7	7	8
	Lung	19	22.9	2	14
	Cornea (piece)	263	15.1	N/A ³	306
	Skin	N/A ⁴			3
	Bone				1
2022	Kidney	2 451	56.8	N/A ²	56 (Cadaveric donation : 45 Living donation : 11)
	Liver	66	38.2	12	29 (Cadaveric donation : 17 Living donation : 12)

Year (as at December 31)	Organ/ Tissue	Number of Patients Waiting for Transplant	Average Waiting Time (months)¹	Number of Patients who Passed Away while Waiting for Transplant	Number of Donation Cases⁵
	Heart	81	23.5	6	11
	Lung	13	27.6	6	7
	Cornea (piece)	357	21.2	N/A ³	244
	Skin	N/A ⁴			5
	Bone				0
2023	Kidney	2 429	60	N/A ²	52 (Cadaveric donation : 41 Living donation : 11)
	Liver	81	33.4	15	30 (Cadaveric donation : 17 Living donation : 13)
	Heart	76	36.8	7	8
	Lung	21	28.2	3	2
	Cornea (piece)	474	31.3	N/A ³	253
	Skin	N/A ⁴			2
	Bone				0
2024	Kidney	2 476	61	N/A ²	59 (Cadaveric donation : 41 Living donation : 18)
	Liver	79	33.4	11	37 (Cadaveric donation : 23 Living donation : 14)
	Heart	77	37.7	4	4
	Lung	21	32.3	4	2
	Cornea (piece)	532	31.6	N/A ³	306
	Skin	N/A ⁴			7
	Bone				1

Note:

1. “Average waiting time” is the average of the waiting time for patients on the organ/tissue transplant waiting list as at the end of that year.
2. The lives of patients suffering from renal failure may be prolonged by means of dialysis treatment. Lack of organ transplant may not be a direct and main cause of the patients’ death.
3. Lack of cornea transplant may not be a direct and main cause of the patients’ death.

4. Cases of skin and bone transplant are sudden and emergency in nature. Substitutes will be used if no suitable skin or bone is identified for transplant.
5. Living donation applies to liver/kidney transplant only.

3)

On the basis of the case of the first cross-boundary organ transplant in December 2022, the Government has been making continued efforts to actively take forward the cross-boundary organ transplant mutual assistance mechanism with the relevant authorities of the Mainland. Currently, Hong Kong and the Mainland have established standardised channel and co-operation procedures for handling emergency cross-boundary organ transplant. When a patient in moribund condition is confirmed to be in need of urgent organ transplantation to extend his/her life, subject to the fulfilment of relevant criteria and the consent of his/her family members, the Government will seek assistance from the Country. The operational procedures for handling emergency cross-boundary organ transplant adopt a second-tier allocation mechanism, which will be activated only when local matching is unsuccessful for a donated cadaveric organ, so as to ensure that the respective organ donation and allocation systems of the two places will not be affected. Each case will be notified to the relevant government departments and an application will be made. The relevant departments will then vet the application and implement the arrangements in accordance with the established mechanism to ensure that the transportation and transplantation processes are in compliance with the laws and regulations of both places.

Moreover, the HA has formulated and implemented a set of standardised clinical protocols in terms of technical requirements, criteria and procedures for handling emergency cross-boundary organ transplant cases in a consistent approach. This is to ensure that organ donation is conducted in a legal, fair, equitable and safe manner to benefit patients with the greatest need. The Government will continue to seek assistance from the Country for patients in urgent need of organ transplant in accordance with the mechanism, and improve the cross-boundary organ transplant mutual assistance mechanism based on the experience gained from handling more successful cases.

- End -

CONTROLLING OFFICER'S REPLY

HHB112

(Question Serial No. 0346)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the Hospital Authority (HA)'s partnership with large chain pharmacies to provide community collection service, will the Government inform this Committee of the number of patients who have arranged the collection of their medications at community collection points via the HA's mobile application "HA Go"; and among such patients, of the respective percentages of those who have received specialist out-patient services and the TeleHealth service via "HA Go"?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 27)

Reply:

With the introduction of the Hospital Authority (HA)'s medication delivery service in March 2023, patients attending specialist out-patient clinics (SOPCs) or general out-patient clinics, discharged from hospital, or receiving accident and emergency services may choose to have their medications delivered to their homes or other specified addresses through the "HA Go" mobile application. Since September 2024, patients can also choose to collect the HA-dispensed medications at community collection points with on-site pharmacists, without the need to return to or wait at the pharmacies of the HA hospitals or clinics after their consultations. As at February 2025, a total of 2 435 patients opted for the community collection service, of whom 96% were SOPC patients and 6% were those who received telehealth service via "HA Go". Relevant figures of the service usage are tabulated as follows:

<u>Service</u>	<u>Number of patients who sought consultation at the HA in person</u>	<u>Number of patients who received the TeleHealth service via “HA Go”</u>	<u>Total</u>
SOPC service	2 205	136	<u>2 341 (96%)</u>
Others	84	10	94 (4%)
<u>Total</u>	2 289 (94%)	<u>146 (6%)</u>	2 435 (100%)

On the other hand, the Chief Executive’s 2024 Policy Address announced the Government’s plan to develop a community drug formulary and launch a community pharmacy programme to help the public obtain affordable drugs through central purchasing and the community network. As the core platform supporting primary healthcare services, eHealth+ will serve as a crucial bridge connecting the HA, community pharmacies and relevant healthcare providers. To tie in with the future synergistic development of community pharmacies and primary healthcare services, we will work to connect and integrate the medication records of the HA and various healthcare providers to support the relevant medication management processes (e.g. prescribing and dispensing medications), and launch the eMedication function in the eHealth mobile application (eHealth App) to facilitate the collection of medications by the citizens. We will also further rationalise the relevant medication management functions of the eHealth App and “HA GO”, with a view to making it more convenient for citizens to manage their health.

- End -

CONTROLLING OFFICER'S REPLY

HHB113

(Question Serial No. 0347)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the community pharmacy programme, will the Government inform this Committee:

- 1) of the average number of persons served by each community pharmacy per month since the launch of community pharmacies; and
- 2) of the respective services (i.e. dispensing prescription drugs, selling over-the-counter drugs, providing professional advice by pharmacists, etc.) selected by members of the public?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 28)

Reply:

(1)

The Government will launch the community pharmacy programme (the Programme) by phases starting from the fourth quarter of 2026. Currently, the Government is developing the service model, drug supply methods and related information systems. To solicit feedback from the industry and assess the market's acceptance level, the Government conducted a market consultation in November 2024. The Government plans to extend the services of the Programme across all 18 districts of Hong Kong, with at least 4 to 5 community pharmacies in each district.

The Programme will provide drug dispensing and professional pharmacist services to patients of the Hospital Authority (HA) and participants of primary healthcare programmes. The Programme will also provide HA-prescribed drugs to residential care homes (RCHs) for the elderly and persons with disabilities, and assist in the management and accurate dispensing of medication to their residents.

(2)

Under the Programme, community pharmacies will arrange more frequent drug dispensing to reduce medication waste and ensure accurate drug dispensing meeting the clinical needs of patients, thereby improving their use of medication. In addition to providing basic dispensing services, professional pharmacists in community pharmacies will also offer professional value-added services, including medication consultation and counselling, drug reconciliation, drug safety information, home drug management, smoking cessation counselling and health education.

Community pharmacies providing services to RCHs will package the daily required medications of individual residents according to prescriptions, and adopt modern technology to ensure safe and accurate dispensing of medications by RCHs. Such community pharmacies will also provide professional value-added services, including medication consultation and counselling, medication reconciliation, medication safety information, establishment of medication dispensing systems, medication management and storage for RCHs, health education and staff training. Patients and RCHs may opt to use these value-added services tailored to their individual needs.

- End -

CONTROLLING OFFICER'S REPLY

HHB114

(Question Serial No. 0348)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (514) Hospital Authority

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Medical negligence is an important factor affecting the doctor-patient relationship and the healthy operation of the healthcare system. In this connection, will the Government inform this Committee of:

- 1) the numbers of claims received by various public hospitals in the past 3 years in respect of medical negligence, with a breakdown by type of claims;
- 2) the numbers of substantiated complaints in the past 3 years and the numbers of healthcare personnel who were disciplined for the relevant incidents (with a breakdown by profession, e.g. doctors, nurses and allied health professionals); and
- 3) whether it knows the numbers of claims in respect of which compensation was paid by the Hospital Authority to the patients concerned or their families in each of the past 3 years, as well as the total amount of compensation paid and the expenses incurred?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 29)

Reply:

The Hospital Authority (HA) attaches great importance to service quality and patient safety. It has put in place mechanisms and guidelines to enhance reporting, management and monitoring of medical incidents in public hospitals. Under relevant arrangements, clusters/hospitals should report sentinel and serious untoward events to the HA Head Office within 24 hours through the Advance Incident Reporting System. They should also handle the incidents properly in accordance with the established procedures so as to minimise any possible harm to patients brought by the events while providing necessary support to the family members and staff involved. Subject to the circumstances of individual cases, the HA will appoint an expert group (such as Root Cause Analysis Panel or Clinical Coordinating Committee/Central Committee) as necessary to conduct detailed analysis, identify the possible causes of the incident, study and formulate improvement measures or optimise clinical practice standards and guidelines to prevent similar incidents from happening again in the future. Each year, the HA Head Office will submit to the HA Board a report of sentinel and serious untoward events, which will also be released to the public. The HA will continue to review the relevant mechanism and arrangements from time to time and make suitable adjustments when necessary.

In addition, in response to systemic issues and the need for reform in the management of public hospitals, the HA set up a review committee on 2 July 2024 to conduct an in-depth review on various fronts. The scope of the review was comprehensive, covering areas of governance, appraisal, accountability, operations, risk control, and compliance with procedural guidelines, etc. and touching upon various aspects, including HA Head Office, hospital clusters, hospitals, service units/ teams and staff levels. After detailed deliberations, the review committee consolidated its observations and made a total of 31 improvement recommendations in 5 areas, namely, governance and accountability, safety culture, compliance and monitoring, incident management and enabling factors. The HA announced the review committee's report on 22 November 2024. The HA is implementing the improvement measures in an orderly manner and monitoring the progress and effectiveness of implementation on an ongoing basis, with regular progress reports submitted/to be submitted to the Health Bureau.

1)

The HA does not maintain statistics on claims arising from medical incidents classified by nature. The table below sets out the numbers of claims received by the HA from 2022 to 2024:

Hospital Cluster	Reporting year and number of claims ^{Note}		
	2022	2023	2024
Hong Kong East	1	10	8
Hong Kong West	13	5	4
Kowloon Central	21	26	19
Kowloon East	13	14	9
Kowloon West	13	24	20
New Territories East	16	11	12
New Territories West	17	15	9

Note: Claims reported under the medical incidents insurance scheme of the HA.

2)

The table below sets out the breakdown of complaints by hospital cluster in the past 3 years:

Cluster \ Year	Hong Kong East	Hong Kong West	Kowloon Central	Kowloon East	Kowloon West	New Territories East	New Territories West
2021-22	193	150	705	286	150	76	50
2022-23	227	190	674	228	352	263	228
2023-24	226	142	724	212	435	228	130

Note: The figures listed in the table above do not include complaints lodged in relation to the services of the HA in general and the HA Head Office.

One of the main objectives of the HA's complaint mechanism is to help resolve problems for the complainants and improve service delivery in the course of complaint handling.

Therefore, regardless of whether the complaints are substantiated or not, the HA will take appropriate follow-up actions as long as room for improvement in service delivery is identified when handling the complaint cases. Previously, the HA did not maintain any statistics on whether individual complaints handled by the hospital clusters were substantiated or not. Subsequent to the review and enhancement made by the HA in 2023 regarding the prevailing procedures for handling complaints, the hospital clusters has maintained such statistics starting from 2024. From January to March 2024, the hospital clusters received a total of 419 complaints, of which 25 and 30 cases were substantiated or partially substantiated respectively.

The HA's established two-tier complaint system provides that where complainants are not satisfied with the outcome of the case as handled by the hospital/HA, they may appeal to the second tier, i.e. the Public Complaints Committee (PCC) of the HA. The PCC is a committee established under the HA Board to independently consider and decide on all appeal cases in an impartial and just manner.

The table below sets out the statistics on the appeal cases handled by the PCC in the past 3 years:

Year	Total number of appeal cases	Number of substantiated or partially substantiated cases
2021-22	237	21
2022-23	210	9
2023-24	233	14

The HA has an established mechanism to handle disciplinary matters of its staff. Disciplinary actions taken in the past were not confined to cases relating to medical complaints or claims. The HA will consider the seriousness of the incidents in determining the appropriate disciplinary actions, including counselling, verbal or written warnings, and dismissal in case of gross misconduct.

The table below sets out the numbers of disciplinary actions taken against healthcare personnel by profession in the past 3 years, i.e. 2021-22 to 2023-24:

Year	Number of disciplinary actions taken against healthcare personnel			
	Doctors	Nurses	Allied health professionals	Total
2021-22	14	96	40	150
2022-23	21	101	10	132
2023-24	33	145	23	201

Note: The number of disciplinary actions taken in 2024-25 is not yet available.

3)

The table below sets out the statistics on claims received by the HA in respect of medical incidents from 2022 to 2024 (as at early March 2025; figures in million dollars):

Reporting year of claims^{Note}	2022	2023	2024
Cumulative number of claims for which compensation was paid	12	15	4
Total amount of compensation paid in respect of claims settled out of court	5.94	10.09	3.21
Total amount of compensation paid pursuant to arbitration awards	0	0	0
Total amount of compensation paid pursuant to court rulings	0	0	0
Fees paid by the HA to mediators	0.01	0	0
Arbitration fees paid by the HA	0	0	0
Legal costs paid by the HA in respect of claims settled out of court	2.84	1.35	0.45

Note:

1. The claims reported refer to those reported under the medical incidents insurance scheme of the HA.
2. A medical negligence claim may only be received by the HA after a period of time following the medical incident. The HA needs time to investigate the claim, consult medical experts and seek legal advice before responding to the claimant/the claimant's lawyer. Subject to the expert opinions and legal advice, the HA will appoint a loss adjustor or lawyer to negotiate a settlement as and when appropriate. Where legal proceedings have commenced, it will take time for the parties to prepare and submit all the necessary documents and evidence in accordance with court directions. Moreover, the duration taken for reaching a settlement will depend on the nature and complexity of each claim. For example, for the 81 claims reported in 2024, only 4 claims were settled as at 6 March 2025. On the other hand, according to the information available, the HA, in 2024, reached out-of-court settlements for 28 claims, covering reporting years from 2016 to 2024.

- End -

CONTROLLING OFFICER'S REPLY**HHB115****(Question Serial No. 0352)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: ()Controlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

Regarding the Pilot Accredited Registers Scheme for Healthcare Professions, will the Government inform this Committee of the following:

- 1) the numbers of clinical psychologists, educational psychologists, dietitians, speech therapists and audiologists registered under the scheme by profession in the past 3 financial years; and
- 2) whether the Government has plans to implement statutory registration for the above professions in 2025-26; if so, what is the timetable; if not, what are the reasons?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 33)Reply:

- (1) The Government introduced the Pilot Accredited Registers Scheme for Healthcare Professions (AR Scheme) in end-2016, aiming to optimise the society-based regulatory regime, so as to uphold professional standards and enhance information transparency, thereby facilitating the selection of qualified healthcare service providers by the public. Since the introduction of the AR Scheme, 1 professional body from each of the 5 healthcare professions, namely audiologists, clinical psychologists, dietitians, educational psychologists and speech therapists, passed the rigorous accreditation assessment procedures and were granted full accreditation status. According to the information provided on the websites of these accredited healthcare professional bodies, the number of voluntary registrants in each of these professions by year is as follows:

Accredited Healthcare Professional Body	Total Number of Registrants (as at December of each year)		
	2022	2023	2024
Hong Kong Institute of Speech Therapists	305	341	327
Hong Kong Institute of Audiologists	49	64	69

Hong Kong Academy of Accredited Dietitians	100	129	138
Hong Kong Association of Educational Psychologists	229	225	205
Hong Kong Institute of Clinical Psychologists	396	423	459

- (2) Healthcare professions in Hong Kong have all along observed the principle of professional autonomy. Various healthcare professions are subject to different levels of regulation based on their professional risks and development needs, including mandatory statutory registration regimes, registration under accredited schemes and voluntary registration under a society-based arrangement. A mandatory statutory registration regime is not the only effective mode of regulation, nor is it applicable to the actual situation of all healthcare professions.

The Government's policy is to first and foremost adopt a risk-based approach to determine the most suitable mode of regulation for individual healthcare professions based on the level of risk on public health and healthcare quality and safety posed by them when providing services. In general, the Government will prioritise the implementation of mandatory statutory registration for healthcare professionals engaging in medical procedures which are invasive or of a higher risk. At the same time, the Government will continue to maintain communication with the professions and regulate healthcare professions taking into consideration the actual situation of their development. The factors to be considered include the following 4 points:

- (1) whether the profession has a broadly representative organisation or association with an effective governance structure;
- (2) whether the profession is capable of formulating professional standards and registration criteria with recognition;
- (3) the scale of the profession, including the service volume and the number of professionals; and
- (4) the views of the organisations and members of the profession.

To enhance the recognition of the AR Scheme, the Department of Health and the Hospital Authority have included registration with the accredited bodies as one of the priority considerations in the recruitment of the relevant healthcare professionals. Also, starting from April 2023, the Government has extended the scope of the Elderly Health Care Voucher Scheme to cover primary healthcare services provided by 4 categories of healthcare professionals registered under the AR Scheme (i.e. audiologists, dietitians, clinical psychologists and speech therapists). This notwithstanding, there is still a considerable room for improvement in the number of registrants and ratio of registration under the AR Scheme.

The purpose of introducing the AR Scheme is to encourage individual healthcare professions to promote voluntary registration based on the principle of professional autonomy, so as to enhance the representativeness of the healthcare professional bodies, forge consensus and promote professional development within healthcare professions. The accredited bodies should focus on promoting their accreditation status and enhancing their professional representation in order to attract more healthcare professionals to apply for registration. Based on the risk-based approach, the Government has no plan at this stage to legislate in respect of the relevant healthcare

professions to set up mandatory registration regimes or to preclude non-registrants from practising.

- End -

CONTROLLING OFFICER'S REPLY

HHB116

(Question Serial No. 0354)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (514) Hospital Authority

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Pilot Scheme for Supporting Patients of the Hospital Authority in the Guangdong-Hong Kong-Macao Greater Bay Area (Pilot Scheme) will expire on 31 March this year. In this connection, will the Government inform this Committee:

- 1) of the number of eligible patients participating in the Pilot Scheme and the distribution of their attendances at major specialist out-patient clinics and general out-patient clinics;
- 2) among these patients, of the percentage of those who are residing in the Guangdong Province;
- 3) of the total amount of subsidies provided under the Pilot Scheme?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 35)

Reply:

1.

Drawing reference on the experience of the Special Support Scheme during the COVID-19 epidemic, the Government launched the Pilot Scheme for Supporting Patients of the Hospital Authority in the Guangdong-Hong Kong-Macao Greater Bay Area (Pilot Scheme) on 10 May 2023, so that patients with scheduled follow-up appointments at designated out-patient clinics of the Hospital Authority (HA) (eligible patients) can receive subsidised consultations at the designated collaborating healthcare institution in the Guangdong-Hong Kong-Macao Greater Bay Area (GBA). The Pilot Scheme has been extended to 31 March next year and is currently applicable to the University of Hong Kong-Shenzhen Hospital (HKU-SZH). The scope of services covers out-patient services provided by the HA, namely anaesthesiology (pain clinic only); cardiothoracic surgery; clinical oncology; ear, nose and throat; ophthalmology; gynaecology; internal medicine; neurosurgery; obstetrics; orthopaedics and traumatology (orthopaedics); paediatrics; surgery and general out-patient services. According to the categorisation of specialties of the HKU-SZH, among the major specialties attended by the participants, Family Medicine Clinics (Chronic Diseases) accounts for 78% of the attendances, Internal Medicine Clinic and Surgery Clinic (including Ear, Nose and Throat, Cardiothoracic Surgery, Neurosurgery) together account for 17% of the

attendances. Other specialties attended by the participants include Ophthalmology Clinic and Orthopaedic Clinic. Since the launch of the Pilot Scheme up to 31 December 2024, a total of over 4 900 participants were recorded, among whom over 60% were elderly aged over 65. According to statistics dated September last year, for those who participated in the first phase of the Pilot Scheme, 390 of them did not join the second phase of the Pilot Scheme and chose to receive follow-up at HA.

2.

According to records, the registered address of about 85% of the eligible patients participating in the Pilot Scheme are in Hong Kong, while Mainland addresses account for about 14%.

3.

Under the Pilot Scheme, eligible patients are required to pay on their own a consultation fee of RMB100 for each consultation received at the designated out-patient clinic of the HKU-SZH (except for specified persons whose medical fees would be waived upon verification by the HA). The remaining consultation fee will be subsidised by the Pilot Scheme, subject to a cap of RMB2,000 each year. Such consultation fee payable by eligible patients will be adjusted on 1 January next year in accordance with the specialist out-patient consultation fee as set under the fees and charges reform for public healthcare. The Government will announce the details in due course. Since inception on 10 May 2023 and up to 31 December 2024, the total amount of service fees paid to the HKU-SZH under the Pilot Scheme was HK\$9.31 million.

- End -

CONTROLLING OFFICER'S REPLY

HHB117

(Question Serial No. 0355)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the usage of eHealth, will the Government inform this Committee:

- 1) of the total number of members of the public registered with eHealth and their percentage in the total population;
- 2) of the number of private healthcare facilities registered with eHealth, and the respective numbers of private medical practitioners, Chinese medicine practitioners and dentists registered with the system;
- 3) of the respective numbers and percentages of records uploaded to eHealth by public and private healthcare professionals in each of the past 3 years;
- 4) of the average monthly number of accesses to records by private healthcare professionals; and
- 5) whether there are plans to introduce measures to increase the number of electronic health records uploaded by private healthcare professionals; if so, of the details; if not, the reasons for that?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 36)

Reply:

eHealth is a territory-wide electronic health record sharing system launched by the Government in 2016 that enables citizens to authorise healthcare providers (HCPs) in the public and private sectors to view and share their electronic health records (eHRs) for healthcare purposes. Building on the strengths of the existing infrastructure of eHealth, the Government announced in the 2023 Policy Address the initiative to roll out a five-year development plan of eHealth+ to transform eHealth into a comprehensive healthcare information infrastructure that integrates multiple functions of data sharing, service delivery and care journey management. eHealth+ aims to facilitate care coordination, cross-sector collaboration, as well as active health management and surveillance, thereby better serving our citizens in obtaining optimal healthcare services, and supporting the healthcare reform and various healthcare policies more effectively, such as primary healthcare and cross-boundary healthcare services. In July 2024, the Finance Committee of the Legislative Council approved a capital funding of \$1,395.8 million to support the eHealth+ development.

The Government is taking forward the eHealth+ development in phases in accordance with the patient-centric principle and four strategic directions, namely, “One Health Record”, “One Care Journey”, “One Digital Front Door to Empowering Tool” and “One Health Data Repository”.

The reply to the questions raised by the Hon LAM Tzit-yuen, David is as follows:

(1) and (2) As of end-February 2025, over 6.1 million citizens have registered with eHealth, accounting for over 80% of the Hong Kong population. The number of HCPs registered with eHealth by the type of organisation is tabulated as follows:

Type of HCPs	Number of HCPs Registered with eHealth (on an Organisational Basis)	Number of Healthcare Service Locations Registered with eHealth
Public hospitals (i.e. hospitals under the Hospital Authority (HA))	1	43
Public clinics (e.g. clinics under the HA and the Department of Health)	11	390
Other public HCPs (e.g. District Health Centres)	20	217
Private hospitals	13	43
Other private HCPs (e.g. clinics, residential care homes for the elderly, and social welfare organisations providing healthcare services)	3 681	6 018
Total	3 726	6 711

Besides, as of end-February 2025, about 58 800 healthcare professionals (HCProfs) have registered with eHealth. The number of registered HCProfs by profession is tabulated as follows:

Type of HCProfs	Number of HCProfs Registered with eHealth	Percentage of Registered HCProfs
Doctor	13 190	82%
Dentist	1 731	60%
Chinese medicine practitioner	966	9%
Other HCProfs (e.g. nurse, pharmacist, and radiographer)	42 940	48%
Total	58 827	49%

(3) to (5) Under the strategic development direction of “One Health Record”, we seek to consolidate the longitudinal eHRs of citizens spread across a multitude of healthcare processes into their personal eHealth accounts. A comprehensive and complete eHR profile enables the HCPs authorised by citizens to respond to their health needs more effectively, thus enhancing clinical outcomes and saving costs of the care process. In 2024-25 (as of end-February 2025), the average amount of eHRs accessed by HCPs per month was about

260 000, and nearly 60% of the eHRs access was made by private HCPs, showing that private HCPs have been actively using eHealth in supporting clinical processes. However, more than 99% of some 4.5 billion eHRs shared on eHealth are from public HCPs.

The Government has been taking a multi-pronged approach to incentivise and facilitate the provision of citizens' eHRs into eHealth by private HCPs, thereby assisting citizens in accessing, managing and using their own eHRs during the healthcare process more conveniently. Last year, the Government launched a platform enabling self-service data compliance testing to simplify the technical testing procedures, and provided dedicated technical support to healthcare institutions. When taking forward various public-private partnership programmes, the Government would require HCPs to deposit the related medical records of the participating citizens into eHealth. The Government also rolled out the eHealth Adoption Sponsorship Pilot Scheme (the Pilot Scheme) by partnering with electronic medical record (eMR) solutions vendors and medical groups to co-fund system enhancements in achieving seamless eHR sharing between eHealth and eMR systems in the market. From July 2023 to February 2025, about 80 private HCPs (involving around 480 private doctors and 200 service locations) connected to eHealth and provided more than 1.12 million eHRs under the Pilot Scheme.

With the Government's endeavours, the eHRs deposited by private HCPs to eHealth have significantly increased. The annual number of eHRs deposited to eHealth by public and private HCPs and the respective percentage over the past 3 years are tabulated as follows:

Financial Year	Number of eHRs Deposited by Public HCPs in million (percentage)	Number of eHRs Deposited by Private HCPs in million (percentage)	Total (in million)
2022-23	918.40 (99.8%)	1.52 (0.2%)	919.92 ^{Note}
2023-24	585.28 (99.5%)	2.66 (0.5%)	587.94
2024-25 (as of end-February 2025)	577.72 (99.4%)	3.40 (0.6%)	581.12

Note: During the COVID-19 epidemic, the Government implemented the territory-wide COVID-19 Vaccination Programme through the eHealth platform, including the relevant inoculation and record-keeping. eHealth registration was also incorporated into the appointment and inoculation workflows of the Programme. As a result, with the significant increase in eHealth registrants in 2022-23, the number of eHRs deposited to eHealth also correspondingly saw a remarkable growth that year.

The Government will continue to collaborate with the private healthcare sector to enhance the connectivity between eHealth and their eMR solutions. In particular, given the positive impacts of the Pilot Scheme, we have progressively expanded the scheme to include more eMR solution vendors, medical groups and other sectors, including Chinese medicine. We will also launch the eHealth+ accreditation scheme in 2025 to enable citizens to easily identify if an HCP has the capability to deposit health records into their personal eHealth accounts and the extent of data involved. Citizens can make reference to such information in choosing a suitable HCP, to ensure that their medical records will be deposited in their personal eHealth accounts.

Besides, the Government introduced the Electronic Health Record Sharing System (Amendment) Bill 2025 (the Amendment Bill) into the Legislative Council this year to provide a legal framework to assist citizens in building a more comprehensive eHR profile. Among other things, the Amendment Bill will streamline the consent mechanism such that once citizens agree to join eHealth, their HCPs will be able to deposit health data into their personal eHealth accounts. Meanwhile, citizens will continue to retain full control over their personal data and can grant individual HCPs access to their eHealth records at their own will. The Amendment Bill will also empower the Secretary for Health to require specified HCPs to provide specified important health data into the personal eHealth accounts of citizens registered with eHealth and with their consents, in order to facilitate citizens' easy access and control of their key health information.

The Government will continue to provide support and collaborate with the private healthcare sector to enable the majority of private HCPs to seamlessly connect with eHealth; and will consider providing additional assistance to healthcare institutions and HCProfs that are less prepared for digitalisation.

- End -

CONTROLLING OFFICER'S REPLY

HHB118

(Question Serial No. 0356)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (514) Hospital Authority

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the healthcare manpower of the Hospital Authority (HA), will the Government inform this Committee of:

- 1) the intake rate (the proportion of new recruits to the total number in the profession), the retirement rate (the proportion of retirees to the total number in the profession) and the “retire and rehire” rate (the proportion of rehired retirees to the total number of retirees) of doctors in each cluster in the past 3 years in table form;
- 2) the intake rate (the proportion of new recruits to the total number in the profession), the retirement rate (the proportion of retirees to the total number in the profession) and the “retire and rehire” rate (the proportion of rehired retirees to the total number of retirees) of registered nurses in the past 3 years;
- 3) the 3 specialties with the highest net attrition rates of HA specialists (the proportion of attrition to the total number of specialists in the specialty); and
- 4) the 3 departments with the highest net attrition rates of HA registered nurses?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 37)

Reply:

1) and 2)

The table below sets out the intake and full-time attrition (wastage) of doctors by cluster from 2022-23 to 2024-25 (April to December 2024):

Financial Year	Cluster	Intake (including full-time and part-time doctors)	Full-time attrition (wastage)	
			Retirement	Non- retirement
2022-23	HKEC	74	6	52
	HKWC	63	8	46
	KCC	111	16	65
	KEC	64	6	45
	KWC	108	14	59
	NTEC	87	8	52
	NTWC	72	10	47
2023-24	HKEC	86	1	35
	HKWC	72	1	44
	KCC	148	3	60
	KEC	70	2	53
	KWC	87	4	39
	NTEC	98	2	50
	NTWC	99	4	42
2024-25 (April to December 2024)	HKEC	80	2	24
	HKWC	87	4	21
	KCC	115	1	49
	KEC	81	1	29
	KWC	81	5	30
	NTEC	123	3	34
	NTWC	99	1	39

Note:

- (1) Intake refers to the total number of permanent and contract staff joining the Hospital Authority (HA) on a headcount basis during the period. Transfers, promotions and movements within the HA are not counted.
- (2) Intake of doctors includes the number of Interns appointed as Residents.
- (3) Intake excludes staff retired and rehired under “Extending Employment Beyond Retirement” (EER) with effect from January 2024. Information of the previous years, if provided, is for reference only and direct comparison with the data under the revised calculation method is not appropriate.
- (4) Attrition (wastage) includes all types of cessation of service (including retirement) from the HA for permanent and contract staff on a headcount basis.
- (5) Attrition (wastage) excludes staff retired and rehired under EER with effect from January 2024. Information of the previous years, if provided, is for reference only and direct comparison with the data under the revised calculation method is not appropriate.
- (6) The manpower figures of doctors exclude those of Interns and Dental Officers.

The table below sets out the full-time attrition (wastage) rates of doctors by cluster from 2022-23 to 2024-25 (the rolling 12 months from January to December 2024):

Financial year	Cluster	Full-time attrition (wastage) rate
2022-23	HKEC	9.1%
	HKWC	8.2%
	KCC	6.1%
	KEC	6.7%
	KWC	6.9%
	NTEC	5.8%
	NTWC	6.6%
2023-24	HKEC	5.5%
	HKWC	6.8%
	KCC	4.6%
	KEC	7.0%
	KWC	4.0%
	NTEC	5.0%
	NTWC	5.2%
2024-25 (the rolling 12 months from January to December 2024)	HKEC	5.4%
	HKWC	4.9%
	KCC	4.4%
	KEC	6.5%
	KWC	4.3%
	NTEC	5.4%
	NTWC	6.3%

Notes:

- (1) Attrition (wastage) includes all types of cessation of service (including retirement) from the HA for permanent and contract staff on a headcount basis.
- (2) Rolling attrition (wastage) rate = (total number of staff left the HA in the past 12 months / average strength in the past 12 months) x 100%.
- (3) Attrition (wastage) excludes staff retired and rehired under EER with effect from January 2024. Information of the previous years, if provided, is for reference only and direct comparison with the data under the revised calculation method is not appropriate.
- (4) The manpower figures of doctors exclude those of Interns and Dental Officers.

The table below sets out the intake and full-time attrition (wastage) of nurses from 2022-23 to 2024-25 (April to December 2024):

Financial year	Intake (including full-time and part-time nurses)	Full-time attrition (wastage)	
		Retirement	Non-retirement
2022-23	2 506	485	2 455
2023-24	2 534	251	1 939
2024-25 (April to December 2024)	2 374	204	1 298

Notes:

- (1) Intake refers to the total number of permanent and contract staff joining the HA on a headcount basis during the period. Transfers, promotions and movements within the HA are not counted.
- (2) Intake excludes staff retired and rehired under EER with effect from January 2024. Information of the previous years, if provided, is for reference only and direct comparison with the data under the revised calculation method is not appropriate.
- (3) Attrition (wastage) includes all types of cessation of service (including retirement) from the HA for permanent and contract staff on a headcount basis.
- (4) Attrition (wastage) excludes staff retired and rehired under EER with effect from January 2024. Information of the previous years, if provided, is for reference only and direct comparison with the data under the revised calculation method is not appropriate.

The table below sets out the full-time attrition (wastage) rates of nurses from 2022-23 to 2024-25 (the rolling 12 months from January to December 2024):

Financial year	Full-time attrition (wastage) rate
2022-23	10.9%
2023-24	8.1%
2024-25 (the rolling 12 months from January to December 2024)	7.5%

Notes:

- (1) Attrition (wastage) includes all types of cessation of service (including retirement) from the HA for permanent and contract staff on a headcount basis.
- (2) Rolling attrition (wastage) rate = (total number of staff left the HA in the past 12 months / average strength in the past 12 months) x 100%.
- (3) Attrition (wastage) excludes staff retired and rehired under EER with effect from January 2024. Information of the previous years, if provided, is for reference only and direct comparison with the data under the revised calculation method is not appropriate.

At its meeting in September 2021, the HA Board endorsed the EER policy which aims at attracting more retired staff who are willing to serve after retirement for support in training and passing on of knowledge, with a view to alleviating the shortage of manpower.

Generally speaking, whether a staff member will continue to work in the HA after retirement depends on his/her retirement plan and personal preference. He/she may choose the commencement date of the extended employment, either starting immediately after retirement or any time after retirement. Furthermore, a retiree may, based on personal needs, flexibly

consider different options of extended employment including full-time or part-time employment, and the duration of contract may also be adjusted according to personal preference. A staff member who is interested in EER may express such intention to his/her supervisor, after which the HA will discuss the form of extended employment with him/her before proceeding with the EER arrangement through the appropriate screening mechanism. Given the flexible arrangements under the EER policy, it is difficult to calculate the attrition rate and the EER rate separately.

As at December 2024, a total of 181 doctors and 565 nurses work full-time in the HA after retirement.

3) and 4)

The table below sets out the 3 specialties with the highest overall attrition (wastage) rates of full-time doctors and full-time nurses in the HA in 2024-25 (the rolling 12 months from January to December 2024):

Specialty	The 3 specialties with the highest overall attrition (wastage) rate	
	Full-time doctors ^(1, 2, 3, 4)	Full-time nurses ^(1, 2, 3)
1	Obstetrics & Gynaecology	Intensive Care Unit
2	Paediatrics	Accident & Emergency
3	Pathology	Surgery

Note:

- (1) Attrition (wastage) includes all types of cessation of service (including retirement) from the HA for permanent and contract staff on a headcount basis.
- (2) Rolling attrition (wastage) rate = (total number of staff left the HA in the past 12 months / average strength in the past 12 months) x 100%.
- (3) Attrition (wastage) excludes staff retired and rehired under EER with effect from January 2024. Information of the previous years, if provided, is for reference only and direct comparison with the data under the revised calculation method is not appropriate.
- (4) The manpower figures of doctors exclude those of Interns and Dental Officers.

Abbreviations:

HKEC – Hong Kong East Cluster
 HKWC – Hong Kong West Cluster
 KCC – Kowloon Central Cluster
 KEC – Kowloon East Cluster
 KWC – Kowloon West Cluster
 NTEC – New Territories East Cluster
 NTWC – New Territories West Cluster

- End -

CONTROLLING OFFICER'S REPLY

HHB119

(Question Serial No. 0358)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (514) Hospital Authority

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the General Outpatient Clinic Public-Private Partnership Programme of the Hospital Authority, will the Government provide this Committee with:

- 1) the number of private doctors in the 18 districts participating in the programme in each of the past 3 years and the expenditure involved in tabular form; and
- 2) the number of participating patients in the past 3 years and the average number of times they used the services each year?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 39)

Reply:

1) & 2)

The Hospital Authority (HA) has implemented the General Outpatient Clinic Public-Private Partnership Programme (GOPC PPP) by phases since mid-2014 to subsidise clinically stable patients with hypertension (HT) and/or diabetes mellitus (DM) (with or without hyperlipidemia) to receive primary healthcare services from private services providers. The programme offers an additional option for patients who require long-term follow-up at general outpatient clinics, allowing them to access private primary healthcare services in the community. This enhances the convenience of primary healthcare services and promotes the concept of "Family Doctor for All". The GOPC PPP now covers all 18 districts in Hong Kong, enabling patients to freely choose a family doctor in any district.

Under the GOPC PPP, patients fulfilling pre-defined clinical criteria and programme requirements and have been attending HA's outpatient clinics for at least 12 months will be invited for voluntary participation. Each participating patient is entitled to up to 10 subsidised visits per year, including medical consultations covering both chronic and episodic illnesses. They can also obtain drugs for treating their chronic conditions and episodic illnesses directly from private doctors at their clinics, and upon a private doctor's referral, receive specified laboratory tests and electrocardiography at HA's designated private laboratories, or X-ray examinations at the HA, at no cost for all related services.

Participating patients are only required to pay the HA general outpatient clinic fee of \$50 per visit (as published in the Gazette). Patients who wish to join the GOPC PPP must first register with the Electronic Record Sharing System.

Patients participating in the GOPC PPP can freely choose Participating Service Providers (PSPs) participating in the GOPC PPP in the 18 districts. The table below lists the number of PSPs participating in the GOPC PPP in each district:

District	Number of GOPC PPP PSPs		
	2022-23	2023-24	2024-25 (as at end-2024)
Eastern	48	47	43
Southern	19	13	15
Wan Chai	21	24	18
Central and Western	45	46	43
Kowloon City	25	26	23
Kwun Tong	65	64	71
Sham Shui Po	37	38	37
Wong Tai Sin	28	27	27
Yau Tsim Mong	61	66	63
Islands	13	12	12
Kwai Tsing	33	34	40
Northern	21	25	27
Sai Kung	40	36	36
Sha Tin	44	42	39
Tai Po	20	20	17
Tsuen Wan	36	37	38
Tuen Mun	56	59	56
Yuen Long	40	40	38
Total	652	656	643

The table below lists the expenditures of the GOPC PPP from 2022-23 to 2024-25:

	2022-23 Actual (\$M)	2023-24 Actual (\$M)	2024-25 Estimate (\$M)
GOPC PPP	101.8	127.2	127.7

As at end-2024, there were 51 656 registered patients participating in the GOPC PPP. On average, they visited the participating doctors 6 times per year. The table below lists the number of patients participating in the GOPC PPP from 2022-23 to 2024-25:

	2022-23	2023-24	2024-25 (as at end-2024)
Number of patients participating in the GOPC PPP	49 384	54 716	51 656

In addition, the Government has launched the three-year Chronic Disease Co-Care (CDCC) Pilot Scheme from November 13, 2023 to provide subsidised DM and HT screening services in the private healthcare sector to Hong Kong residents aged 45 or above with no known medical history of DM or HT.

The CDCC Pilot Scheme is a three-year pilot programme and its overall effectiveness will be evaluated and examined. To review its effectiveness, the Government commissioned a local university in the first quarter of 2024 to conduct a study to assess the extent to which the objectives of the CDCC Pilot Scheme are met and the overall performance, including the service quality, effectiveness, as well as the cost-effectiveness. Additionally, the Government will review the service model and operational details of the CDCC Pilot Scheme in a timely manner and make enhancements as necessary to ensure its effectiveness. Based on the assessment results, the Government will consider whether to expand the service scope of the CDCC Pilot Scheme, including examining the feasibility of integrating the HA's GOPC PPP into the CDCC Pilot Scheme.

- End -

CONTROLLING OFFICER'S REPLY**HHB120****(Question Serial No. 3056)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): (514) Hospital AuthorityProgramme: (3) Subvention: Hospital AuthorityControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

Regarding the \$10 billion Hospital Authority Public-Private Partnership (PPP) Fund to operate clinical PPP programmes, will the Government inform this Committee of:

- 1) the financial position of the PPP Fund of the Hospital Authority in the past 3 financial years;
- 2) the service provision and actual expenditure of each PPP programme under the above Fund in the past 3 financial years; and
- 3) whether it has considered including new medical services in the PPP programmes in 2025-26; if so, the relevant details and estimated expenditure involved?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 40)Reply:

1)

In 2016, the Government allocated \$10 billion to the Hospital Authority (HA) for setting up the HA Public-Private Partnership (PPP) Fund to generate investment returns for implementing clinical PPP initiatives so as to alleviate pressure on the public healthcare system.

The financial position of the HA PPP Fund in the past 3 years is as follows:

	2022-23 Actual (\$ million)	2023-24 Actual (\$ million)	2024-25 Projected (\$ million)
Opening balance	11,033.5	11,063.1	10,830.7
Income	560.0	423.8	428.8
Expenditure	(530.4)	(656.2)	(718.9)
Closing balance	11,063.1	10,830.7	10,540.6
Investment yield	5.1%	3.7%	3.9%

2)

In the past 3 years, the HA continued to operate a series of PPP programmes, including the Cataract Surgeries Programme (CSP), Haemodialysis PPP Programme (HD PPP), Project on Enhancing Radiological Investigation Services through Collaboration with the Private Sector (Radi Collaboration), General Outpatient Clinic PPP Programme (GOPC PPP)/Co-care Service Model (Co-care), Colon Assessment PPP Programme (Colon PPP) and Glaucoma PPP Programme (Glaucoma PPP).

To cope with the COVID-19 epidemic since early 2020, the HA has expanded the service scope of some of the initial PPP Programmes, including expanding the service group of the Radi Collaboration to cover all eligible cancer patients, increasing the service quota of the HD PPP, as well as extending the Colon PPP to cover the colonoscopy cases that were delayed due to the epidemic (Colon PPP Surge Special). Furthermore, the HA has also launched new PPP initiatives as contingency COVID-19 PPPs to divert suitable patients from public hospitals to the private sector for treatment. These initiatives include the Trauma Operative Service Collaboration Programme (Trauma Collaboration), Breast Cancer Operative Service Collaboration Programme (Breast Cancer Collaboration), Radiation Therapy Service PPP Programme (RT PPP) and Oesophago-Gastro-Duodenoscopy Collaboration Programme (OGD Collaboration). The HA will make timely adjustments to the arrangements of the PPP programmes in the light of actual need and effectiveness of the programmes. Among the above 4 contingency PPP programmes, Trauma Collaboration, Breast Cancer Collaboration and RT PPP are still being run by the HA whereas OGD Collaboration has ceased operation. On another front, the HA launched the Investigation PPP Programme (Investigation PPP) in March 2024, under which laboratory services, including testing of blood, urine and sputum and electrocardiogram, are provided to GOPC PPP patients by designated private laboratories.

Service provisions by PPP programme in the past 3 years are tabulated below:

Programme	2022-23 Actual Provision	2023-24 Actual Provision	2024-25 Planned Provision
CSP (surgeries)	2 914	4 850	5 000
HD PPP ¹ (places)	376	426	441
Radi Collaboration ² (scans)	56 148	70 629	56 000
GOPC PPP/Co-care (participating patients)	49 384	54 716	56 280
Colon PPP & Surge Special ³ (colonoscopies)	2 924	1 780	2 200
Glaucoma PPP (participating patients)	2 686	2 673	2 700
Trauma Collaboration ⁴ (patients)	586	647	700

Programme	2022-23 Actual Provision	2023-24 Actual Provision	2024-25 Planned Provision
Breast Cancer Collaboration ⁵ (patients)	379	356	430
RT PPP ⁶ (patients)	98	155	100
OGD Collaboration ⁷ (patients)	1 151	N/A	N/A
Investigation PPP ⁸ (investigations)	N/A	4	112 560

The expenditures by HA's PPP programme in the past 3 years are tabulated below:

Programme	2022-23 Actual Expenditure ⁹ (\$ million)	2023-24 Actual Expenditure ⁹ (\$ million)	2024-25 Projected Expenditure ⁹ (\$ million)
CSP	25.3	40.8	41.8
HD PPP	89.5	102.8	114.8
Radi Collaboration	167.9	214.9	232.1
GOPC PPP/Co-care	101.8	127.2	127.7
Colon PPP & Surge Special	33.9	31.4	32.0
Glaucoma PPP	6.4	7.7	9.9
Trauma Collaboration	40.1	49.2	54.1
Breast Cancer Collaboration	26.8	27.7	34.5
RT PPP	4.7	7.5	5.4
OGD Collaboration	8.9	N/A	N/A
Investigation PPP	N/A	-	15.7

Note:

1. HD PPP benefited 416 patients and 500 patients in 2022-23 and 2023-24 (on a full-year basis) respectively.
2. The HA, in the light of service demand, increased the actual service provision under the Radi Collaboration in 2023-24, with adjustments made to such service provision based on demand in 2024-25.
3. In view of the development of the COVID-19 epidemic, the Surge Special was introduced for Colon PPP between April and August 2022 to cope with the colonoscopy cases that were delayed or cancelled due to the epidemic.

4. Launched in April 2020 as a PPP programme in response to the COVID-19 epidemic, Trauma Collaboration continued as a PPP programme.
5. Launched in June 2020 as a COVID-19 PPP, Breast Cancer Collaboration continued as a PPP programme.
6. First launched in February 2020 and ended in February 2021, RT PPP was then re-activated in July 2022 as a PPP programme.
7. First launched in June 2020 and ended in April 2021, OGD Collaboration was then re-activated in March 2022 and ended in August 2022.
8. Launched in late March 2024, Investigation PPP is applicable to GOPC PPP/Co-care.
9. Spending on information technology and administration support is excluded.

3)

To dovetail with the Government's healthcare policies, enhance healthcare system operational efficiency and address service demands more effectively, the Health Bureau established the Strategic Purchasing Office in 2022 to develop and roll out a common platform for strategic purchasing, facilitating integrated purchasing of healthcare services, including consolidation of existing HA's and the Department of Health's PPP programmes. With the development of the healthcare reform, the Government is reviewing various PPP programmes, integrating those programmes aimed at relieving short-term pressure back into HA's routine services, and the Strategic Purchasing Office will refine and consolidate those PPP programmes with long-term development needs so that such programmes can be managed and developed under the model of strategic purchasing.

The 2025-26 Budget puts forward bringing back the unspent balance of six seed capital funds, including the HA PPP Fund, to the Government's accounts after setting aside resources to meet the necessary expenditure of these funds for the next 5 years so that their sustainable operation will not be affected. This will provide a more comprehensive picture of the Government's fiscal position and enable better use of its financial resources. To this end, the HA has reviewed the latest financial position of the HA PPP Fund and projected the cash flow requirements for the next 5 years having regard to the past expenditure, needs of relevant programmes and the related development strategies, and set aside resources to meet the necessary expenditure for the next 5 years.

- End -

CONTROLLING OFFICER'S REPLY**HHB121****(Question Serial No. 3057)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): (514) Hospital AuthorityProgramme: (3) Subvention: Hospital AuthorityControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

A complainant dissatisfied with the investigation results and response of the hospital regarding the initial complaint may appeal to the Public Complaints Committee (PCC) of the Hospital Authority. In this connection, will the Government inform this Committee of the number of appeals received by the PCC in each of the past 3 years, and the outcomes of the appeals by complaint category?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 41)Reply:

The Hospital Authority (HA) has a two-tier system to handle complaints from patients and the public. The first tier is at the hospital level which covers the handling of all complaints lodged for the first time. If the complainants are not satisfied with the outcome of the complaints, they may appeal to the second tier, that is the Public Complaints Committee (PCC) of HA. PCC is a committee established under the HA Board responsible for independently considering and deciding on all appeal cases and putting forward recommendations on service improvement to HA. Members of PCC are not employees of HA and, by virtue of their independent status, will handle all complaints fairly and impartially.

The table below sets out the number of such appeal cases received by the PCC in the past 3 years and the outcome of the appeals by complaint category:

2021-22

Nature Outcome	Medical services	Staff attitude	Administrative procedure	Others	Total
Substantiated / Partially substantiated	12	2	7	0	21
Unsubstantiated	137	16	18	3	174
Inconclusive	2	1	0	0	3
Others (outside the purview of the PCC or withdrawn)	29	1	6	3	39

Total	180	20	31	6	237

2022-23

Nature Outcome	Medical services	Staff attitude	Administrative procedure	Others	Total
Substantiated / Partially substantiated	5	1	3	0	9
Unsubstantiated	127	14	26	1	168
Inconclusive	1	2	0	0	3
Others (outside the purview of the PCC or withdrawn)	26	1	3	0	30
Total	159	18	32	1	210

2023-24

Nature Outcome	Medical services	Staff attitude	Administrative procedure	Others	Total
Substantiated / Partially substantiated	6	2	4	2	14
Unsubstantiated	137	12	17	2	168
Inconclusive	1	3	2	0	6
Others (outside the purview of the PCC or withdrawn)	39	0	5	1	45
Total	183	17	28	5	233

- End -

CONTROLLING OFFICER'S REPLY

HHB122

(Question Serial No. 3153)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (514) Hospital Authority

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Over the past few years, there has been a constant increase in the application of equipment and technology under the “Smart Hospital” project in public hospitals. In light of the rapid advancement in medical devices, will the Government inform this Committee whether any funding has been earmarked for upgrading or replacing these smart medical devices and equipment?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 42)

Reply:

“Developing Smart Hospitals” is put forward in the Hospital Authority (HA) Strategic Plan 2022-2027 entitled “Towards Sustainable Healthcare” as one of the major development strategies for public hospital services. The strategic goal of developing Smart Hospitals is to integrate medical equipment, digital technologies and devices, information technology (IT) and systems to jointly promote clinical excellence, operational efficiency and patient-centred services. Alongside data-driven care empowered by artificial intelligence, technology-enabled healthcare facilities like smart wards, smart clinics and smart pharmacies have been incorporated into the Smart Hospital projects.

To tie in with the development needs of Smart Hospitals and to enhance patient safety and service quality, the HA acquires and replaces a wide variety of medical equipment from time to time. Cluster management makes plans for medical equipment by deliberating and formulating annual medical equipment requirement plan in the relevant committees, based on factors such as risk assessment (e.g. risk of equipment obsolescence, service lifespan of equipment, as well as patient and staff safety), impact on patient care, operational needs and additional equipment essential for the provision of new or enhanced services.

The HA upgrades and acquires medical equipment and information systems with the designated funding, recurrent funding and other relevant funding provided by the Government. In 2025-26, the Government will allocate a designated funding of \$1.2 billion to the HA for the upgrading and acquisition of major and essential medical equipment and information systems, including medical equipment for Smart Hospitals. The HA will also

make use of the recurrent funding for upgrading and acquiring minor smart medical equipment and IT systems. Moreover, the HA has earmarked funding to meet the future needs for upgrading medical and IT equipment.

- End -

CONTROLLING OFFICER'S REPLY**HHB123****(Question Serial No. 3272)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (2) HealthControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

Regarding the services of the District Health Centres (DHCs) and DHC Expresses (DHCEs), will the Government inform this Committee of the following:

- (1) the respective numbers of members of the DHCs and DHCEs in various districts, broken down by age, as well as the respective numbers of attendances of the DHCs and DHCEs in the previous year, broken down by type of service;
- (2) the staff establishment and estimated expenditure of the DHCs and DHCEs in 2025-26; and
- (3) what are the performance assessment indicators of the DHCs and DHCEs, and how does the Primary Healthcare Office review and adjust their operating contracts and evaluate their service effectiveness?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 43)Reply:

(1)

The cumulative numbers of members and attendances of District Health Centres (DHCs) and DHC Expresses (DHCEs) are set out in the table below:

DHC/DHCE Service Commencement Date	Cumulative Number of members^{Note 1} (as at 31 December 2024) [Provisional Figures]	Cumulative Number of Attendances^{Notes 1, 2, 3, 4} (as at 31 December 2024) [Provisional Figures]
DHC		
Kwai Tsing 24 September 2019	46 100	498 300
Sham Shui Po 30 June 2021	34 300	296 600
Tuen Mun 31 May 2022	38 100	344 100

DHC/DHCE Service Commencement Date	Cumulative Number of members^{Note 1} (as at 31 December 2024) [Provisional Figures]	Cumulative Number of Attendances^{Notes 1, 2, 3, 4} (as at 31 December 2024) [Provisional Figures]
Wong Tai Sin 30 June 2022	34 700	200 900
Southern 17 October 2022	23 900	175 300
Yuen Long 24 October 2022	42 500	255 000
Tsuen Wan 30 December 2022	26 000	175 700
DHCE		
Sai Kung 1 September 2021	10 600	84 900
Kowloon City 1 October 2021	11 300	57 300
Yau Tsim Mong 1 October 2021	9 600	48 500
Wan Chai 4 October 2021	6 800	53 000
North 18 October 2021	8 700	53 700
Islands 18 October 2021	6 400	35 900
Kwun Tong 21 October 2021	10 800	49 300
Tai Po 22 October 2021	7 800	45 000
Sha Tin 30 October 2021	13 300	71 400
Central and Western 30 October 2021	7 900	50 200
Eastern 30 October 2021	10 900	54 700
Total	349 900	2 549 900

Note:

1. Figures are rounded to the nearest hundred.
2. The figures only include service figures captured from the DHC/DHCE information system, and do not include those relating to medical laboratory tests.
3. As different services are provided by the 11 DHCEs, the attendance figures are not directly comparable.
4. The service figures above have included services provided by DHCs/DHCEs for participants of the Chronic Disease Co-care Pilot Scheme which was launched on 13 November 2023.

(2)

The tentative staff establishment (including healthcare professionals and other supporting staff) of DHCs in Kwai Tsing, Sham Shui Po, Tuen Mun, Wong Tai Sin, Southern, Yuen Long and Tsuen Wan for 2025-26 and their revised estimates (including the provisions for service contracts, site maintenance and rental cost) for 2024-25 are set out in the table below:

	DHC						
	Kwai Tsing	Sham Shui Po	Tuen Mun	Wong Tai Sin	Southern	Yuen Long	Tsuen Wan
Staff establishment ^{Note 5}							
Executive Director	1	1	1	1	1	1	1
Medical Consultant ^{Note 6}	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Chief Care Coordinator	1	1	1	1	1	1	1
Care Coordinator/ Nurse	21	18.5	26	25	16	29	21
Physiotherapist	3.5	2	3	3	3	3	2
Occupational Therapist	1.5	2	2	2	3	3	2
Dietitian	1	1	1	2	1	2	2
Pharmacist	1	1	1	1	1	1	1
Social Worker, Administrative Staff and Supporting Staff	55	69	62	62	59	50	48
Total	85.5	96	97.5	97.5	85.5	90.5	78.5
2024-25 Revised Estimate ^{Note 7} (\$ million)	62	63	80	69	58	73	78

Note:

5. The staff establishment is proposed by DHC operators through tendering procedures according to the service demand in the community and manpower estimation, and is approved by the Government. The 0.5 staff establishment refers to a part-time position with half of the working hours of a full-time position. The actual number of staff may vary from time to time, depending on factors such as service demand and short-term manpower turnover, etc. The Government will continue to monitor the situation to ensure that services are not affected.
6. Medical Consultants are part-time or outsourced positions.
7. The Health Bureau is handling the contract issues of some DHCs and the estimate of expenditure for 2025-26 is therefore not yet available.

The tentative staff establishment (including healthcare professionals and other supporting staff) of all DHCEs for 2025-26 and their revised estimates (including the provisions for service contracts, site maintenance and rental cost) for 2024-25 are set out in the table below:

	DHCE										
	Central and Western	Eastern	Islands	Kowloon City	Kwun Tong	North	Sai Kung	Sha Tin	Tai Po	Wan Chai	Yau Tsim Mong
Staff establishment Notes 8, 9											
Project Coordinator	1	1	1	1	1	1	1	1	1	1	1
Medical Consultant Note 10	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Care Coordinator	3	3	3	1	2	1	2	5	5	5	1
Nurse	1	3		5	4	3	4				4
Physiotherapist	1	1	1	1	1	1	1	1	1	1	1
Occupational Therapist					1		1		0.5	1	
Pharmacist	0.5	0.5					1	1		1	
Dietitian				1	1	0.5	1		1		1
Social Worker, Administrative Staff and Supporting Staff	14	15	12	13	15.5	14.5	12	18	14	7.5	14
Total	21	24	17.5	22.5	26	21.5	23.5	26.5	23	17	22.5
2024-25 Revised Estimate Note 11 (\$ million)	15	14	13	14	14	14	14	14	14	15	14

Note:

8. The staff establishment is proposed by DHCEs according to the service demand in the community and manpower estimation, and is reviewed and approved by the Government before entering into contracts with operators. The 0.5 staff establishment refers to a part-time position with half of the working hours of a full-time position. The actual number of staff may vary from time to time, depending on factors such as service demand and short-term manpower turnover, etc. The Government will continue to monitor the situation to ensure that services are not affected.
9. The staff establishment of each DHCE is dependent on the service demand and service delivery model of the district concerned, and so the figures are not directly comparable.
10. Medical Consultants are part-time or outsourced positions.
11. The Health Bureau is handling the contract issues of some DHCEs and the estimate of expenditure for 2025-26 is therefore not yet available.

(3)

The Primary Healthcare Commission (PHCC) was established in July 2024 to oversee primary healthcare service delivery, standard setting and quality assurance, etc. under one roof. Regarding the services of DHCs, the PHCC appoints non-governmental organisations as operators through open tender. The relevant operation service contracts have specified the facilities and service requirements, including the qualifications and relevant experience of key staff, the districts and number of ancillary centres/service points to be set up and the staffing establishment of the centres, etc.

The PHCC continuously reviews the services of DHCs so as to strengthen their role as the co-ordinators of community primary healthcare services and case managers. As such, the PHCC has adjusted the terms of the operating service contracts, including adjusting the categorisation of service targets to tie in with the enhancement of DHC services, such as the pairing of family doctors with citizens and the provision of nurse clinic services. Also, operators are required to achieve or exceed the predetermined service targets within the contract period to be eligible for contract gratuities and incentive payment, so as to encourage the operators to actively enhance their service standards. The contract also states that the Government shall have the right to terminate the contract if an operator fails to comply with the contract requirements.

The PHCC uploaded the DHC performance indicators, including “DHC new members received information and knowledge on life course preventive care (LCPC) together with individualised LCPC health advice” and “Seasonal flu vaccination rate”, onto the DHC website for public access in December 2024. In addition, the PHCC is progressively enhancing the performance monitoring mechanism of the DHCs by regularly reviewing a number of quantitative and qualitatively related aspects, including service volume, operational effectiveness and health-related outcomes, to assess the performance of the DHCs, and to make timely recommendations to the operators for improvement. The PHCC will take into account the relevant assessment results when renewing the operating service contracts.

- End -

CONTROLLING OFFICER'S REPLY

HHB124

(Question Serial No. 1392)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It was mentioned in the paragraph 207 of the Budget Speech that the Government was progressively implementing and completing the 16 works projects, which entailed a total of about \$190 billion, under the First Hospital Development Plan. In this connection, please inform this Committee of the following:

- 1) the expenditure and completion dates of various hospital redevelopment and expansion projects;
- 2) the expenditure for repair and maintenance of each public hospital in each of the past 3 financial years and the estimated expenses for these work for the coming financial year;
- 3) the numbers of incidents related to “Facilities and Environment” and “Medical Equipment, Apparatus and Consumables” at each public hospital in the past 3 years, and the follow-up actions to such incidents; and
- 4) the reasons for an increased level of provision for the Hospital Authority (HA) to \$100.2 billion for 2025-26, a 3% increase on the revised estimate for 2024-25, and how the HA will cut costs, enhance efficiency and reduce wastage.

Asked by: Hon LAU Ip-keung, Kenneth (LegCo internal reference no.: 28)

Reply:

(1)

In 2016, the Government and the Hospital Authority (HA) commenced the implementation of the First Hospital Development Plan (HDP) to carry out a total of 16 projects, including the redevelopment and expansion of 11 hospitals, the construction of a new acute hospital, 3 community health centres and 1 supporting services centre.

As of now, out of the 16 works projects under the First HDP, 15 have been upgraded to Category A. Among them, projects that have been completed or substantially completed include the expansion of Haven of Hope Hospital, the extension of Operating Theatre Block for Tuen Mun Hospital (new building), the redevelopment of Kwong Wah Hospital (phase 1), the construction of a community health centre in North District, the construction of Hospital Authority Supporting Services Centre, and the redevelopment of Queen Mary

Hospital (phase 1). Other projects the main works of which are underway include the redevelopment of Kwai Chung Hospital (phases 2 and 3), the construction of a new acute hospital at Kai Tak Development Area, the redevelopment of Grantham Hospital (phase 1), the redevelopment of Our Lady of Maryknoll Hospital, the expansion of Lai King Building in Princess Margaret Hospital, the redevelopment of Prince Wales Hospital, phase 2 (stage 1), the expansion of United Christian Hospital, the redevelopment of Kwong Wah Hospital (phase 2), and the expansion of North District Hospital. As for the redevelopment of Shek Kip Mei Health Centre which has recently been upgraded to Category A project, its construction works are expected to commence in the second quarter of 2025. The remaining Category B project, namely the construction of a community health centre building at On Sau Road in Kwun Tong, is currently under planning.

(2)

The HA will conduct building surveys and inspections for facilities under its management, including public hospitals and clinics, and carry out relevant repairs and preventive maintenance works according to inspection reports and the conditions of buildings with the funding from the Capital Works Reserve Fund (CWRF). Under the CWRF, the average annual expenditure for the related works over the past 3 financial years (2022-23 to 2024-25) were about \$120 million. The estimate for 2025-26 is about \$150 million.

(3)

The number of “Facilities and Environment” or “Medical Equipment, Apparatus and Consumables” incidents reported through the “Advance Incident Reporting System” in the past 3 years are tabulated below:

Year	Facilities and Environment	Medical Equipment, Apparatus and Consumables
2022	1 495	461
2023	1 685	521
2024	1 066	544

Regarding the maintenance of building facilities, the HA has already implemented the improvement measures recommended by the “Review Committee on Medical Equipment and Facility Maintenance” in the report submitted in 2023 in relation to organisational structure, application of technology, human resources and training, etc. For example, under the rolling inspection and maintenance programmes, the HA has formulated and commenced a series of inspection programmes. The building facilities involved will be regularly inspected thereunder according to their risk categories (i.e. these building facilities are categorised into different risk levels based on a number of factors such as their usage, service age, degree of aging and the impact on hospital safety and operation, etc.). The inspection frequency for the facilities is set in a targeted manner to reduce the possibility of sudden breakdown or damage. After each building facility-related incident, the facility management teams will conduct on-site inspection and risk assessment to arrange suitable maintenance works so as to minimise any impact on the operation of the hospitals. They will also analyse the causes of the incidents and formulate appropriate preventive strategies, such as assessing the service life of the facilities and replacing obsolete facilities in an orderly manner. At the same time,

the HA will also share the information on individual cases internally to enhance the overall facility management knowledge and improve the efficiency in addressing building conditions.

In respect of medical equipment, apparatus and consumables, the HA has formulated and adopted immediate risk mitigation measures according to the severity, scope of impact and potential risks of the incidents. If necessary, the HA will formulate and implement improvement measures aimed at addressing the root cause of the incidents to prevent similar occurrence. It will also follow up on the progress of implementing such measures in a timely manner.

(4)

In 2025-26, the Government's recurrent subvention to the HA is \$99 billion, representing a 3.7 % increase as compared to the 2024-25 revised provision (\$95.4 billion). The HA will implement the following key initiatives in 2025-26:

- (a) implement the reform on governance and management to enhance the quality and sustainability of public healthcare services and to improve the support to patients;
- (b) implement the fees and charges reform for public healthcare progressively to guide the public to make optimal use of healthcare resources, reduce wastage and abuse, and enhance healthcare protection for "poor, acute, serious, critical" patients on all fronts, thereby enhancing the sustainability of the healthcare system;
- (c) fully dovetail with the Government's policies and development directions and continue to enhance the capacity and quality of public healthcare services to cope with the demand, including providing around 330 additional hospital beds; enhancing the capacity of operating theatre services, endoscopic services and cataract surgeries; enhancing clinical services such as cancer, ophthalmology, mental health, radiology, nuclear medicine and pathology, genetic and genomic services, as well as non-clinical supporting services; implementing measures to shorten the waiting time of specialist out-patient clinics; enhancing general out-patient clinic services and the role of general out-patient clinics as primary healthcare service providers for the underprivileged, including introducing chronic disease screening services and strengthening nurse clinic services; and integrating paediatric services at the Hong Kong Children's Hospital;
- (d) further expand the integrated Chinese-Western medicine services, progressively extend the cancer care programme to all hospital clusters and launch pilot programmes for other disease areas on which Chinese medicine has an advantage;
- (e) strengthen centralised procurement of drugs and medical devices to promote cost-effectiveness and ensure optimised use of healthcare resources;
- (f) develop smart hospital initiatives with advanced technology to enhance patients' experience, operational processes and efficiency;
- (g) continue with the review and planning of Second HDP projects;

- (h) augment the workforce by attracting and retaining staff, and attract healthcare professionals to work in Hong Kong through Mainland and global healthcare talent visiting programmes to establish a regional healthcare talent pool in the long run in order to become the citizens' demand for healthcare services in future; and
- (i) continue to implement the Preceptorship Programme in recruiting experienced nurses as clinical preceptors to provide guidance for newly recruited junior nurse to enable them to become familiarised with the work procedures and environment of the hospital wards.

With an ageing population and the increasing prevalence of chronic diseases, the public healthcare system is facing mounting pressure. To further enhance the efficiency of public healthcare services, the HA Board set up the Task Group on Sustainability in 2019 with the mandate to identify the major challenges faced by the HA and to develop strategic directions in areas such as human resources, infrastructure, smart technology and operational efficiency, with the goal of driving the sustainable development of the public healthcare system.

The HA has implemented corresponding measures to optimise resources utilisation and enhance efficiency. These include optimising the existing drug dispensing mechanism in public hospitals and adjusting the prescribing quantity of drugs as necessary to reduce wastage caused by excessive prescription of drugs; expanding sources of drug supply, streamlining the process for introducing new drugs and optimising the procurement procedures for medical devices to control costs effectively; formulating infrastructure and digital technology solutions, integrating IT systems and data, leveraging technologies such as big data analysis and artificial intelligence to support hospital administrative operations and clinical management, thereby enhancing the quality and efficiency of healthcare services; and creating a green and sustainable healthcare system through hospital development and redevelopment projects as well as by implementing various energy saving measures in hospitals to reduce energy consumption.

- End -

CONTROLLING OFFICER'S REPLY

HHB125

(Question Serial No. 1393)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Hong Kong Children's Hospital suspended the services of its Ear, Nose & Throat (ENT) Department due to manpower shortage. As a result, over 500 ENT outpatients were transferred to other public hospitals for treatment. In this regard, please inform this Committee of the following:

- (1) the attendances, numbers of inpatient bed days and inpatient bed occupancy rates at Hong Kong Children's Hospital in the past 3 years;
- (2) the wastage rates of doctors and nurses at Hong Kong Children's Hospital in the past 3 years, and the ratio of newly recruited doctors and nurses to the number of wastage; and
- (3) how will the Hospital Authority implement service integration of Paediatrics at Hong Kong Children's Hospital in the future?

Asked by: Hon LAU Ip-keung, Kenneth (LegCo internal reference no.: 29)

Reply:

(1)

The Hospital Authority (HA) operates its paediatric services under a hub-and-spoke model. As a tertiary referral centre for severe, complex and uncommon paediatric cases requiring multi-disciplinary management, the Hong Kong Children's Hospital (HKCH) provides diagnosis, treatment and rehabilitation services for patients of the whole territory from birth to 18 years of age with relevant clinical needs. The paediatric departments in public hospitals in different regions are mainly responsible for secondary, emergency and community care services. Under this hub-and-spoke model, the HKCH and regional hospitals work together as a co-ordinated and coherent paediatric service network

The table below sets out the attendances of specialist out-patient clinics (SOPCs) (clinical), the numbers of inpatient bed days and inpatient bed occupancy rates of the HKCH in 2022-23 to 2024-25 (up to 31 December 2024):

Financial Year	Attendance of SOPCs	Inpatient Bed Day	Inpatient Bed Occupancy Rate (%)
2022-23	51 240	43 090	52%
2023-24	60 535	51 704	64%
2024-25 (up to 31 December 2024)	50 230	41 419	66%

Note:

- (1) According to the HA's classification, day in-patients refer to those who are admitted to hospital for non-emergency treatment and discharged on the same day, while in-patients are those who are admitted to hospital via the Accident and Emergency department or have stayed in hospital for more than 1 day. The numbers of both in-patients and day in-patients are taken into account when calculating the number of inpatient bed days. The number of day in-patients, however, is excluded in calculating the inpatient bed occupancy rate.
- (2) In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA has adjusted its services to cope with the outbreak. This should be taken into consideration when comparing the service capacity of the HA in previous years. With the cessation of anti-epidemic measures in early 2023, the HA's public healthcare services have resumed normalcy gradually.

(2)

Attrition (wastage) rates of full-time doctors and nurses working in the HKCH⁽¹⁾⁽²⁾⁽³⁾

	2022-23	2023-24⁽⁴⁾	2024-25 (rolling 12 months from January to December 2024) ⁽⁴⁾
Doctor	7.4%	6.2%	6.7%
Nurse	13.6%	9.9%	5.3%

Note:

- (1) Attrition (wastage) includes all types of cessation of service (including retirement) from the HA for permanent and contract staff on a headcount basis.
- (2) Rolling attrition (wastage) rate = (Total number of staff left the HA in the past 12 months / Average number of staff in the past 12 months) x 100%.
- (3) Doctors exclude Interns and Dental Officers.
- (4) From January 2024 onwards, the number of staff under the arrangement of Extending Employment Beyond Retirement (EER) is excluded from attrition (wastage). The figures prior to that month are for reference only and direct comparison with the data under the current revised calculation method is inappropriate.

The intake and attrition (wastage) numbers of full-time doctors and nurses working in the HKCH⁽¹⁾⁽²⁾

	2022-23		2023-24 ⁽⁵⁾		2024-25 ⁽⁵⁾ (April to December 2024)	
	Intake Number (including full-time and part-time staff)	Full-time Attrition (Wastage) Number	Intake Number (including full-time and part-time staff)	Full-time Attrition (Wastage) Number	Intake Number (including full-time and part-time staff)	Full-time Attrition (Wastage) Number
Doctor (3)(4)	22	12	18	11	18	10
Nurse	97	50	34	37	37	14

Note:

- (1) Intake refers to the total number of permanent and contract staff joining the HA on a headcount basis during the period. Transfers, promotions and movements within the HA are not counted.
- (2) Attrition (wastage) includes all types of cessation of service (including retirement) from the HA for permanent and contract staff on a headcount basis.
- (3) The intake of doctors includes the number of Interns appointed as Residents.
- (4) Doctors exclude Interns and Dental Officers.
- (5) From January 2024 onwards, the number of staff under the EER arrangement is excluded from attrition (wastage). The figures prior to that month are for reference only and direct comparison with the data under the current revised calculation method is inappropriate.

(3)

As announced in the Chief Executive's 2024 Policy Address, the HKCH will fully integrate the paediatric services of various clusters and develop more advanced healthcare services to best fulfil its function as a "Centre of Excellence in Paediatrics". In this connection, the HA is exploring the expansion of paediatric services at the HKCH, including increasing the scope of newborn screening; collaborating with foetal medicine teams to perform magnetic resonance imaging of the brain and spine of foetuses and newborns; developing advanced and complex neurosurgical procedures; establishing an evidence-based therapeutic centre targeting patients with rare neurological diseases, introducing advanced gene therapy and maintaining case directories of neuromuscular disorders. Additionally, the HA is exploring more service models including private services to meet public expectation, while providing support to other healthcare organisations in the region on the management of complex cases that the latter find difficult to handle.

The HA is actively integrating paediatric services in various clusters with HKCH as the core of paediatric services, and has set up various paediatric sub-specialty working groups comprising staff of paediatric departments from HKCH and regional hospitals to discuss the specific arrangements for integrating the governance and management of paediatric services in HKCH. These include aligning the operation of paediatric facilities in accordance with

the hub-and-spoke model and defining the service model with HKCH as the core and regional hospitals as the nodes. This aims to expedite the centralisation of treatment of complex paediatric cases in the HKCH in the near future, so that patients can receive appropriate treatment and the resources of the HKCH can be better utilised.

Besides, as announced in the Chief Executive's 2024 Policy Address, to enhance the health of the people of Hong Kong, improve healthcare protection and quality, and capitalise on our healthcare professions' strengths, the Government is conducting a comprehensive review on the positioning and objectives of the healthcare system. The review covers the reform of functions and division of work among the HA, the Department of Health (DH) and the Primary Healthcare Commission. In this connection, the DH is discussing with the HA the detailed arrangements for the integration of the Child Assessment Service into HKCH under the HA, with a view to enhancing inter-specialty collaboration and streamlining the service flow through the integration of public paediatric services, so that children suspected with developmental or behavioural problems can receive the necessary integrated multi-disciplinary assessment, treatment and rehabilitation services in a timely manner, and that the referral arrangements and services to patients can also be optimised. The HA and the DH expect to complete the transfer of the entire service within 2026 and will announce the relevant details in a timely manner.

- End -

CONTROLLING OFFICER'S REPLY

HHB126

(Question Serial No. 1394)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (-) Not Specified

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Matters Requiring Special Attention in 2025-26 under this programme mentions that the next phase of tobacco control measures will be taken forward. Regarding the tobacco control policy in Hong Kong, will the Government advise on the following:

- 1) the expenditure and estimate involved in the work on tobacco control by the Tobacco and Alcohol Control Office (TACO) as well as the approved establishment for the past three financial years and the estimated expenditure for the coming financial year;
- 2) the number of fixed penalty notices and summonses issued by the TACO to smoking offenders in the past three years and the total amount of fines collected;
- 3) in view of the Government has increased the tobacco duty consecutively over the past two years, the changes in smoking prevalence in Hong Kong; and
- 4) as the increase in tobacco duty is not mentioned in this year's Budget, how will the Government achieve the target of lowering the smoking prevalence rate to 7.8% within 2025?

Asked by: Hon LAU Ip-keung, Kenneth (LegCo internal reference no.: 30)

Reply:

1) & 2)

The Tobacco and Alcohol Control Office (TACO) of the Department of Health (DH) is the principal enforcement agency for the Smoking (Public Health) Ordinance (Cap. 371) and the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600). The TACO will conduct inspections and investigation in response to smoking and related complaints. In general, the TACO will issue fixed penalty notices (FPNs) to smoking offenders without warning. Apart from smoking offences, the TACO also issued summonses for offences under Cap. 371 (including aiding and abetting smoking offences, offences relating to smoking product advertisements, the promotion, manufacture, sale, or possession for commercial purposes of alternative smoking products (ASPs), obstruction of inspectors, etc.), and for the offence of importing ASPs under the Import and Export Ordinance (Cap. 60). The expenditure on and provision for tobacco and alcohol control initiatives taken forward by the TACO, and the

approved establishment of the TACO from 2022-23 to 2025-26, are at **Annex 1** and **Annex 2** respectively.

The numbers of FPNs/ summonses issued by the TACO from 2022 to 2024 for smoking and other offences are at **Annex 3**. The TACO will continue to closely monitor the market situation and take enforcement actions to crack down on all activities in violation of the Smoking (Public Health) Ordinance.

3) & 4)

Increasing tobacco duty is recognised internationally as the most effective means of reducing tobacco use. Through raising the costs of smoking, it provides a greater incentive for smokers to quit smoking, and dampens the eagerness of non-smokers, the youth in particular, to smoke. Past experience in increasing tobacco duty indicated that increasing tobacco duty is conducive to reducing smoking prevalence. The greater the tax hike, the greater the drop in smoking prevalence. The number of calls to the DH's Quitline immediately after the increase in tobacco duty is also a sensitive indicator of smokers' response (i.e. their intention to quit smoking) to the duty increase. In the first month after the duty increase was announced in the 2023-2024 and 2024-2025 Budget, the number of calls to the Quitline increased by about 3 times respectively when compared to the monthly number of calls received in the previous three months, reflecting the strong intention of smokers to quit smoking as a result of the duty increase. The number of calls received by the DH's Quitline increased from about 7 400 in 2022 to about 9 300 in 2024, representing an increase of more than 20%.

After the Government increased the tobacco duty in 2023, the result of the Thematic Household Survey (THS) on smoking pattern conducted by the Census and Statistics Department from May to August that year revealed that smoking prevalence dropped from 10.2% in 2019 and 9.5% in 2021 to 9.1% in 2023. The number of cigarettes consumed by smokers per day also dropped from 12.7 sticks in 2019 and 2021 to 12.1 sticks in 2023. The Government further increased tobacco duty in 2024. In this connection, a THS will be conducted later and it is expected that the reduction in the demand for tobacco products will be reflected in the survey.

The Health Bureau (HHB) introduced in June 2024 the new tobacco control strategy, outlining the short, medium and long-term measures to further reduce smoking prevalence incrementally through various measures, with a view to minimising the harmful effects of tobacco products on the community and safeguarding public health through a multi-pronged approach. These measures are formulated around 4 directions under the tobacco control strategy, namely, reducing the demand for and supply of tobacco products, minimising the attractiveness of tobacco products, protecting the public from the hazard of second-hand smoke and strengthening the provision of smoking cessation services, aiming to take forward the tobacco control process incrementally. The HHB plans to introduce the proposed legislative amendments for the next-phase tobacco control measures to the Legislative Council for scrutiny by the end of this month.

The Government will continue to step up its work on smoking cessation and explore various tobacco control measures in the medium and long term in order to eliminate the social hazards posed by tobacco products in all aspects and safeguard the health of the community with a progressive and multi-pronged approach.

**Expenditure on/provision for
the Department of Health's Tobacco and Alcohol Control Office**

	2022-23 (\$ million)	2023-24 (\$ million)	2024-25 Revised Estimate (\$ million)	2025-26 Estimate (\$ million)
<u>Enforcement</u>				
Programme 1: Statutory Functions	100.4	123.3	167.4	174.8
<u>Health Education and Smoking Cessation</u>				
Programme 3: Health Promotion	149.0	151.4	170.5	180.9
<u>(a) General Health Education and Promotion of Smoking Cessation</u>				
TACO	73.0	83.7	88.2	87.0
Subvention to Hong Kong Council on Smoking and Health (COSH)	26.8	26.6	27.9	27.3
<i>Sub-total</i>	<u>99.8</u>	<u>110.3</u>	<u>116.1</u>	<u>114.3</u>
<u>(b) Expenditure on/Provision for Smoking Cessation and Related Services by Non-Governmental Organisations</u>				
Subvention to Tung Wah Group of Hospitals	29.4	10.2	14.0	17.8
Subvention to Pok Oi Hospital	7.6	14.8	17.9	20.9
Subvention to Lok Sin Tong	3.3	3.6	3.6	3.6
Subvention to United Christian Nethersole Community Health Service	5.8	6.1	8.9	13.8
Subvention to Life Education Activity Programme	2.8	2.9	3.0	3.0
Subvention to Christian Family Service Centre	-	3.5	7.0	4.5
Subvention to The University of Hong Kong	0.3	-	-	3.0
<i>Sub-total</i>	<u>49.2</u>	<u>41.1</u>	<u>54.4</u>	<u>66.6</u>
Total	<u>249.4</u>	<u>274.7</u>	<u>337.9</u>	<u>355.7</u>

Approved Establishment of
the Department of Health's Tobacco and Alcohol Control Office

Rank	Number of Staff from 2022-23 to 2025-26
<u>Head, TACO</u>	
Consultant	1
<u>Enforcement</u>	
Senior Medical & Health Officer	1
Medical & Health Officer	1
Scientific Officer (Medical)	1
Land Surveyor	1
Police Officer	5
Overseer/Senior Foreman/Foreman	125
Senior Executive Officer/Executive Officer	13
<i>Sub-total</i>	<u>147</u>
<u>Health Education and Smoking Cessation</u>	
Senior Medical & Health Officer	1
Medical & Health Officer	1
Scientific Officer (Medical)	2
Nursing Officer/Registered Nurse	3
Hospital Administrator II	4
<i>Sub-total</i>	<u>11</u>
<u>Administrative and General Support</u>	
Senior Executive Officer/Executive Officer	4
Clerical and Support staff	19
Motor Driver	1
<i>Sub-total</i>	<u>24</u>
Total	<u>183</u>

**Numbers of FPNs / summonses issued by the TACO for
smoking and other offences under the Smoking (Public Health) Ordinance (Cap. 371),
the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600) and the Import and
Export Ordinance (Cap. 60)**

		2022	2023	2024
FPNs issued (for smoking offences)		6 296	10 261 ^(Note 2)	13 488
Total Fine		\$9,444,000	\$15,391,500	\$20,232,000
Summonses issued	for smoking offences	35	48	64
	for other offences (Note 1)	130	657	871

Note:

- 1 Other offences include willful obstruction, failure to produce identity document, displaying smoking product advertisement, ASP related offences, and aiding and abetting another person committing a smoking offence, etc.
- 2 To effectively mitigate the impact of passive smoking on the public and enhance the deterrent effect against illegal smoking, the TACO has flexibly deployed resources and adopted new enforcement strategies since 2023, including extension of the time of surveillance and inspections in no smoking areas, deploying plain-clothes officers to take proactive enforcement actions, strengthening enforcement action in venues (such as bars and food premises) where waterpipes were offered for smoking, as well as prosecuting people inciting, aiding and abetting illegal smoking. The number of prosecutions against illegal smoking has surged due to the new enforcement strategies, reflecting their enhanced effectiveness.

- End -

CONTROLLING OFFICER'S REPLY

HHB127

(Question Serial No. 0894)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the work to continue to take forward and implement the five-year plan of eHealth+, will the Government advise this Committee of the following:

1. the respective numbers of citizens, healthcare institutions and healthcare professionals (HCPs) registered with eHealth to date; the number of registered citizens who have given sharing consent to private healthcare providers (HCPs);
2. the respective numbers of new registrations for the use of eHealth by citizens, healthcare institutions and HCPs in each of the past 3 years;
3. the measures taken by the authorities to promote registration with eHealth and encourage citizens to give sharing consent to private HCPs; the actual expenses for promoting eHealth in the past 3 years and the estimated expenses for the current year;
4. the numbers of electronic health records (eHRs) uploaded to eHealth by private healthcare institutions and HCPs in each of the past 3 years;
5. the number of private HCPs who have successfully connected with eHealth through the eHealth Adoption Sponsorship Pilot Scheme (Pilot Scheme) since its launch in 2023; the actual expenditures for implementing the Pilot Scheme in the past 2 years and the estimated expenditure for the current year;
6. the measures by the authorities to encourage more private HCPs to upload eHRs to eHealth; and
7. the operating expenses of eHealth in each of the past 3 years and the estimated operating expenses for the current year.

Asked by: Hon LEE Tsz-king, Dominic (LegCo internal reference no.: 31)

Reply:

eHealth is a territory-wide electronic health record sharing system launched by the Government in 2016 that enables citizens to authorise healthcare providers (HCPs) in the public and private sectors to view and share their electronic health records (eHRs) for healthcare purposes. Building on the strengths of the existing infrastructure of eHealth, the Government announced in the 2023 Policy Address the initiative to roll out a five-year development plan of eHealth+ to transform eHealth into a comprehensive healthcare

information infrastructure that integrates multiple functions of data sharing, service delivery and care journey management. eHealth+ aims to facilitate care coordination, cross-sector collaboration, as well as active health management and surveillance, thereby better serving our citizens in obtaining optimal healthcare services, and supporting the healthcare reform and various healthcare policies more effectively, such as primary healthcare and cross-boundary healthcare services. In July 2024, the Finance Committee of the Legislative Council approved a capital funding of \$1,395.8 million to support the eHealth+ development. The Government is taking forward the eHealth+ development in phases in accordance with the patient-centric principle and four strategic directions, namely, “One Health Record”, “One Care Journey”, “One Digital Front Door to Empowering Tool” and “One Health Data Repository”.

The reply to the questions raised by the Hon LEE Tsz-king, Dominic is as follows:

(1) to (3) The Government has been actively promoting and facilitating eHealth registration to bring every citizen on board, including providing more registration channels. At present, all Hong Kong residents can register with eHealth online and use “iAM Smart” for identity verification to instantly create their eHealth accounts. Citizens can also register with eHealth in person at over 60 registration centres under the Hospital Authority (HA) and the Department of Health (DH) or create their eHealth accounts at designated post offices in 18 districts across Hong Kong. From February 2025 onwards, they can instantly create eHealth accounts and complete identity verification for their children aged below 16 via the one-stop eHealth mobile application. We have also integrated the eHealth registration into certain health services provided by the DH (e.g. Maternal and Child Health Centres and the Human Papillomavirus Vaccination Catch-up Programme) and required mandatory eHealth registration for citizens participating in the Public-Private Partnership (PPP) programmes (e.g. the Chronic Disease Co-Care Pilot Scheme). We will gradually expand this requirement to all government-funded programmes and all public healthcare services provided by the DH and HA.

As of end-February 2025, over 6.1 million citizens have registered with eHealth, accounting for over 80% of the Hong Kong population. The number of HCPs registered with eHealth by the type of organisation is tabulated as follows:

Type of HCPs	Number of HCPs Registered with eHealth (on an Organisational Basis)	Number of Healthcare Service Locations Registered with eHealth
Public hospitals (i.e. hospitals under the HA)	1	43
Public clinics (e.g. clinics under the HA and DH)	11	390
Other public HCPs (e.g. District Health Centres)	20	217
Private hospitals	13	43
Other private HCPs (e.g. clinics, residential care homes for the elderly, and	3 681	6 018

social welfare organisations providing healthcare services)		
Total	3 726	6 711

Besides, as of end-February 2025, about 58 800 healthcare professionals (HCProfs) have registered with eHealth. The number of registered HCProfs by profession is tabulated as follows:

Type of HCProfs	Number of HCProfs Registered with eHealth	Percentage of Registered HCProfs
Doctor	13 190	82%
Dentist	1 731	60%
Chinese medicine practitioner	966	9%
Other HCProfs (e.g. nurse, pharmacist, and radiographer)	42 940	48%
Total	58 827	49%

The number of healthcare recipients (HCRs), HCPs and HCProfs newly registered with eHealth in the past 3 years are tabulated as follows:

Financial Year	Number of Newly Registered HCRs	Number of Newly Registered HCPs	Number of Newly Registered HCProfs
2022-23	466 554	374	9 032
2023-24	262 598	263	8 721
2024-25 (as of 28 February 2025)	189 957	678	9 386

Under the current mechanism, an HCR needs to first give “joining consent” to register with eHealth and then provide “sharing consent” to individual HCP before that particular HCP can provide and obtain the Electronic Health Records (eHRs) in the HCR’s eHealth account. Once HCRs have given “joining consent”, it will be taken as giving “sharing consent” to the HA and DH. As of end-February 2025, among the more than 6.1 million registered HCRs, around 3.9 million (64%) have not given “sharing consent” to any private HCP, implying that many citizens have yet to enable the provision of eHRs by private HCPs to fully utilise eHealth.

The Government has continuously optimised the process for citizens to give consent to private HCPs through promotion and publicity as well as facilitation measures. At present, citizens can use the “sharing consent” function of the eHealth mobile application to grant “sharing consent” to individual private HCP at anytime and anywhere. Besides, the Government introduced the Electronic Health Record Sharing System (Amendment) Bill 2025 (the Amendment Bill) into the Legislative Council this year to provide a legal framework to assist citizens in building a more comprehensive eHR profile. Among other things, the Amendment Bill will streamline the consent mechanism such that once citizens agree to join eHealth, their HCPs will be able to deposit health data into their personal eHealth accounts. Meanwhile, citizens will continue to retain full control over their personal data and can grant individual HCPs access to their eHealth records at their own will.

The expenditure on public engagement activities (including publicity) of eHealth from 2022-23 to 2025-26 are tabulated as follows:

Financial Year	Expenditure on Public Engagement Activities of eHealth (\$ million)
2022-23 (actual)	8.7
2023-24 (actual)	19.3
2024-25 (revised estimate)	24.2
2025-26 (estimate)	28.9

(4) to (6) Under the strategic development direction of “One Health Record”, we seek to consolidate the longitudinal eHRs of citizens spread across a multitude of healthcare processes into their personal eHealth accounts. A comprehensive and complete eHR profile enables the HCPs authorised by citizens to respond to their health needs more effectively, thus enhancing clinical outcomes and saving costs of the care process. Nevertheless, while private HCPs have been actively using eHealth in supporting clinical processes as evidenced by the fact that nearly 60% of eHR access by HCPs as of end-February 2025 were by private HCPs, more than 99% of some 4.5 billion eHRs shared on eHealth are from public HCPs.

The Government has been taking a multi-pronged approach to incentivise and facilitate the provision of citizens’ eHRs into eHealth by private HCPs, thereby assisting citizens in accessing, managing and using their own eHRs during the healthcare process more conveniently. Last year, the Government launched a platform enabling self-service data compliance testing to simplify the technical testing procedures, and provided dedicated technical support to healthcare institutions. When taking forward various PPP programmes, the Government would require HCPs to deposit the related medical records of the participating citizens into eHealth. The Government also rolled out the eHealth Adoption Sponsorship Pilot Scheme (Pilot Scheme) by partnering with electronic medical record (eMR) solutions vendors and medical groups to co-fund system enhancements in achieving seamless eHR sharing between eHealth and eMR systems in the market. From July 2023 to February 2025, about 80 private HCPs (involving around 480 private doctors and 200 service locations) connected to eHealth and provided more than 1.12 million eHRs under the Pilot Scheme. The expenditure of the Pilot Scheme incurred from 2023-24 to 2025-26 is tabulated as follows:

Financial Year	Expenditure of the Pilot Scheme (\$ million)
2023-24 (actual)	1.0
2024-25 (revised estimate)	2.4
2025-26 (estimate)	6.9

With the Government’s endeavours, the eHRs deposited by private HCPs to eHealth have significantly increased. The annual number of eHRs deposited to eHealth by private HCPs over the past 3 years are as follows:

Financial Year	Number of eHRs Deposited by Private HCPs^{Note} (million)
2022-23	1.52
2023-24	2.66
2024-25 (as of end-February 2025)	3.40

Note: Given that eHealth registration and related deposit of eHRs is HCP-based, we do not have any record of the eHRs deposited to eHealth by HCPs.

The Government will continue to collaborate with the private healthcare sector to enhance the connectivity between eHealth and their eMR solutions. In particular, given the positive impacts of the Pilot Scheme, we have progressively expanded the scheme to include more eMR solution vendors, medical groups and other sectors, including Chinese medicine. We will also launch the eHealth+ accreditation scheme in 2025 to enable citizens to easily identify if an HCP has the capability to deposit health records into their personal eHealth accounts and the extent of data involved. Citizens can make reference to such information in choosing a suitable HCP, to ensure that their medical records will be deposited in their personal eHealth accounts. Additionally, the Secretary for Health will be empowered under the Amendment Bill, to require specified HCPs to provide specified important health data into the personal eHealth accounts of citizens registered with eHealth and with their consents, in order to facilitate citizens' easy access and control of their key health information.

The Government will continue to provide support and collaborate with the private healthcare sector to enable the majority of private HCPs to seamlessly connect with eHealth; and will consider providing additional assistance to healthcare institutions and HCPs that are less prepared for digitalisation.

(7) The operational expenditure of eHealth from 2022-23 to 2025-26 are tabulated as follows:

Financial Year	Operational Expenditure of eHealth (\$ million)
2022-23 (actual)	243.2
2023-24 (actual)	265.8
2024-25 (revised estimate)	312.6
2025-26 (estimate)	320.0

- End -

CONTROLLING OFFICER'S REPLY

HHB128

(Question Serial No. 0895)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the Chronic Disease Co-Care Pilot Scheme (CDCC Pilot Scheme), will the Government inform this Committee of:

- (1) Since the launch of the CDCC Pilot Scheme, how many members of the public have participated; what is the average age of the participants; what are the respective numbers and proportions of participants diagnosed with prediabetes, diabetes mellitus or hypertension after screening;
- (2) What measures will be taken to encourage members of the public aged 45 or above to participate in the Pilot Scheme;
- (3) How many family doctors are currently participating in the Pilot Scheme; what measures will be taken to encourage more family doctors to participate in the Pilot Scheme;
- (4) What are the expenditures and estimated expenditures of the Pilot Scheme for the previous and current year;
- (5) During the screening phase of the Pilot Scheme, what were the amounts of subsidies allocated by the Government for consultation and laboratory services respectively in the previous year;
- (6) During the treatment phase of the Pilot Scheme, what were the amounts of subsidies allocated by the Government for consultations, medication, laboratory tests, nursing and allied health services respectively in the previous year?

Asked by: Hon LEE Tsz-king, Dominic (LegCo internal reference no.: 32)

Reply:

(1)

The Government has launched the three-year Chronic Disease Co-Care Pilot Scheme (CDCC Pilot Scheme) since 13 November 2023, which is the first major initiative under the Primary Healthcare Blueprint. The Scheme provides subsidised diabetes mellitus (DM) and hypertension (HT) screening services in the private healthcare sector to Hong Kong residents aged 45 or above with no known medical history of DM or HT, with a view to encouraging citizens to gain a better understanding of their own health status as early as possible through screening, so as to achieve the goals of “early prevention, early identification and early treatment”.

As at 27 March 2025 [provisional figures], about 114 200 citizens and over 600 family doctors have joined the Scheme, of which around 65 000 participants (i.e. nearly 60%) have completed the screenings for DM and HT, and around 25 230 of them (i.e. nearly 40%) have been diagnosed with prediabetes ^{Note 1}, DM or HT. The latter patients can proceed to the treatment phase and will be subsidised by the Government to continue their treatment with self-selected family doctors, and subject to their health conditions, be prescribed medication, or referred to follow-up care at nurse clinics and allied health services. In addition, the Government has established a bi-directional referral mechanism with the HA under CDCC Pilot Scheme. Family doctors can refer participants with clinical needs to receive a one-off specialist consultation at a designated Medicine SOPC of the HA according to clinical diagnosis and pre-defined criteria and guidelines; 50 participants have received one-off specialist consultation at the HA through the mechanism. As at 31 December 2024, around 70% of the participants aged ^{Note 2} between 45 and 64.

With regard to the promotion of multidisciplinary care, in accordance with the Government's earlier announcement, the dedicated nurse clinic and allied health services (including optometrists, physiotherapists and dietitians) have been introduced to devise more comprehensive chronic disease management programmes for the CDCC Pilot Scheme participants since 20 January 2025. Since the introduction of the relevant services, as at 27 March 2025 [provisional figures], 504 participants have made reservations for relevant services and 417 of them have already received services. From 28 March 2025, the CDCC Pilot Scheme has been expanded to cover blood lipid testing for eligible participants, allowing a more comprehensive approach to the assessment and proper management of cardiovascular disease risk factors, including the “three highs” (high blood pressure, high blood sugar and high cholesterol). Starting from the same day, the Scheme will be expanded in phases to provide preventive screening and care services in GOPCs of the HA for the underprivileged group.

As mentioned in the Primary Healthcare Blueprint, local studies have shown that the healthcare system can achieve savings in healthcare expenses and reduce the burden of disease through the provision of subsidised screening and management services for DM management to suitable patients. The CDCC Pilot Scheme is a pilot scheme that encourages eligible citizens to undergo screening for DM and HT, two common chronic diseases, so that hidden patients can be detected at an early stages and their complications can be treated and prevented as early as possible, thereby reducing the need for hospitalisation. In order to further examine the effectiveness of the CDCC Pilot Scheme, the Government commissioned a local university in the first quarter of 2024 to conduct a study to assess the extent to which the objectives of the scheme are met and the overall performance, including the service quality

and effectiveness, as well as the cost-effectiveness. The Government will review the service model and operational details of the CDCC Pilot Scheme in a timely manner and make enhancements as necessary to ensure its effectiveness, including considering whether to expand the service scope of the Scheme.

Note:

1. Prediabetes with glycated haemoglobin level of 6.0 to 6.4 % or fasting plasma glucose level of 6.1 to 6.9 mmol/L.
2. It refers to the age at enrolment for the CDCC Pilot Scheme.

(2)

Since the launch of the CDCC Pilot Scheme, the Government has promoted the Scheme through various channels, among which the District Health Centres/District Health Centre Expresses (collectively DHCs) play an important role. In addition to inviting existing eligible members to participate in the CDCC Pilot Scheme, the DHCs also organise large-scale promotional activities in respective districts and strengthen connection with the public through community outreach activities, mobile outreach vehicles and promotional booths in community complexes. The DHCs have been actively co-operating with community service partners, such as district councillors and the District Services and Community Care Teams to organise community activities to recruit eligible individuals to become Scheme participants. In view of the relatively low proportion of male participants (as at 31 December 2024, about 67% of the participants were female and 33% were male), DHCs are enhancing their promotional efforts focusing on men, including stepping up promotional efforts targeting at practitioners of particular industries such as transport, construction and catering, and arranging promotional activities on non-working days, especially Sundays.

At the same time, the Government has also been carrying out other forms of publicity activities to promote the CDCC Pilot Scheme through various television and media channels, and providing the public and healthcare service providers with latest information of the CDCC Pilot Scheme through various communication platforms (such as website, telephone hotline, posters and brochures, electronic newsletters and online briefings).

(3)

As at 5 March 2025, there are 610 family doctors participating in the CDCC Pilot Scheme.

The Primary Healthcare Commission (PHCC) will strive to encourage more family doctors to participate in the CDCC Pilot Scheme and increase the number of family doctor service points in various districts, with a view to providing the public with more choices. In this connection, the PHCC has organised 5 webinars to promote and introduce the CDCC Pilot Scheme to family doctors, and actively invited family doctors/clinics, in particular, doctors who enrolled in the General Outpatient Clinic Public-Private Partnership Programme and those enlisted in the Primary Care Directory, to participate in the Scheme. The PHCC and the Hong Kong College of Family Physicians co-organised the World Family Doctor Day Symposium 2024 on 18 May 2024, to share and discuss with healthcare professionals the promotion of primary healthcare services in a concerted manner. The Symposium also highlighted the enhancements introduced by the Government to support family doctors in

providing necessary care to CDCC Pilot Scheme participants, and successfully encouraged more doctors to join the Scheme.

Furthermore, the Government has been optimising the operational details of the Scheme by streamlining various administrative procedures and workflow, with a view to enhancing the family doctors' ease of operation of the system. Moreover, to increase the flexibility of the CDCC Pilot Scheme, starting from March 2024, members of the public can choose to directly enrol at certain participating clinics of the Scheme to pair with a family doctor in the clinic for screening. In addition, having reviewed the actual needs of participants, the Government has expanded the basic-tier drug list of the CDCC Pilot Scheme since August 2024 to increase the coverage of its basic-tier drugs from 43 items at the initial stage to 59 drug items, providing family doctors with greater flexibility in prescribing drugs according to the clinical needs of participants.

(4) to (6)

The expenditure of the CDCC Pilot Scheme for 2023-24 and the estimated expenditure for 2024-25 are provided below:

2023-24 Expenditure (\$ million)	2024-25 Estimated expenditure (\$ million)
10	43.1

- End -

CONTROLLING OFFICER'S REPLY

HHB129

(Question Serial No. 0685)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Please provide the following information in relation to each hospital within the Kowloon Central Cluster in the past 1 year, with a breakdown by District Council districts:

1. the general outpatient attendance of patients from various districts;
2. the specialist outpatient attendance of patients from various districts;
3. the Accident & Emergency service attendance of patients from various districts; and
4. the overall situation of hospitals within the Kowloon Central Cluster receiving patients from various districts.

Asked by: Hon LEE Wai-king, Starry (LegCo internal reference no.: 16)

Reply:

The following table sets out attendances on the general outpatient (GOP) services, specialist outpatient (SOP) services and Accident & Emergency (A&E) services provided by the Kowloon Central Cluster (KCC) of the Hospital Authority (HA) for 2024-25 (up to 31 December 2024):

Patient's residential district (by District Council district)	GOP attendances	SOP (clinical) attendances	A&E attendances
Central & Western	2 191	4 963	798
Wan Chai	1 700	4 108	647
Eastern	7 208	12 727	1 911
Southern	3 174	5 772	955
Yau Tsim Mong	138 218	169 098	56 719
Sham Shui Po	50 652	93 674	18 883
Kowloon City	203 321	266 890	60 044
Wong Tai Sin	306 956	289 768	58 968
Kwun Tong	64 460	124 515	16 754
Kwai Tsing	19 493	39 334	5 132
Tsuen Wan	9 601	23 105	2 128
Tuen Mun	7 613	17 427	2 344
Yuen Long	8 317	23 682	3 063
North	6 203	13 061	1 703
Tai Po	7 366	12 811	1 585
Sha Tin	37 684	39 263	5 662
Sai Kung	18 498	55 449	4 536
Islands	3 054	9 456	1 115
Others (e.g. Macao and Mainland China)	390	1 699	2 761
Overall	896 099	1 206 802	245 708

Note:

1. Patient's residential district is based on the address information provided by the patient or his/her relative and does not necessarily reflect the actual place of residence.
2. "Others" includes cases where the patient provided addresses outside of Hong Kong or no information on residential address was provided.

- End -

CONTROLLING OFFICER'S REPLY**HHB130****(Question Serial No. 0686)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): (000) Operational expensesProgramme: (3) Subvention: Hospital AuthorityControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

Please set out the number of attendances at the Accident & Emergency (A&E) department of the Queen Elizabeth Hospital over the past 3 years.

Asked by: Hon LEE Wai-king, Starry (LegCo internal reference no.: 17)

Reply:

The table below sets out the attendances for accident and emergency (A&E) services under various triage categories at the Queen Elizabeth Hospital in 2022-23, 2023-24 and 2024-25 (up to 31 December 2024).

Year	No. of A&E attendances				
	Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
2022-23	3 884	3 895	82 243	56 116	3 369
2023-24	4 610	4 169	101 014	77 192	5 842
2024-25 (up to 31 December 2024)	3 259	2 826	70 054	58 383	4 644

The attendances for A&E services under various triage categories at the hospital under the Hospital Authority (HA) exclude (i) first-time visits without triage categories, and (ii) follow-up visits to the A&E department.

Note:

In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA has adjusted its services to cope with the outbreak. This should be taken into consideration when comparing the service capacity of the HA in the relevant previous years. With the cessation of anti-epidemic measures in early 2023, the services of the HA have resumed to normalcy gradually.

- End -

CONTROLLING OFFICER'S REPLY

HHB131

(Question Serial No. 0687)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

One of the Matters Requiring Special Attention in 2025-26 is to expand the Elderly Health Care Voucher Greater Bay Area Pilot Scheme. Please advise:

1. the estimated number of beneficiaries of the above Scheme;
2. whether the Bureau will consider further extending the Hong Kong's Elderly Health Care Vouchers to cover services such as inpatient services and day surgery procedures, so that Hong Kong elderly persons residing on the Mainland can obtain basic medical services without having to come back to Hong Kong; and
3. whether the Bureau will consider further refining the scope of "two-way sharing" of individual medical records by sharing information such as radiological images and laboratory results, in order to facilitate Hong Kong elderly persons living in the Greater Bay Area to receive medical treatment locally.

Asked by: Hon LEE Wai-king, Starry (LegCo internal reference no.: 18)

Reply:

1.
The Government launched the Elderly Health Care Voucher Greater Bay Area Pilot Scheme (Pilot Scheme) in 2024 to extend the coverage of Elderly Health Care Vouchers (EHCVs) to suitable medical institutions in the Guangdong-Hong Kong-Macao Greater Bay Area (GBA). As at September 2024, the coverage of EHCVs has been extended to 7 integrated medical/dental institutions in the GBA. Together with the 2 existing service points operated by the University of Hong Kong-Shenzhen Hospital (HKU-SZH), eligible elderly persons can use EHCVs to pay for outpatient healthcare services provided by the designated departments at 9 service points in the GBA, located at Guangzhou, Zhongshan, Dongguan and Shenzhen, offering more convenience and flexibility for eligible Hong Kong elderly persons residing in Mainland cities in the GBA by providing more service points for them to better use their EHCVs on primary healthcare services for improving their health. As at 31 December 2024, there were 9 064 eligible Hong Kong elderly persons using their EHCVs at the 7 pilot medical institutions under the Pilot Scheme, involving a total of 15 468 EHCV claim transactions and approximately HK\$19.78 million claimed amount in total.

The Chief Executive's 2024 Policy Address announced the extension of the Pilot Scheme to cover the 9 Mainland cities in the GBA. The Health Bureau and the Department of Health are actively taking forward the related work. The initial plan is to commence the relevant arrangements under the Pilot Scheme at the locations concerned by the 4th quarter of 2025. Eligible Hong Kong elderly persons can use EHCVs to pay for the fees of outpatient healthcare services provided by designated departments/clinics of the pilot medical institutions under the Pilot Scheme. It is estimated that more than 1.78 million eligible Hong Kong elderly persons will benefit from the initiative.

2.

The Government launched the Elderly Health Care Voucher Scheme (EHVS) in 2009, which aims at providing financial incentives for elderly persons to choose private primary healthcare services, including outpatient healthcare services, health assessment, disease screening, etc., that best suit their health needs, so as to provide them with additional choices on top of the existing public primary healthcare services. To ensure the optimal use of resources to effectively achieve the objectives of promoting primary healthcare and preventing abuse, EHCVs cannot be used for inpatient services, prepaid healthcare services and day surgery procedures. The Government's policy of allowing EHCVs to be used in the GBA aims to provide more convenience and flexibility for eligible Hong Kong elderly persons residing in Mainland cities in the GBA by offering them more service points to use EHCVs to meet their primary healthcare needs and improve their health. To ensure that EHCVs can effectively support the policy objective of implementing primary healthcare, the scope and principles of the use of EHCVs under the Pilot Scheme are largely the same as those in Hong Kong and under the HKU-SZH Scheme, which do not include inpatient services, prepaid healthcare services or day surgery procedures.

On the other hand, in addition to the EHVS, the Government, having made reference to the experience from the Special Support Scheme during the COVID-19 epidemic, launched the Pilot Scheme for Supporting Patients of Hospital Authority in Guangdong-Hong Kong-Macao Greater Bay Area (Patient Support Pilot Scheme) in May 2023, under which patients with scheduled follow-up appointments at designated specialist outpatient clinics or general outpatient clinics of the Hospital Authority (HA) (eligible patients) can receive subsidised consultations at the HKU-SZH. The Government has announced the extension of the Patient Support Pilot Scheme to 31 March next year. Eligible patients can continue to receive subsidised consultation services at the HKU-SZH and they only need to pay a consultation fee of RMB 100 for each subsidised outpatient consultation (except for specified persons whose medical fees would be waived upon verification by the HA). Such consultation fee payable by eligible patients will be adjusted on 1 January next year in accordance with the specialist out-patient consultation fee as set under the fees and charges reform for public healthcare. The Government will announce the details in due course. The remaining consultation fee will be subsidised by the Patient Support Pilot Scheme, subject to a cap of RMB2,000. The validity period of the relevant subsidy is up to 31 March next year.

3.

In accordance with the overarching principles of ensuring due compliance of laws and regulations of both places, and safeguarding data security and patients' privacy, the Government has been facilitating the sharing of cross-boundary medical records via the eHealth platform to support Hong Kong citizens' participation in various cross-boundary

healthcare collaboration programmes and meet their cross-boundary healthcare needs. Among other things, the Government launched the “Cross-boundary Health Record” (CBHR) and “Personal Folder” functions of the eHealth mobile application (eHealth App) at the HKU-SZH and 7 medical institutions under the Pilot Scheme in 2024 to enable Hong Kong citizens to self-carry their electronic health records (eHRs) for cross-boundary uses, thereby obtaining more coherent healthcare services. The CBHR function enables eligible Hong Kong elderly persons using EHCVs at designated medical institutions in the GBA to apply for a copy of their eHRs (including laboratory records, radiology records and other investigation reports) in the eHealth over the past 3 years through the eHealth App in advance. Healthcare professionals of the designated medical institutions can then access and browse the relevant eHRs by scanning the QR codes presented by the elderly persons at the time of consultation to assist in diagnoses and treatment. The “Personal Folder” function enables citizens to deposit eHRs obtained during medical consultations within and outside Hong Kong into their personal eHealth accounts to facilitate storage and use of eHRs, including access by Hong Kong medical institutions authorised by users through the eHealth system during follow-up care.

The feedback on the cross-boundary functions has been positive. The Government will continue to streamline the workflow and improve the user experience, and progressively extend the relevant cross-boundary functions to more medical institutions under cross-boundary healthcare collaboration programmes as well as enhance the role of the eHealth as the core system for cross-boundary health data sharing. The Government notes that requiring citizens to carry their own eHRs for cross-boundary use each time is not the most convenient, secure, and effective way for both citizens and healthcare providers. For example, given the more stringent technical requirements, it is difficult for citizens to self-upload high-resolution radiology images to their eHealth accounts. In accordance with the current legislation, healthcare providers outside Hong Kong are unable to register with the eHealth. To support citizens’ needs more effectively, the Government proposed in the Electronic Health Record Sharing System (Amendment) Bill 2025 to empower the Commissioner for the Electronic Health Record to recognise healthcare providers or public health record systems outside Hong Kong subject to their due compliance with specified requirements and conditions. By so doing, and on the premise that sufficient protection of data privacy and system security are in place, healthcare providers outside Hong Kong will be able to deposit and access citizens’ eHRs through the eHealth with the explicit consent of the citizens concerned while using their services, so as to enhance the quality and safety of cross-boundary healthcare services.

- End -

CONTROLLING OFFICER'S REPLY

HHB132

(Question Serial No. 0704)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (1) Director of Bureau's Office

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

To further promote the measure of using Hong Kong registered drugs and medical devices used in Hong Kong public hospitals in Guangdong-Hong Kong-Macao Greater Bay Area (GBA) and the application of Real World Data (RWD) in the GBA to facilitate the development of the pharmaceutical industry for medical innovation, will the Government inform this Committee:

1. whether efforts have been made to seek the introduction of policies from the Central Government to use Hong Kong's RWD as an important reference for approval of drugs and medical devices by the National Medical Products Administration; what progress has been made in the negotiations on such policies; and how it ensures that the data can accelerate the registration and use of overseas drugs and medical devices in the Mainland;
2. whether there are plans to establish a regular liaison mechanism with relevant departments of Guangdong in 2025-26 to proactively provide a list of advanced drugs and medical devices for expediting the inclusion of drugs under the measure of using Hong Kong registered drugs and medical devices used in Hong Kong public hospitals in the GBA; and of the details of the mechanism;
3. how it will promote the establishment of the GBA Clinical Trial Collaboration Platform and the Real-World Study and Application Centre to enable the cross-boundary use of data, samples, drugs and medical devices; and of the details, estimated provision and progress; and
4. how it will expand the sharing of cross-boundary medical records via the eHealth platform and explore its application in the Hetao Shenzhen-Hong Kong Science and Technology Innovation Co-operation Zone; and of the details and the estimated provision of the plan?

Asked by: Hon LEE Wai-king, Starry (LegCo internal reference no.: 35)

Reply:

The HKSAR Government has been actively developing Hong Kong into an international health and medical innovation hub by complementing technological innovation with institutional innovation, including enhancing the evaluation and approval mechanism for drugs, and setting up the Hong Kong Centre for Medical Products Regulation so as to achieve the long-term objective of setting up an authority which registers drugs and medical devices under the “primary evaluation” approach while further enhancing the clinical trial capability of Hong Kong on all fronts and facilitating the translation of innovative biomedical research results into clinical applications, with a view to providing patients with the benefits of good drugs and research and development (R&D) through medical innovation. In addition, through promoting cross-boundary healthcare collaboration, the HKSAR Government will capitalise on the strengths of Hong Kong’s healthcare system to enhance the Guangdong-Hong Kong-Macao Greater Bay Area (GBA)’s healthcare services and talent pool, and strengthen its international competitiveness.

The Chief Executive proposed in the 2024 Policy Address the establishment of Real-World Study and Application Centre (Application Centre), to promote co-operation between Hong Kong and Shenzhen for integrating data generated from the “measure of using Hong Kong-registered drugs and medical devices used in Hong Kong public hospitals in the GBA” (the Measure), and promoting real-world studies, thereby accelerating approval and marketing of new drugs in Hong Kong, the Mainland and overseas. Through the “GBA Clinical Trial Collaboration Platform” which the Greater Bay Area International Clinical Trial Institute (the Institute) plans to establish jointly with the Shenzhen Municipal Government within 2025, healthcare institutions in the GBA will be linked up to integrate Real World Data (RWD) generated from the Measure¹ so as to facilitate the application of real-world studies in the evaluation and approval of drugs and medical devices, R&D of new drugs and other areas.

The Health Bureau (HHB) has consulted the National Medical Products Administration (NMPA) on the use of RWD collected from the GBA to support the development of registration for drugs and medical devices in the Mainland. The NMPA agreed to further liaise and provide guidance on the promotion of real-world studies, conduct studies on how the relevant policies can be optimised, and explore options to facilitate cross-boundary flow and application of data, biological samples, and innovative drugs and medical devices, with a view to accelerating the development of the pharmaceutical industry for medical innovation. The HKSAR Government will also continue to maintain close liaison with the relevant approving authority in the Mainland on the Measure and real-world studies and application in the light of Hong Kong’s progress in reforming its evaluation and approval mechanism for drugs and medical devices, and developing into an international health and medical innovation hub, and to actively complement the relevant work of the approving authority in the Mainland so as to enable more eligible Hong Kong drugs and medical devices to be used in designated Mainland healthcare institutions in the GBA. In fact, 49 drugs and 48 medical devices have been allowed by the Guangdong Provincial Medical Products Administration to be used in the 45 designated healthcare institutions through the Measure as at 28 February 2025, which is a significant increase as compared with the time when the current-term Government took office (i.e. 20 drugs and 13 medical devices allowed to be used in 5 healthcare institutions). The relevant expenditure on taking forward the above work will be covered by the HHB’s internal resource and the estimates of the Institute and the Application Centre in the 2025-26 financial year.

In addition, the HKSAR Government is now implementing a five-year development plan of eHealth+ to transform eHealth from a health record sharing system into a comprehensive healthcare information infrastructure that integrates multiple functions of data sharing, service delivery and care journey management, with a view to facilitating the healthcare reform and implementing various healthcare policies. In July 2024, the Finance Committee of the Legislative Council (LegCo) approved the capital funding of \$1,395.8 million for the eHealth+ development. The development of eHealth+ will connect and integrate the medical records of Hong Kong's public and private healthcare systems, establishing a comprehensive and centralised health databank augmented by data analytic tools to provide a robust foundation for promoting clinical research and trials, and to tie in with the GBA clinical trial collaboration and health and medical innovation development. To create an enabling environment, at the technical level, the HHB will work to establish an analytics platform with appropriate tools. The HHB will also develop an appropriate governance framework to ensure the safe and appropriate use of data with patients' consent and sufficient safeguards for data security and personal data privacy.

On the other hand, to support citizens' participation in various cross-boundary healthcare collaboration programmes and address their cross-boundary healthcare needs, the HKSAR Government has been facilitating the sharing of cross-boundary medical records via the eHealth platform in accordance with the overarching principles of ensuring due compliance of laws and regulations of both places and that data security and patients' privacy are safeguarded. Among other things, the Government launched the "Cross-boundary Health Record" and "Personal Folder" functions of the eHealth mobile application at the University of Hong Kong-Shenzhen Hospital and 7 medical institutions under the Elderly Health Care Voucher Greater Bay Area Pilot Scheme in 2024, to enable citizens to self-carry their electronic health records (eHRs) for cross-boundary uses, thereby enhancing the continuity of healthcare services. The feedback on relevant cross-boundary functions has been positive. The HHB will continue to streamline the workflow and improve the user experience, and progressively extend the functions to more medical institutions under cross-boundary healthcare collaboration programmes, as well as enhance the role of eHealth as the core system for cross-boundary health data sharing, in order to support citizens' cross-boundary healthcare needs more effectively.

The HHB also notes that requiring citizens carrying their own eHRs for cross-boundary use each time is not the most convenient, secure, and effective way for both citizens and healthcare providers (HCPs). For example, given the more stringent technical requirements, it is difficult for citizens to self-upload high-resolution radiology images to their eHealth accounts. In accordance with the current legislation, HCPs outside Hong Kong are unable to register with eHealth. The Government introduced the Electronic Health Record Sharing System (Amendment) Bill 2025 into the LegCo this year to provide a legal framework to assist citizens in building a more comprehensive eHR profile. Among other things, the Government proposed to empower the Commissioner for the Electronic Health Record to recognise individual HCPs and public health record systems outside Hong Kong, subject to sufficient protection of data privacy and system security as well as due compliance with specified requirements and conditions. This will enable citizens to use their eHRs across the boundary in a more convenient and secure manner. If an individual citizen uses services at a recognised HCP outside Hong Kong, he/she can choose to authorise the HCP to securely access his/her eHRs and deposit the health records of the services received into his/her

personal eHealth account, with a view to enhancing the quality and safety of cross-boundary healthcare services. HCPs outside Hong Kong can only access and deposit citizens' eHRs when a registered citizen provides explicit consent while using the services. Under no other circumstances will eHealth records be transmitted across the boundary.

- 1 The National Medical Products Administration announced the Work Plan for Regulatory Innovation and Development of Pharmaceutical and Medical Device in the Guangdong-Hong Kong-Macao Greater Bay Area in November 2020. It allows designated healthcare institutions operating in the Mainland cities of the GBA to use drugs registered in Hong Kong and Macao with urgent clinical use, and medical devices used in Hong Kong and Macao public hospitals with urgent clinical use, subject to the approval of Guangdong Province (i.e. the Measure).

- End -

CONTROLLING OFFICER'S REPLY

HHB133

(Question Serial No. 0706)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (1) Director of Bureau's Office

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

To enhance Hong Kong's self-sufficiency in the blood product and advanced therapy field and to promote national biosecurity as well as the development of the healthcare industry, will the Hong Kong Special Administrative Region Government inform this Committee of:

1. whether it will support establishing an international blood product centre in the Loop in collaboration with Mainland enterprises so as to reduce our reliance on the blood products abroad and enhance our manufacturing know-how; if so, what are the details; if not, what are the reasons for that;
2. whether the Government will co-ordinate with the National Health Commission, the General Administration of Customs and the Red Cross Society of China to set up an early and pilot green lane, allowing point-to-point export of raw plasma from designated units in the Mainland to the Loop to promote the local production of blood products; if so, what are the details; if not, what are the reasons for that;
3. will it support making facilitated entry arrangement for the blood and advanced therapy products manufactured in the Loop after completing the relevant approval procedure, so as to promote the internationalisation of the medical products of Hong Kong; if so, what are the details; if not, what are the reasons for that?

Asked by: Hon LEE Wai-king, Starry (LegCo internal reference no.: 37)

Reply:

1, 2 and 3

The Resolution of the Communist Party of China (CPC) Central Committee on Further Deepening Reform Comprehensively to Advance Chinese Modernization adopted by the Third Plenary Session of the 20th CPC Central Committee pointed out the need to deepen the medical and healthcare reform and to support the development mechanism for innovative drugs and medical devices. The National 14th Five-Year Plan has expressed clear support

for Hong Kong to develop into an international innovation and technology hub, which brings enormous opportunities to the development of medical technology and biotechnology in the city. Moreover, the Development Plan for Shenzhen Park of Hetao Shenzhen-Hong Kong Science and Technology Innovation Co-operation Zone promulgated by the State Council in 2023 explicitly supports the co-ordinated and complemented development of Hong Kong and Shenzhen under the “one zone, two parks” model to promote the innovative application of cutting-edge biomedical technologies, vigorously develop innovative drugs and establish a public research and development (R&D) service platform for biomedicine. While supporting the world’s top-notch pharmaceutical R&D outsourcing service enterprises in providing integrated pharmaceutical R&D services, the development plan mentions the need to capitalise on the role of the Greater Bay Area International Clinical Trial Centre to accelerate and promote the evaluation, inspection and clinical trials of drugs and medical devices in alignment with international standards, and explore the establishment of new management models suitable for the R&D of new biological drugs and medical devices, such as cell therapy and gene therapy.

As stated in the Chief Executive’s 2023 Policy Address and 2024 Policy Address, the Hong Kong Special Administrative Region (HKSAR) Government will complement technological innovation with institutional innovation, actively developing Hong Kong into an international health and medical innovation hub. The development of advanced therapy products (ATPs) is one of the fast moving areas in the medical field, bringing new hope to patients suffering from high-risk diseases that are currently untreatable and enabling them to receive appropriate treatment. Besides, building up the local production capacity for blood products will not only ensure stable supply but also enhance the HKSAR’s ability to respond to public health crises, effectively reducing risks and providing the most reliable protection for members of the public during major epidemics, thereby enhancing medical safety and health. To further promote the development of advanced biomedical technology, the HKSAR Government will, by fully leveraging Hong Kong’s unique advantages of enjoying strong support of the Motherland and being closely connected to the world, actively explore opportunities for collaboration with enterprises in the Mainland and overseas, including studying the establishment of an industrial base for ATPs and blood products in the Hetao park to facilitate technological innovation and industrial development.

The HKSAR Government has been maintaining close contact with the relevant Mainland authorities concerning the progress of reforming the approval mechanism for drugs and medical devices and developing Hong Kong into an international health and medical innovation hub. At present, there are established national regulations governing the entry and exit of human genetic resources and raw plasma. The HKSAR Government will continue to work with the relevant mainland authorities to explore ways to improve policy innovation and streamline the cross-boundary process, fully leveraging the advantages enjoyed by the Hetao park, including establishing an industrial base for ATPs and blood products, promoting the development of the biomedical industry.

The specific work and advantages of the HKSAR Government in promoting the relevant development include:

- (i) Hong Kong has a regulatory system and standards that are highly compatible with international standards. The Pharmacy and Poisons Board of Hong Kong (the Board) has been a member of the Pharmaceutical Inspection Co-operation Scheme (PIC/S)

since 2016. Pharmaceutical products (including blood products and ATPs) manufactured in Hong Kong with the license obtained from the Board signify full compliance with the PIC/S Good Manufacturing Practice standards to international standards. Leveraging on Hong Kong's internationally recognised high level of drug manufacturing supervision and high degree of convergence with international standards, and in conjunction with the special policies formulated by the country for the development of Hetao, an international centre for blood products and ATPs can be established in Hong Kong, thereby ensuring the supply of blood products locally and facilitating innovation in ATPs, and also assisting these products to enter the global market.

- (ii) With the strong support of the country, the HKSAR Government has become an observer of the International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use (ICH) on 31 October 2023, which enables Hong Kong to keep abreast of the latest developments in drug regulation and to advance the drug regulatory regime in Hong Kong. On the basis of joining the ICH as an observer, the HKSAR Government will progressively promote the implementation of the ICH guidelines in the HKSAR, strengthen the local capacity of drug approval, and facilitate relevant software, hardware and manpower development, with becoming an ICH regulatory member as the ultimate goal, in order to further align Hong Kong with the World Health Organization-Listed Authority. At the same time, the HKSAR Government is enhancing the drug registration regime from “secondary evaluation” to “primary evaluation”, i.e. approving drugs in Hong Kong based on clinical data without making reference to the approvals from other drug regulatory authorities. The HKSAR Government launched the “1+” mechanism on 1 November 2023 and has widen its applicability to all new drugs, including any new drugs and new indications, vaccines and ATPs, with effect from 1 November 2024. With enhanced standards and capacity of drug approval, drugs (including blood products and ATPs) manufactured and registered in Hong Kong can bringing the benefits of good drugs and R&D to Hong Kong patients. The HKSAR can capitalise on the unique advantages of “one country, two systems” and play an important role as a springboard for “going global and attracting foreign investment” for innovative medical technologies.
- (iii) The HKSAR has put in place a clear regulatory framework for ATPs (including gene therapy products, somatic cell therapy products and tissue engineered products). The relevant regulations under the Pharmacy and Poisons Ordinance (Cap. 138) include licensing criteria and conditions, requirements for clinical trials and registration of drugs, contents of labels and record-keeping period, etc. to ensure the drug safety for patients. This not only ensures the safety and efficacy of the products, but also facilitates the R&D and application of local ATPs, thereby attracting more research institutes and enterprises to move in and forming a favourable innovative ecosystem.
- (iv) The HKSAR Government has set up the Preparatory Office for the Hong Kong Centre for Medical Products Regulation (CMPR) under the Department of Health (DH) in June 2024. The Preparatory Office is proactively reviewing the regulatory functions on Chinese and Western medicines and medical devices under the DH, and studying the potential restructuring and strengthening of the current regulatory and approval regimes for medical products and medical technologies. The Preparatory Office will

also put forward proposals and steps for the establishment of the CMPR which will be a step towards the transition to the “primary evaluation” approach in approving applications for registration of new medical products. This will help accelerate the clinical application of new medical products, and foster the development of emerging industries relating to the R&D and testing of medical products. The Preparatory Office is drawing up the timetable for establishing the CMPR and the roadmap towards adoption of “primary evaluation”, which will be announced in the first half of 2025 as planned. The HKSAR Government will also establish the Real-World Study and Application Centre to promote co-operation between Hong Kong and Shenzhen in integrating data generated from the measure of using Hong Kong-registered drugs and medical devices used in Hong Kong public hospitals in GBA to facilitate real-world studies, thereby accelerating approval for registration of new drugs in Hong Kong, the Mainland and overseas.

- (v) The HKSAR Government will further enhance Hong Kong’s clinical trial capability on all fronts and facilitate the translation of innovative medical research results; bring the benefits of good drugs and R&D to Hong Kong patients through health and medical innovation. To this end, the HKSAR Government established the Greater Bay Area International Clinical Trial Institute (GBAICTI) in 2024 to provide a one-stop clinical trial support platform for medical research institutions. The GBAICTI would co-ordinate clinical trial resources in the public and private healthcare sectors in Hong Kong to promote the coordinated development of the Hong Kong and Shenzhen Parks. In 2025, the GBAICTI will collaborate with the Shenzhen Municipal Government to establish the “GBA Clinical Trial Collaboration Platform”, working with the Greater Bay Area International Clinical Trials Center located in the Shenzhen Park to provide consultation, matching, and referral services for medical research organisations conducting clinical trials in Hong Kong and the GBA. This includes co-ordinating the launch of multicentre cross-boundary clinical trials that can meet both national and international standards.

- End -

CONTROLLING OFFICER'S REPLY

HHB134

(Question Serial No. 1827)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

In Programme (2) under Head 140, the provision to subvented sector in 2025-26 is 33.8% lower than the original estimate for 2024-25. In this connection, please advise this Committee:

The list of subvented organisations and the reduction in subvention for each of the organisations.

How will the Government ensure the quality of services delivered by the subvented organisations will not decline with the reduction in provision?

Asked by: Hon LEE Wai-wang, Robert (LegCo internal reference no.: 25)

Reply:

The subvented organisation concerned is the Hong Kong Genome Institute (HKGI). The 2025-26 estimate for the organisation is \$299.2 million, which is \$153.1 million (33.8%) lower than the 2024-25 original estimate.

The HKGI was established in 2020, with more substantial funding required at its initial stage of operation for developing facilities such as sequencers, bioinformatics platforms, and other infrastructure to implement the Hong Kong Genome Project. With the project gradually on track, the fixed cost needed for acquisition of additional facilities has proportionally reduced and the budget reduction will not affect the standard of the HKGI's work in maintaining and implementing services related to its genomic project. As a matter of fact, the corporate governance structure of the HKGI comprises a board of directors and several functional committees, comprising representatives from the Government, experts in various fields as well as representatives from patient groups. They will continue to oversee the HKGI's operation to ensure the proper use and disbursement of government funds.

- End -

CONTROLLING OFFICER'S REPLY**HHB135****(Question Serial No. 1828)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (3) Subvention: Hospital AuthorityControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

Under Programme (3) of Head 140, it is stated that the number of full-time staff classified as “Others” exceeds 46 000, which is higher than the total number of nursing staff and doctors, approximately 38 000. In this connection, will the Government inform this Committee of the following:

What types of staff are included in the “Others” category and what are the numbers under each category?

Can the Hospital Authority downsize the number of administrative staff other than healthcare personnel by making good use of technology? Will a target be set for downsizing of manpower?

Asked by: Hon LEE Wai-wang, Robert (LegCo internal reference no.: 26)

Reply:

Staff in the “Others” group include “management/administrative staff”, “care-related support staff” and “other supporting staff”.

The table below sets out the number of staff calculated on a full-time equivalent basis in the Hospital Authority (HA) (by staff group) in 2024-25 (as at 31 December 2024) ⁽¹⁾.

Staff group	2024-25 (as at 31 December 2024) ⁽²⁾
Doctors ⁽³⁾	7 726
Nurses ⁽⁴⁾	29 538
Allied health professionals ⁽⁵⁾	9 886
Management/administrative staff ⁽⁶⁾	4 196
Care-related support staff ⁽⁷⁾	18 838
Other supporting staff ⁽⁸⁾	23 514
Total	93 698

Note:

1. The manpower figures are calculated on a full-time equivalent basis including permanent, contract and temporary staff in the HA. Individual figures may not add up to the total due to rounding.
2. Starting from January 2024, the full-time equivalent for all temporary part-time staff is calculated on the basis of their actual working hours. Information of the previous years, if provided, is for reference only and direct comparison with the data under the revised compilation method is not appropriate.
3. The “doctors” group includes Consultants, Senior Medical Officers/Associate Consultants, Medical Officers/Residents, Interns and Dental Officers.
4. The manpower figure of the “nurses” group includes that of Senior Nursing Officers, Department Operations Managers, Nurse Consultants, Associate Nurse Consultants, Ward Managers, Nursing Officers, Advanced Practice Nurses, Registered Nurses, Enrolled Nurses, Nursing Trainees, etc.
5. The “allied health professionals” group includes Radiographers, Medical Technologists/Medical Laboratory Technicians, Occupational Therapists, Physiotherapists, Pharmacists, Medical Social Workers, etc.
6. The “management/administrative staff” group includes Chief Executives, Cluster Chief Managers, Directors, Hospital Administrators, Information Officers, Finance Managers, Legal Officers, Supplies Officers, Statisticians, Systems Managers, etc.
7. “Care-related support staff” include Health Care Assistants, Ward Attendants, Patient Care Assistants, etc.
8. “Other supporting staff” include Clerks, Personal Secretaries, Workers, Operation Assistants, Executive Assistants, etc.

The HA has been actively making good use of technology in recent years to develop Smart Hospitals, in order to strengthen support for frontline healthcare staff and enhance the efficiency of hospital management and administrative support, with a view to achieving sustainable development. Key measures include:

1. Enhancing operational efficiency of hospitals
 - (a) utilising various types of robots to promote automation and enhance effectiveness in daily operation, with services areas covering logistics, cleansing, warehouse management, etc.;
 - (b) establishing a digital platform for administrative management of wards to enhance the effectiveness of routine administrative work on wards and staff communication; and
 - (c) adopting a real-time location tracking system to enhance bed management.
2. Enhancing the efficiency of hospital resource allocation
 - (a) launching Hospital Command Centres for coordination of hospital beds, support staff and information on patients’ condition to enhance operational efficiency of hospitals; and
 - (b) launching an array of digitalisation and automation tools such as digital signatures and software robots to promote paperless and automated management in hospitals.

3. Enhancing work efficiency of staff

- (a) promoting digital workplace by launching digital platforms for staff communication such as an HA messaging platform, chatbots and a platform for virtual meetings, covering more than 99.9% of full-time staff to enhance effectiveness of staff communication;
- (b) enhancing the staff self-service platform by integrating personnel, financial, welfare and training services on a single mobile platform to elevate staff experience and bring about greater convenience for them; and
- (c) promoting digital transformation in human resources by digitalising and automating various human resource workflows and introducing artificial intelligence technologies to reduce manual operation and enhance effectiveness.

The HA will continue to closely monitor its manpower situation and operational needs, improving operational workflows and streamlining procedures through utilising advanced technologies with a view to allocating human resources in a more appropriate manner and putting them to optimal use, thereby enhancing the overall efficiency and effectiveness in support of the HA's service demand and development.

- End -

CONTROLLING OFFICER'S REPLY

HHB136

(Question Serial No. 2093)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Government has launched the Healthy Mind Pilot Project (the Pilot Project) at 3 District Health Centres (DHCs)/District Health Centre Expresses (DHCEs) since August 2024 to offer free initial mental health assessments to members of the public on a trial basis at the community level. Please advise this Committee of the following:

1. What are the respective numbers of members of the public having received initial mental health assessments under the first phase of the Pilot Project at the 3 DHCs since its implementation? Please provide a breakdown by districts.
2. What are the respective numbers of the aforementioned participants having received initial mental health assessments at each of the 3 DHCs who are in the age group between 18 and 39?
3. What is the number of the aforementioned participants subject to further assessments following initial mental health assessments?
4. Despite the fact that the mental health of students and adolescents has been a matter of grave concern in recent years, only members aged 18 or above receiving health risk assessments are eligible to take the preliminary mental health questionnaire assessments under the current Pilot Project. Currently, what are the recommended follow-up actions to be taken by the DHCs if parents wish their children aged under 18 to receive initial mental health assessments there? Are there any plans for children aged under 18 to receive such initial mental health assessments? If yes, what are the details? If no, what are the reasons?
5. What will be the estimated expenses for and anticipated number of beneficiaries of the Pilot Project for 2025-26?
6. What will be the specific plans and estimated expenses for the continued implementation of the mental health promotion and public education initiatives?

Asked by: Hon LEUNG Hei, Edward (LegCo internal reference no.: 16)

Reply:

(1) to (3) and (5)

The Government launched the “Healthy Mind Pilot Project” (the Pilot Project) in August 2024 at Tuen Mun District Health Centre (DHC), Yau Tsim Mong District Health Centre Express (DHCE) and Eastern DHCE to provide free initial mental health assessments to members of the public at the community level on a trial basis, with the aim of achieving the objective of “early detection and early intervention” of primary healthcare development, and providing more appropriate support for persons in need. As of 1 March 2025, the above 3 designated DHC/DHCEs have completed health assessments for approximately 17 000 members of the public, and simultaneously conducted preliminary mental health assessments for them under the Pilot Project. Among these participants, around 1 000 (approximately 6% of the total) of them were recommended for follow-up by collaborative service providers (“service providers”) in the same district under the Pilot Project, including further health emotional assessments. If necessary, the service providers will provide low-intensity psychological therapy or advise the persons concerned to consult the Integrated Community Centres for Mental Wellness or to receive multi-disciplinary support services in the community for more comprehensive and professional care and support. Additionally, the follow-up services of the Pilot Project also cover individuals who are directly assessed by the service providers as having mental health needs during the outreach activities. The whole project is expected to provide required follow-up services for at least 5 500 people. The time-limited recurrent expenditure for 2025-26 is about \$4.8 million.

(4)

The DHCs provide basic health risk assessments, with the aim of identifying and dealing with health risk factors at an early stage. If members of the public (including children and adolescents) are found to have emotional problems, nurses and social workers at the DHCs will provide them with health consultations and counselling services. Additionally, the DHCs serve as hubs for primary healthcare in the districts to work with other community partners providing primary healthcare services and co-ordinate referral and support services, including mental health support, for members of the public in need.

(6)

On mental health promotion and public education, the Government has earmarked an annual recurrent funding of \$50 million for the implementation of the “Shall We Talk” mental health promotion and public education initiative (the Initiative). Launched in July 2020 with the support of the Advisory Committee on Mental Health, the Initiative aims to step up public engagement in promoting mental well-being; to enhance public awareness of mental health with a view to encouraging help-seeking and early intervention; and to reduce stigma towards people with mental health needs. The Initiative continues to make use of both offline channels and emerging online platforms to reach out to people from all walks of life, which include: (a) launching a one-stop mental health thematic website (shallwetalk.hk) to provide one-stop information and resources on mental health to the public and broadcasting videos on social media platforms, featuring the sharing of personal experiences and feelings by various stakeholders (including artists and key opinion leaders) to encourage the public to recognise mental health issues; (b) implementing the “Mental Health Workplace Charter” (the Charter) to promote mental well-being at workplace. Additionally, as announced in the Chief

Executive's 2024 Policy Address, an annual promotional theme will be set for the Charter and recognition will be given to participating organisations for achieving targets; (c) broadcasting promotional videos on the television, radio and other media; and (d) organising tours in different districts, as well as primary schools, secondary schools, and tertiary institutions to promote mental health messages.

- End -

CONTROLLING OFFICER'S REPLY

HHB137

(Question Serial No. 2095)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Hospital Authority (HA), funded by the Government, has made good use of the facilities at the “Central Government-Aided Emergency Hospital” in the Lok Ma Chau Loop since April 2023 to enhance diagnostic and other services. In this connection, will the Government inform this Committee of the following:

1. How many clusters of the HA have used the Emergency Hospital, and how many patient-oriented services are provided? What is the number of attendance at the hospital since the introduction of the scheme in April 2023? (Please list by programme)
2. What is the daily number of HA staff stationed and working at the hospital? Do the staff working at the hospital receive additional allowance?
3. Will the Government plan to ask the HA to further expand the utilisation of the Emergency Hospital in order to shorten patients' waiting time?
4. What is the annual operational cost of the shuttle service for transporting patients to the Emergency Hospital in each cluster under the HA? Which department will absorb the cost involved?

Asked by: Hon LEUNG Hei, Edward (LegCo internal reference no.: 18)

Reply:

(1)

Located in the Lok Ma Chau Loop, the Central Government-Aided Emergency Hospital (CGAEH) was commissioned by the Central Government under the fifth wave of the COVID-19 epidemic in Hong Kong and handed over to the SAR Government on 30 December 2022 for operation and management. With the resumption of normalcy in Hong Kong, the Government handed CGAEH over to the Hospital Authority (HA) for planning of ambulatory services, with the New Territories East (NTE) Cluster being responsible for its management and operation, so as to make good use of resources gifted to Hong Kong by the Central

Government. The Government and HA will continue to optimise the use of the resources and make relevant arrangements having regard to the progress and needs of the development of the Loop. The HA launched the Ambulatory Diagnostic Radiology Service Pilot Programme (Pilot Programme) in April 2023 to provide Computed Tomography (CT), Magnetic Resonance Imaging (MRI), and subsequently ultrasonography services. To optimise the use of healthcare facilities in CGAEH, the HA also started to provide other services in the hospital in the past year or so, including endoscopy, sleep study, microbiological laboratory and serum 25-hydroxyvitamin D analysis. All clusters of the HA will invite patients with suitable clinical conditions to receive day hospital services at CGAEH, and patients can choose whether to use the services.

The table below sets out the number of attendances for the services currently provided by CGAEH as at February 2025:

Service	Number of attendances (April 2023 to February 2025)
CT	28 232
MRI	5 850
Ultrasonography	6 632
Microbiological laboratory	104 645
Endoscopy	4 637
Sleep study	3 512
Serum 25-hydroxy vitamin D analysis	6 723

(2)

At present, there are about 60 HA staff members working in CGAEH each day. Frontline staff responsible for day-to-day operation may apply for the “Special Allowance for Designated Settings”. The rate of daily allowance is 20% of the basic daily wage or \$500 per day, whichever is higher.

(3)

CGAEH currently provides CT, MRI, ultrasonography, microbiological laboratory, endoscopy, sleep study and serum 25-hydroxy vitamin D analysis services, and is preparing to commence intravitreal injection service in the hospital. The HA will continue to explore ways to make good use of CGAEH’s facilities with a view to providing more healthcare services for the public.

(4)

CGAEH provides free shuttle service for patients travelling between Sheung Shui, Yuen Long and Siu Hong MTR stations and the hospital. At present, the monthly number of shuttle bus passengers exceeds 10 000. Based on the current number of passengers, it is estimated that the average cost per passenger is about \$56. The operating costs incurred are absorbed by the NTEC’s operating expenses.

- End -

CONTROLLING OFFICER'S REPLY**HHB138****(Question Serial No. 2117)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (2) HealthControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

Regarding the implementation of Voluntary Health Insurance Scheme (VHIS), please advise this Committee on the following:

1. What is the number of policies currently in force? Please provide a breakdown by age groups and sum assured.
2. What are the VHIS claims ratios and average claims amounts over the past 3 years to date?
3. Please list the top 10 insurance companies with the highest market share and insurance premiums.
4. Has the Government undertaken any statistical works and studies regarding the ratios of policyholders who ultimately used private hospitals for related claims, and the extent to which it helps to alleviate pressure on public hospitals? If yes, what are the details; if not, the reasons?
5. Has the Government conducted any regular inspections and reviews of the underwriting and solvency of the relevant insurance companies, and followed up on rejected claims? If yes, what are the details; if not, the reasons?

Asked by: Hon LEUNG Hei, Edward (LegCo internal reference no.: 129)

Reply:

1. As at 31 March 2024, the number of the Voluntary Health Insurance Scheme (VHIS) policies reached 1 341 000. The breakdown by the age of insured persons is as follows:

Age of insured persons	Number of VHIS policies *
0 – 9	129 000
10 – 19	122 000
20 – 29	179 000
30 – 39	278 000
40 – 49	263 000
50 – 59	212 000
60 or above	157 000
Total	1 341 000

* Breakdown figures may not add up to the total due to rounding.

“Sum assured” is common in critical illness insurance products, and applies to the one-off lump sum payment received by the insured upon diagnosis of a critical illness. VHIS Certified Plans are individual indemnity hospital insurance products (IHIPs) under which insurance companies cover the insured’s medical expenses on a reimbursement basis, and therefore no sum assured is involved.

2. According to the latest statistics, the success rates of VHIS insurance claims and the average claims amounts for the past 3 years were as follows:

	2021	2022	2023
Success rate of claims	93%	92%	93%
Average claims amount	\$22,000	\$24,000	\$23,000

Note: Insurance companies provide the figures on claim cases by calendar year (as at 31 December of each year), and thus the Health Bureau (HHB) does not have the relevant statistics by financial year. Successful claim cases include cases receiving full reimbursement and those receiving partial reimbursement.

3. As market shares of different insurance companies are sensitive commercial data which may affect market operation, it is inappropriate to make disclosure on the premise that no significant public interest is involved. The HHB is unable to provide such data accordingly.
4. The VHIS has been fully implemented since April 2019, aiming to provide the general public with a choice of individual IHIPs which are subject to specific regulation and of high market transparency. It offers consumers with greater confidence in purchasing health insurance and using private healthcare services when in need, thereby alleviating pressure on public healthcare system in the long run.

Since the full implementation of the VHIS, the number of policies under the scheme has been increasing. That said, the period is still relatively short and affected by the 3-year long COVID-19 epidemic, during which the use of private healthcare services by Hong Kong citizens was significantly impacted. More time is thus needed to objectively review and assess the effectiveness of the scheme. The Government believes that the VHIS will become the mainstream standard for the individual IHIP market in the long run and boost citizens’ confidence in purchasing VHIS products and choosing private healthcare services when in need, thereby reducing the burden on the public healthcare system.

Based on the latest statistics, in 2023 (when society gradually returned to normalcy as the epidemic subsided) about 39% of successful claims under VHIS Certified Plans involved services provided by local private hospitals, while the majority of the remaining claims involved services of other local private healthcare institutions (such as day procedure centres, clinics, etc.).

5. The VHIS Office is responsible for implementing the VHIS. Its duties include registration of the participating insurance companies, vetting of insurance products for certification of compliance status, executing regulatory and promotional work, as well as handling of public enquiries and complaints, etc.

As the regulator of the insurance industry, the Insurance Authority monitors and examines the financial position of insurance companies to ensure their financial soundness and safeguard the interests of policy holders.

- End -

CONTROLLING OFFICER'S REPLY**HHB139****(Question Serial No. 3197)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (3) Subvention: Hospital AuthorityControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

It is mentioned in Matters Requiring Special Attention in 2025-26 that the Hospital Authority will open a total of around 330 additional hospital beds to meet the growing demand. In this connection, will the Government inform this Committee of:

1. the number of general beds and their growth rate by hospital cluster in the past 3 years;
2. the number of beds in the specialist wards (for mentally ill, mentally handicapped and infirmary services) of public hospitals by hospital cluster in the past 3 years;
3. the growth rate of beds in the specialist wards (for mentally ill, mentally handicapped and infirmary services) of public hospitals by hospital cluster in the past 3 years; and
4. the details of the allocation of a total of around 330 additional hospital beds in 2025-26 by hospital cluster?

Asked by: Hon LEUNG Hei, Edward (LegCo internal reference no.: 154)Reply:

(1) to (3)

The tables below set out the number of hospital beds by general (acute and convalescent), infirmary, mentally ill and mentally handicapped services in each hospital cluster under the Hospital Authority (HA) in 2022-23, 2023-24 and 2024-25 (up to 31 December 2024):

2022-23

Hospital cluster	Number of hospital beds [#]			
	General (acute and convalescent)	Infirmary	Mentally ill	Mentally handicapped*
HKEC	2 283	627	400	N/A
HKWC	2 797	200	82	N/A
KCC	5 353	250	465	N/A
KEC	2 844	76	80	N/A

Hospital cluster	Number of hospital beds [#]			
	General (acute and convalescent)	Infirmary	Mentally ill	Mentally handicapped*
KWC	3 753	196	920	155
NTEC	4 167	477	552	N/A
NTWC	3 060	135	1 176	520
HA Overall	24 257	1 961	3 675	675

Hospital beds as at 31 March 2023

* Mentally handicapped beds are provided in KWC and NTWC only.

2023-24

Hospital cluster	Number of hospital beds [#]			
	General (acute and convalescent) [@]	Infirmary	Mentally ill [@]	Mentally handicapped*
HKEC	2 309 (+26)	627	400	N/A
HKWC	2 797	200	82	N/A
KCC	5 361 (+8)	250	465	N/A
KEC	2 854 (+10)	76	80	N/A
KWC	3 753	196	955 (+35)	155
NTEC	4 183 (+16)	477	552	N/A
NTWC	3 068 (+8)	135	1 176	520
HA Overall	24 325 (+68)	1 961	3 710 (+35)	675

Hospital beds as at 31 March 2024

* Mentally handicapped beds are provided in KWC and NTWC only.

@ Figures in brackets represent the change compared to the number of hospital beds in the previous year.

2024-25 (up to 31 December 2024)

Hospital cluster	Number of hospital beds [^]			
	General (acute and convalescent) [@]	Infirmary	Mentally ill	Mentally handicapped*
HKEC	2 309	627	400	N/A
HKWC	2 797	200	82	N/A
KCC	5 378 (+17)	250	465	N/A
KEC	2 876 (+22)	76	80	N/A
KWC	3 776 (+23)	196	955	155
NTEC	4 237 (+54)	477	552	N/A
NTWC	3 097 (+29)	135	1 176	520
HA Overall	24 470 (+145)	1 961	3 710	675

[^] The number of hospital beds as at 31 December 2024, which does not reflect the 8 additional general beds in KWC planned for the first quarter of 2025.

* Mentally handicapped beds are provided in KWC and NTWC only.

@ Figures in brackets compare the number of hospital beds as at 31 March 2024 with that as at 31 December 2024.

Note:

In the HA, day in-patients (DPs) refer to those who are admitted into hospitals for non-emergency treatment and who are discharged within the same day, while in-patients (IPs) refer to those who are admitted into hospitals via the Accident & Emergency departments or those who have stayed for more than 1 day. The calculation of the number of hospital beds includes that of both IPs and DPs.

(4)

The HA plans to provide additional hospital beds in 2025-26 as set out in the table below:

Hospital cluster	Planned number of additional hospital beds in 2025-26
HKEC	4
HKWC	16
KCC	84
KEC	77
KWC	52*
NTEC	65
NTWC	44
HA Overall	342

* Includes the reorganisation of the existing space at Yan Chai Hospital to convert 20 beds in inpatient wards into 33 beds in day wards, thereby increasing the number of hospital beds by 13.

Abbreviations

HKEC – Hong Kong East Cluster

HKWC – Hong Kong West Cluster

KCC – Kowloon Central Cluster

KEC – Kowloon East Cluster

KWC – Kowloon West Cluster

NTEC – New Territories East Cluster

NTWC – New Territories West Cluster

- End -

CONTROLLING OFFICER'S REPLY**HHB140****(Question Serial No. 1415)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): (171) Health Care Voucher SchemeProgramme: (2) Health, (1) Director of Bureau's OfficeControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

Regarding the Elderly Health Care Voucher Greater Bay Area (GBA) Pilot Scheme (Pilot Scheme) which will be extended to cover 9 cities in the GBA, will the Government inform this Committee:

- (1) of the annual usage rates of health care vouchers since the launch of the Pilot Scheme by age group (65 to 69, 70 to 74, 75 to 79, 80 to 84, and 85 or above);
- (2) of the amount of voucher claim transactions at Mainland medical institutions and the distribution of services used since the launch of the Pilot Scheme; and
- (3) whether it will study the inclusion of more Mainland dental institutions?

Asked by: Hon LEUNG Man-kwong (LegCo internal reference no.: 11)Reply:

(1)

The Government launched the Elderly Health Care Voucher Greater Bay Area Pilot Scheme (Pilot Scheme) in 2024 to extend the coverage of the Elderly Health Care Vouchers (EHCVs) to 7 medical institutions in the Guangdong-Hong Kong-Macao Greater Bay Area (GBA). As at the end of 2024, the number of EHCV claim transactions at the medical institutions under the Pilot Scheme, broken down by age group of the eligible elderly persons receiving such services, is as follows:

Number of EHCV claim transactions under the Pilot Scheme (by age group of elderly persons)						
Age group	65-69	70-74	75-79	80-84	85+	Total
Number of claim transactions	6 014	5 328	2 661	802	663	15 468

(2)

As at the end of 2024, there were a total of 15 468 EHCV claim transactions made at the 7 pilot medical institutions and approximately HK\$19.78 million claimed amount in total. The number of EHCV claim transactions and the amount of EHCVs claimed by each pilot medical institution, broken down by service type are set out in the table below:

Pilot medical institution	Preventive		Follow-up/ Monitoring of chronic disease		Treating acute episodic condition		Rehabilitation		Total	
	Number of claims	Amount claimed (HK\$'000)	Number of claims	Amount claimed (HK\$'000)	Number of claims	Amount claimed (HK\$'000)	Number of claims	Amount claimed (HK\$'000)	Number of claims	Amount claimed (HK\$'000)
The First Affiliated Hospital, Sun Yat-sen University (From 28 June 2024)	158	191	1 254	103	305	500	148	137	1 865	931
Zhongshan Chen Xinghai Hospital of Integrated Traditional Chinese and Western Medicine (From 18 July 2024)	289	305	969	125	505	450	289	115	2 052	995
Shenzhen New Frontier United Family Hospital (From 14 August 2024)	572	762	599	269	229	562	2	1	1 402	1,594
Nansha Division of the First Affiliated Hospital, Sun Yat-sen University (From 6 September 2024) Note: Department of Stomatology yet to commence operation	17	24	188	13	33	56	8	2	246	95
Dongguan Tungwah Hospital (From 6 September 2024)	313	221	335	45	125	174	17	11	790	451
Shenzhen C.K.J. Stomatological Hospital (From 14 August 2024)	2 266	362	4 180	200	87	7,082	2 370	7,620	8 903	15,264
Dental Bauhinia Specialty Service Center (Shenzhen)/ Dental Bauhinia General Care Center (Shenzhen) (From 14 August 2024)	69	65	93	56	17	199	31	132	210	452

(3)

The Government launched the Pilot Scheme in 2024 to extend the coverage of EHCVs to suitable medical institutions in the GBA. As at September 2024, the coverage of EHCVs has been extended to 7 medical institutions in the GBA, including 5 medical institutions providing integrated services (all of which provide dental services) and 2 dental institutions (located near the Lo Wu and Futian Control Points respectively). Together with the 2 existing service points operated by the University of Hong Kong-Shenzhen Hospital (with dental services as well), eligible elderly persons can use their EHCVs to pay for outpatient healthcare services provided by the designated departments (including the Department of Stomatology) at 9 service points in the GBA, located at Guangzhou, Zhongshan, Dongguan and Shenzhen.

The local community has responded very positively to the Pilot Scheme upon its launch. Elderly beneficiaries opine that the additional service points in the GBA have greatly enhanced their convenience and provided them with more options of medical treatment. The Chief Executive's 2024 Policy Address announced the extension of the Pilot Scheme to cover

the 9 Mainland cities in the GBA. The Health Bureau and the Department of Health are actively taking forward the related work. The initial plan is to commence the relevant arrangements under the Pilot Scheme at the locations concerned by the 4th quarter of 2025. The medical institutions providing integrated services included under the Pilot Scheme also provide dental services.

The Chief Executive announced in the 2022 Policy Address to establish the Working Group on Oral Health and Dental Care (Working Group) to review the existing services and advise the Government on enhancing the service scope and delivery mode. The Working Group released its final report in December 2024.

The Working Group recognised the suggestions in the community on purchasing dental services from the Mainland or providing subsidies to citizens to access such services, and considered that the Government should bear the responsibility of protecting Hong Kong citizens' health by providing quality local healthcare services, rather than simply transferring the responsibility to the Mainland healthcare system. Hong Kong's private sector and non-governmental organisations should remain the most accessible service channels for citizens. The Working Group recommended the Government to focus on meeting citizens' dental service needs through the local healthcare system, by investing resources in promoting dental professional development, and work in close rapport with the sector to advance and strengthen the status and services of the local dental profession. Meanwhile, the Working Group agreed that the Pilot Scheme could provide the elderly with additional choices.

- End -

CONTROLLING OFFICER'S REPLY

HHB141

(Question Serial No. 1417)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health, (3) Subvention: Hospital Authority, (4) Subvention: Prince Philip Dental Hospital

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the manpower problem in dental services, will the Government inform this Committee of:

- (1) the establishment, vacancies and wastage rates of the Dental Officer grade and other dental care services personnel in the Government in the past 3 years;
- (2) the number of graduates of recognised dentistry programmes offered by local institutions for the past 3 years, and the ratio between those graduates practising in the public and the private sectors; and
- (3) the number of applications received by the Government so far in respect of the recruitment of non-locally trained dentists; the number of which having been offered employment or granted a conditional offer; and when the first batch of non-locally trained dentists will be expected to commence service?

Asked by: Hon LEUNG Man-kwong (LegCo internal reference no.: 13)

Reply:

(1)

The establishment, actual strength, vacancies and wastage rates of the Dental Officer grade and other dental care services personnel in the Department of Health (DH) are set out in the **Annex**.

(2)

The table below shows the number of graduates from the dentistry programmes funded by the University Grants Committee by level of study from the 2021/22 to 2023/24 academic years (AYs):

Level of study	Number of graduates		
	2021/22 AY	2022/23 AY	2023/24 AY
Undergraduate programme	75	69	73
Taught postgraduate programme ^{Note}	22	16	20
Total	97	85	93

Note: The taught postgraduate programme is designed for the training of specialist dentists.

The table below shows the total number of dentists registered with the Dental Council of Hong Kong (DCHK) by the General Register and the Specialist Register in the past 3 years:

Year	Number of dentists whose names are included in the General Register			Number of dentists whose names are included in the Specialist Register ^{Note}
	Resident in Hong Kong (a)	Resident outside Hong Kong (b)	Total (a) + (b)	
2022	2 506	280	2 786	311
2023	2 572	304	2 876	310
2024	2 620	322	2 942	311

Note: Given that the dentists on the Specialist Register are also included in the General Register, the number of dentists in the General Register covers the number of dentists in the Specialist Register.

According to the 2018 Health Manpower Survey on Dentists conducted by the DH, 73.8% of the active dentists were working in the private sector, while the remaining 26.2% were working in the Government, the subvented sector, the academic sector and the Hospital Authority (HA) respectively. Based on the unofficial statistics from the Faculty of Dentistry of the University of Hong Kong (HKU), the estimated ratio of the number of its graduates working in the public sector to those working in the private sector in the past 3 years is as follows:

AY	2021/22	2022/23	2023/24
Employment ratio between private and public sectors	91% / 9%	93% / 7%	43% / 57%

(3)

The Dentists Registration (Amendment) Bill 2024, which was passed by the Legislative Council in July 2024, took effect on 1 January 2025. The amendment aims to introduce new pathways to admit qualified non-locally trained dentists, including limited registration (LR) which is open to all dentists and special registration (SR) targeting specialist dentists. Non-locally trained dentists who are selected for full-time employment in specified institutions, including the DH, the HA, the HKU and the Prince Philip Dental Hospital (PPDH), may apply to the DCHK for LR or SR and, upon approval, directly practise in the aforementioned specified institutions. In addition to the aforementioned 4 specified institutions, in February 2025, 34 non-governmental organisations participating in designated publicly-funded dental

programmes and 1 training institution for dental care professionals have been further included under the Dentists Registration Ordinance (DRO).

The DH launched a recruitment exercise for full-time Contract Dentists (General Dentistry) from July to September 2024 and accepted applications from both locally trained and non-locally trained dentists. In addition to disseminating information on its website for access from around the world, the DH conducted promotion in different regions through offices outside Hong Kong. At the same time, the relevant information was disseminated to dental training institutions and dentists organisations outside Hong Kong. Online briefing sessions were held to introduce the job opportunities offered by the DH to interested parties in the Mainland and overseas. Over 90 applications in total from non-locally trained dentists were received during the period.

As at 28 February 2025, the DH issued conditional offers to 11 non-locally trained dentist applicants who have been assessed to be suitable for appointment. They will join the DH upon completion of their applications to the DCHK and issuance of LR or SR. Among these 11 appointed non-locally trained dentists, 3 of them have applied to the DCHK for LR and their applications have been approved. They assumed duty on 10 March 2025. The countries/places where the 3 applicants obtained their dentistry qualifications are China (including the Mainland, the Macao Special Administrative Region and Taiwan region) (2 applicants) and the United Kingdom (1 applicant).

**Establishment, actual strength, vacancies and wastage rates of Dental Officer grade
and other dental care services personnel in the DH**

Grade	2022-23				2023-24				2024-25			
									(As at 1 February 2025)			
	Establishment	Actual strength	Vacancies	Wastage Rate (%) ^{Note 1}	Establishment	Actual strength	Vacancies	Wastage Rate (%) ^{Note 1}	Establishment	Actual strength	Vacancies	Wastage Rate (%) ^{Note 1}
Dental Officer	370	294	76	12.9%	370	268	102	13.1%	372	290	82	8.3%
Dental Hygienist	14	9	5	11.1%	14	8	6	12.5%	24	12	12	0%
Dental Surgery Assistant	366	343	23	7.3%	366	342	24	7.3%	397	337	60	4.5%
Dental Technician	47	47	0	6.4%	47	45	2	4.4%	47	42	5	7.1%
Dental Therapist	298	240	58	9.2%	298	236	62	5.9%	298	235	63	6.8%

^{Note 1} The wastage rate is calculated by dividing the number of wastage by the actual strength on the end date of the financial year or as at 1 February 2025.

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CONTROLLING OFFICER'S REPLY

HHB142

(Question Serial No. 1418)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority, (1) Director of Bureau's Office

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

(1) It was mentioned in the Budget that \$15 million would be allocated to provide an online youth emotional support platform. When is the platform anticipated to be commissioned for service? Will it provide support services around the clock? What will the Government do to ensure quality service delivery?

(2) What have been the numbers of attendances by those aged 18 or below in the psychiatric departments in all clusters under the Hospital Authority (HA) over the past 3 years? What is their age distribution?

(3) How many young people were referred to the psychiatric departments of the HA under the "Three-tier Emergency Mechanism" last year? What was the waiting time for services?

(4) What is the number of patients aged 18 or below who have been hospitalised due to severe mental illness? What is the number of severe mental patients who have used the services provided by the HA including those related to outpatient consultation and outreach support?

Asked by: Hon LEUNG Man-kwong (LegCo internal reference no.: 14)

Reply:

(1)

The Social Welfare Department (SWD) has set up 5 Cyber Youth Support Teams (CYSTs) to proactively search and approach at-risk and hidden youth through online platforms commonly used by young people, and provide those in need (including those who are emotionally unstable and have suicidal thoughts) with timely intervention, support and counselling services through online and offline modes. The SWD will enhance the services of the CYSTs in the second quarter of 2025 by setting up an online support platform for emotional wellness of young people to provide real-time online counselling service, among others, so that they can receive support anytime and anywhere. Subvented welfare service operators (the Operators) have to comply with the requirements and standards stipulated in their respective Funding and Service Agreements (FSAs), including the essential service requirements, output and outcome standards, as well as service quality standards. The Operators are required to put in place an effective internal monitoring mechanism to properly monitor and manage their day-to-day operation, so as to meet the requirements of the FSAs. The SWD reviews the operation of various services and monitor the performance of the

service units in accordance with existing mechanisms. It also conducts scheduled or surprise visits at random to assess whether the Operators comply with the terms and requirements of the FSAs.

(2)

The table below sets out the numbers of psychiatric patients aged below 18 receiving treatment in the Hospital Authority (HA) by hospital cluster and age group (below 18) from 2022-23 to 2024-25 (projection as of 31 December 2024).

Year	Age group ³	Number of psychiatric patients aged below 18 ^{1,2,5}	Hospital cluster						
			HKEC ²	HKWC ²	KCC ²	KEC ²	KWC ²	NTEC ²	NTWC ²
2022-23	0 - 5	3 660	140	190	110	380	860	1 230	780
	6 - 11	20 610	540	3 410	270	3 020	5 510	4 770	3 250
	12 - 17	20 830	460	3 700	510	3 380	5 830	4 120	3 200
	Total⁴	45 100	1 140	7 300	880	6 780	12 200	10 120	7 230
2023-24	0 - 5	4 430	220	130	240	470	890	1 210	1 280
	6 - 11	21 470	920	3 200	530	3 140	5 650	4 790	3 380
	12 - 17	22 540	690	3 640	750	3 620	6 320	4 490	3 420
	Total⁴	48 440	1 830	6 970	1 510	7 240	12 870	10 490	8 090
2024-25 (Projection as of 31 December 2024)	0 - 5	3 990	150	80	220	470	850	1 220	1 000
	6 - 11	21 770	1 350	2 910	850	3 010	5 410	4 770	3 660
	12 - 17	24 750	930	3 810	960	3 800	6 920	4 890	3 820
	Total⁴	50 510	2 430	6 790	2 030	7 280	13 190	10 870	8 480

Note:

1. Including inpatients, patients at specialist outpatient clinics (SOPCs) and day hospitals.
2. Figures are rounded to the nearest 10.
3. Refer to the age of the patient as of 30 June of the respective year.
4. Individual figures may not add up to the total due to rounding.
5. The figures for each hospital cluster may not add up to the total as patients may be treated in more than one hospital cluster.

(3)

Regarding the third tier of the Emergency Mechanism, school principals may refer high-risk students to receive services at the HA's psychiatric SOPCs. From 1 December 2023 to 31 January 2025, the HA's psychiatric services received a total of 379 referrals from school principals through the "Three-tier Emergency Mechanism", with about 3% of the cases categorised as Priority 1 (urgent) and about 40% Priority 2 (semi-urgent). The remaining cases were either categorised as Routine (stable) or were already being followed up by the HA's psychiatric services.

After undergoing triage and screening, the referred cases which are categorised as urgent and require early treatment will be accorded priority by the HA. The HA has set specific targets in respect of the median waiting time for new cases at its psychiatric SOPCs, with the median

waiting time for Priority 1 (urgent) cases be kept within 1 week and that for Priority 2 (semi-urgent) be kept within 4 weeks.

(4)

The table below sets out the number of psychiatric patients aged below 18 receiving treatment in the HA in 2024-25 (projection as of 31 December 2024) and, among them, the number of those diagnosed with schizophrenia spectrum disorder.

Year	Number of psychiatric patients aged below 18^{1,2,3}	Number of psychiatric patients aged below 18 diagnosed with schizophrenia spectrum disorder^{1,2,3,4}
2024-25 (projection as of 31 December 2024)	50 510	290

Note:

1. Including inpatients, patients at SOPCs and day hospitals.
2. Figures are rounded to the nearest 10.
3. Refer to the age of the patient as of 30 June of the respective year.
4. In the HA, patients with severe mental illness refer to those with schizophrenic spectrum disorder, and do not include severely mentally ill patients diagnosed with other disorders.

Remark:

In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA adjusted its services to cope with the outbreak. This should be taken into consideration when comparing the service capacity of the HA in the years concerned. With the subsiding of local COVID-19 epidemic situation and cessation of anti-epidemic measures in early 2023, the HA has gradually resumed provision of all of its public healthcare services to tie in with the Government's normalcy measures.

Abbreviations

HKEC – Hong Kong East Cluster
HKWC – Hong Kong West Cluster
KCC – Kowloon Central Cluster
KEC – Kowloon East Cluster
KWC – Kowloon West Cluster
NTEC – New Territories East Cluster
NTWC – New Territories West Cluster

- End -

CONTROLLING OFFICER'S REPLY

HHB143

(Question Serial No. 3016)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: Not Specified

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Manpower shortages in Hong Kong's hospitals have been a long-standing concern. The problems arising are particularly exacerbated during the influenza season. The Hospital Authority (HA) launched the "HA Go" application as early as 2019 to promote telehealth, but the penetration rate of this application is far from satisfactory after 5 years, with only 3.35 million downloads to date. Will the Government inform this Committee of the following:

1. What is the number of medical consultations made through this application, and what is the assessment of its effectiveness? Will the HA consider stepping up promotion to encourage wider usage of this application?
2. What factors contribute to the low level of awareness and penetration rate of telehealth? Are there any plans under consideration to streamline usage procedures or provide access to professional guidance? What measures are in place to mitigate digital divide among grassroots elderly?
3. Despite the publication of the Ethical Guidelines on Practice of Telemedicine (Guidelines) in 2019 and Questions and Answers to the Guidelines in 2022, there are numerous problems due to the lack of clear implementation details and standards, such as unclear guidelines regarding prescriptions from "online pharmacies". Will the Government consider refining the relevant legislation to establish clearer guidelines for telehealth?

Asked by: Hon LEUNG Mei-fun, Priscilla (LegCo internal reference no.: 31)

Reply:

The Hospital Authority (HA) has been striving to optimise the use of technology to enhance the service quality and patient experience, and foster the development of telemedicine as an adjunctive measure, with a view to providing more flexible medical solutions for supporting patients with mobility problems or infection control risks in accessing the required services. In general, telehealth services are more suitable for chronic patients who are clinically stable, follow-up patients, and those who do not need to visit hospitals to undergo physical examinations. The HA will arrange medical and nursing services through telehealth, having taken into account the patient's clinical stability, clinical needs, and operational feasibility. Patients can receive consultations and follow-up care from doctors through the "HA Go"

mobile application or other online platforms. Moreover, the HA will provide guidance on telehealth services for patients in need as appropriate to ensure that they are able to use the telehealth platform and relevant equipment successfully.

The HA has progressively implemented telehealth services in suitable services, including different specialist out-patient clinics, nurse clinics, allied health services and outreach services (e.g. those targeting remote rural areas or covering allied health services and psychological counselling, etc.) As at the end of December 2024, there were over 300 000 teleconsultation cases. The attendance of telehealth services in the past 4 years¹ are tabulated below:

<u>Year</u>	<u>Attendance of telehealth services</u>
2021-22	5 111
2022-23	91 645
2023-24	119 581
2024-25 (as at 31 December 2024)	96 885

Note:

1. Since 2021-22, the HA has stepped up efforts in developing telehealth services and gradually compiled statistics of various types of services to facilitate the relevant management. Statistics on or before 2020-21 are incomplete and we are unable to provide the relevant information.

The HA will regularly review the effectiveness of telehealth application, including refining the clinical workflow so as to better meet patient's needs and to optimise cost-effectiveness. In the long run, the Government will explore more opportunities to further develop telehealth with the HA, and evaluate the suitability of arranging telehealth services and efficiency of related healthcare resource allocation. Among other things, when taking forward the primary healthcare and related eHealth system development, we will look into the feasibility of extending telehealth services and means to improve the user experience.

As for the doctor's guidelines, the Medical Council of Hong Kong (MCHK) issued the "Ethical Guidelines on Practice of Telemedicine" (the Guidelines) in December 2019 to ensure that doctors are in compliance with the "Code of Professional Conduct" while providing telemedicine services. The Guidelines cover a wide spectrum of areas, including doctor-patient relationship, protection of patient's privacy, prescription arrangements and retention of medical records. The MCHK issued "Questions and Answers to the Guidelines" in March 2022 for doctors' reference when they provide telemedicine services, such that the professional quality and safety of telemedicine services are guaranteed. In providing telehealth services, the HA will make reference to the relevant guidelines issued by the MCHK. Meanwhile, the Government will continue to closely monitor the development and penetration of telehealth in Hong Kong. In consultation with the industry, the Government will consider taking appropriate measures as necessary to protect patients' interests, and ensure that the telehealth services are safe and reliable.

CONTROLLING OFFICER'S REPLY

HHB144

(Question Serial No. 3046)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

What measures on the mental health front have the Health Bureau and the Labour and Welfare Bureau been implementing to provide appropriate support to people suffering from mental distress in the past 2 years? What were the additional expenditure involved? What measures has the Government been implementing to promote positive psychology and other information about mental health to the public?

Asked by: Hon LEUNG Mei-fun, Priscilla (LegCo internal reference no.: 4)

Reply:

The Government attaches great importance to the mental health of the public, and adopts an integrated approach to promote mental health, providing services that include prevention, early identification, timely intervention, treatment and rehabilitation services for persons in need. Apart from promotion of self-care, primary healthcare and community support, the Government provides specialist and institutionalised services, and also multi-disciplinary and cross-sectoral services to persons with mental health needs through co-ordination and cooperation among the Health Bureau (HHB), the Labour and Welfare Bureau (LWB), the Education Bureau (EDB), the Department of Health, the Social Welfare Department (SWD), the Hospital Authority (HA), non-governmental organisations (NGOs) and other stakeholders in the community.

The Government set up the Advisory Committee on Mental Health (ACMH) in December 2017, with members comprising professionals from the healthcare sector, social service and education sectors, as well as lay persons with concerns over mental health, to advise the Government on mental health policies and assist the Government in formulating policies, strategies and measures to enhance the mental health services on all fronts.

Over the past 2 years, the HHB and the LWB have introduced or planned to introduce a number of mental health-related policy initiatives, which cover enhancing the manpower for mental health services, strengthening the support for specific groups (including students, ethnic minorities and persons in mental recovery), and enhancing mental health support at district level, etc. The key initiatives and related expenditures are as follows:

- (a) The HA enhanced manpower and further optimised the ratio of case manager under the Case Management Programme to patients to no higher than 1:40 in the fourth quarter of 2023. The HA has earmarked additional funding of around \$127 million in 2024-25 to enhance mental health services. Relevant measures include: (i) enhancing the community psychiatric services by further recruiting additional case managers; (ii) strengthening nursing manpower as well as allied health and peer support for psychiatric inpatient and outpatient services; and (iii) enhancing the use of long-acting injectable antipsychotics in the treatment of mental illness. An additional funding of around \$25 million is earmarked in 2025-26 to further enhance the nursing manpower and allied health support for psychiatric inpatient and outpatient services, enhance mental health services for children and adolescents, and strengthen the “Mental Health Direct” hotline service;
- (b) Through cross-departmental collaboration of the HHB, the EDB and the SWD, the Three-Tier School-based Emergency Mechanism was implemented in December 2023 to provide support to students with higher suicidal risks as early as possible. The initiative has been extended to end-2025. A breakdown is not available as the expenditure and manpower involved in the Three-Tier School-based Emergency Mechanism are absorbed by existing resources of the relevant departments;
- (c) The HHB launched the “18111 - Mental Health Support Hotline” in December 2023 to provide one-stop, round-the-clock support for people with mental needs, rendering immediate mental health support and referral services. The time-limited recurrent expenditure for 2023-24, 2024-25 and 2025-26 is about \$9.9 million;
- (d) The HHB set up a service centre dedicated to emotional support and counselling services for ethnic minorities in December 2023, with a multi-professional team comprising social workers, counsellors and support staff conversant in ethnic minority languages, to provide mental health support and counselling services to ethnic minorities and refers cases to other service platforms for additional support and/or treatment if needed. The time-limited recurrent expenditure for 2023-24, 2024-25 and 2025-26 is about \$8.1 million;
- (e) The HHB launched the Healthy Mind Pilot Project in 3 District Health Centres in August 2024 in collaboration with community organisations for those in need, and to provide mental health assessments for the public and ensure early follow-up and referral of high-risk cases, so that the individuals in question can receive support as appropriate in a timely manner. The time-limited recurrent expenditure for 2024-25 and 2025-26 is about \$9.6 million;
- (f) The HHB provided Care Team members with mental health support training (including Mental Health First Aid training) in 2024 to assist in the early referral of persons in need in the local community for support. The time-limited recurrent expenditure for 2024-25 is about \$0.29 million;
- (g) In 2023-24, the SWD increased the manpower of clinical psychologists in 24 Integrated Community Centres for Mental Wellness (ICCMWs) to strengthen professional support and training, and provided additional funding to assist the ICCMWs in enhancing the

application of information technology in service delivery so as to strengthen the support for persons in mental recovery and their carers. The additional annual recurrent expenditure incurred is about \$23 million;

- (h) The SWD enhanced the services of ICCMWs in 2024-25, including strengthening early identification of persons with mental health needs and early intervention, and scaled up the training of social workers in community mental health service units to raise their capacity in handling complicated cases. The annual expenditure incurred is about \$60 million;
- (i) The SWD strengthened peer support services in 2024-25 by creating additional full-time peer supporter positions, including those of senior level and dedicated to carers. The SWD will also set up 4 additional Parents/Relatives Resource Centres for carers of those in mental recovery in the second quarter of 2025 to support persons in mental recovery and their carers. The annual expenditure incurred in these 2 projects is about \$26 million;
- (j) The SWD plans to enhance the services of Cyber Youth Support Teams in the second quarter of 2025 by providing an online support platform for the emotional wellness of young people, which offers real-time online counselling services to students or young people facing emotional distress or at immediate risk. The estimated expenditure for 2025-26 is about \$25.88 million; and
- (k) The SWD plans to set up an additional ICCMW in the first quarter of 2026 to provide one-stop district-based community support services ranging from prevention to risk management. Additionally, the SWD will regularise the Pilot Project on “Transitional Support Service for Persons in Mental Recovery” in the first quarter of 2026 to offer sustained support to persons preparing to be discharged from hospitals while are on the waiting list for halfway house services. The annual expenditure involved in these 2 projects is about \$37 million.

On mental health promotion and public education, the Government has earmarked an annual recurrent funding of \$50 million for the implementation of the “Shall We Talk” mental health promotion and public education initiative. Launched in July 2020 with the support of the ACMH, the initiative aims to step up public engagement in promoting mental well-being; to enhance public awareness of mental health with a view to encouraging help-seeking and early intervention; and to reduce stigma towards people with mental health needs. The initiative continues to make use of both offline channels and emerging online platforms to reach out to people from all walks of life, which includes: (a) launching a one-stop mental health thematic website (shallwetalk.hk) to provide one-stop information and resources on mental health to the public and broadcasting videos on social media platforms, featuring the sharing of personal experiences and feelings by various stakeholders (including artists and key opinion leaders) to encourage the public to recognise mental health issues; (b) implementing the “Mental Health Workplace Charter” (Charter) to promote mental well-being at workplace. Additionally, as announced in the Chief Executive’s 2024 Policy Address, an annual promotional theme will be set for the Charter and recognition will be given to participating organisations for achieving targets; (c) broadcasting promotional videos on the television, the radio and other media; and (d) organising tours in different districts, primary schools, secondary schools, and tertiary institutions to promote mental health messages.

At the same time, the LWB collaborates with NGOs in organising public education programmes to enhance the public's awareness of mental health and disability inclusion, such as the annual "Mental Health Month" programme in support of the "World Mental Health Day". The SWD also subsidises NGOs to set up mobile vans for publicity across the territory to promote mental health in the community.

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CONTROLLING OFFICER'S REPLY

HHB145

(Question Serial No. 3047)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

1. What is the latest progress in setting up District Health Centres (DHCs) and District Health Centre Expresses (DHCEs) in Hong Kong, how many centres are established at permanent sites and rental properties respectively;
2. Regarding those DHCs which have commenced operation or for which operation service contracts have been awarded, what are the staff establishment and expenditure involved for each DHC for the coming year; and
3. Apart from setting up DHCs and DHCEs across the territory, how many resources has the Government allocated to promoting primary healthcare services, what has been done, what progress has been made, and what are the details of the work plan and estimated expenditure for the coming year?

Asked by: Hon LEUNG Mei-fun, Priscilla (LegCo internal reference no.: 5)

Reply:

(1)

The Government set up 7 District Health Centres (DHCs) and 11 smaller interim District Health Centre Expresses (DHCEs) in rented properties across the territory by 2022, thereby attaining the interim goal of covering all 18 districts of Hong Kong. The Government will upgrade the 3 DHCEs in the Central and Western District, Eastern District, and Yau Tsim Mong District to DHCs within 2025. In April 2024, the Health Bureau (HHB) launched a tender exercise for the operation of the Central and Western DHC and 3 women's health service points named Women Wellness Satellites located in Chai Wan, Lam Tin and Tuen Mun. A 3-year operation service contract with a total value of approximately \$531.7 million was subsequently awarded in January 2025. The Central and Western DHC is expected to commence operation in the third quarter of this year. In July 2024, the HHB conducted tender exercises for the operation of the Eastern and Yau Tsim Mong DHCs. The operation service contracts for these 2 DHCs are expected to be awarded this year.

In addition, the funding proposals for the construction projects of Wan Chai, Kwun Tong, Sai Kung and North District DHCs were approved by the Finance Committee of the Legislative Council (LegCo) in January and October 2021, and in April and July 2024 respectively. These projects will be completed gradually in the next few years. To achieve the long-term development goal of having DHCs in all 18 districts as early as possible, the Government is actively taking forward the plan to establish DHCs in the remaining four districts and will seek LegCo's funding approval in due course. Before the remaining DHCs are set up, the Government will continue to subsidise non-governmental organisations to operate DHCEs in those districts. The services provided by DHCEs will be migrated as appropriate to DHCs in respective districts at a later stage. The Primary Healthcare Commission (PHCC) will, together with the operators of DHCEs, draw up and implement transition plans for upgrading DHCEs to DHCs to ensure a smooth transition of services.

(2)

The tentative staff establishment (including healthcare professionals and other supporting staff) of DHCs in Kwai Tsing, Sham Shui Po, Tuen Mun, Wong Tai Sin, Southern, Yuen Long and Tsuen Wan for 2025-26 and their revised estimates (including the provisions for service contracts, site maintenance and rental cost) for 2024-25 are set out in the table below:

	DHC						
	Kwai Tsing	Sham Shui Po	Tuen Mun	Wong Tai Sin	Southern	Yuen Long	Tsuen Wan
Staff establishment ^{Note 1}							
Executive Director	1	1	1	1	1	1	1
Medical Consultant ^{Note 2}	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Chief Care Coordinator	1	1	1	1	1	1	1
Care Coordinator/ Nurse	21	18.5	26	25	16	29	21
Physiotherapist	3.5	2	3	3	3	3	2
Occupational Therapist	1.5	2	2	2	3	3	2
Dietitian	1	1	1	2	1	2	2
Pharmacist	1	1	1	1	1	1	1
Social Worker, Administrative Staff and Supporting Staff	55	69	62	62	59	50	48
Total	85.5	96	97.5	97.5	85.5	90.5	78.5
2024-25 Revised Estimate ^{Note 3} (\$ million)	62	63	80	69	58	73	78

Note:

1. The staff establishment is proposed by DHC operators through tendering procedures according to the service demand in the community and manpower estimation, and is approved by the Government. The 0.5 staff establishment refers to a part-time position with half of the working hours of a full-time position. The actual number of staff may vary from time to time, depending on factors such as service demand and short-term manpower turnover, etc. The Government will continue to monitor the situation to ensure that services are not affected.
2. Medical Consultants are part-time or outsourced positions.
3. The HHB is handling the contract issues of some DHCs and the estimate of expenditure for 2025-26 is therefore not yet available.

The tentative staff establishment (including healthcare professionals and other supporting staff) of all DHCEs for 2025-26 and their revised estimates (including the provisions for service contracts, site maintenance and rental cost) for 2024-25 are set out in the table below:

	DHCE										
	Central and Western	Eastern	Islands	Kowloon City	Kwun Tong	North	Sai Kung	Sha Tin	Tai Po	Wan Chai	Yau Tsim Mong
Staff establishment Notes 4,5											
Project Coordinator	1	1	1	1	1	1	1	1	1	1	1
Medical Consultant Note 6	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Care Coordinator	3	3	3	1	2	1	2	5	5	5	1
Nurse	1	3		5	4	3	4				4
Physiotherapist	1	1	1	1	1	1	1	1	1	1	1
Occupational Therapist					1		1		0.5	1	
Pharmacist	0.5	0.5					1	1		1	
Dietitian				1	1	0.5	1		1		1
Social Worker, Administrative Staff and Supporting Staff	14	15	12	13	15.5	14.5	12	18	14	7.5	14
Total	21	24	17.5	22.5	26	21.5	23.5	26.5	23	17	22.5
2024-25 Revised Estimate Note 7 (\$ million)	15	14	13	14	14	14	14	14	14	15	14

Note:

4. The staff establishment is proposed by DHCEs according to the service demand in the community and manpower estimation, and is reviewed and approved by the Government before entering into contracts with operators. The 0.5 staff establishment refers to a part-time position with half of the working hours of a full-time position. The actual number of staff may vary from time to time, depending on factors such as service demand and short-term manpower turnover, etc. The Government will continue to monitor the situation to ensure that services are not affected.
5. The staff establishment of each DHCE is dependent on the service demand and service delivery model of the district concerned, and so the figures are not directly comparable.
6. Medical Consultants are part-time or outsourced positions.
7. The HHB is handling the contract issues of some DHCEs and the estimate of expenditure for 2025-26 is therefore not yet available.

Upon the upgrading of the 3 DHCEs in Central and Western District, Eastern District and Yau Tsim Mong District to DHCs this year, the 11 existing DHCEs will gradually reduce to 8, while the number of DHCs will increase to 10. The estimated expenditure for DHCs and DHCEs (including provisions for service contracts, site maintenance and rental cost) for 2025-26 are \$1.083 billion and \$213 million respectively.

(3)

The Government released the Primary Healthcare Blueprint (the Blueprint) in December 2022, setting out the development direction and strategies for coping with the challenges brought about by an ageing population and the increasing prevalence of chronic diseases. The Government is progressively taking forward various recommendations of the Blueprint over the short, medium and long term. Initiatives include the launch of the Chronic Disease Co-Care Pilot Scheme (CDCC Pilot Scheme) in November 2023 and the official establishment of the Primary Healthcare Commission (PHCC) on 15 July 2024 to oversee the service supply, standard setting and quality assurance and personnel training related to primary healthcare.

The 2025-26 estimated primary healthcare development expenses is \$2.028 billion. In 2025-26, the Government will continue to take forward the key initiatives in the following areas to promote the development of primary healthcare:

- (a) Consolidating district healthcare service networks, and enhancing cross-sectoral and inter-organisational co-ordination

In addition to developing DHCs/DHCEs, the Government is integrating women and elderly health services under the Department of Health (DH) into district health networks, including the provision of women's primary healthcare services by Women Wellness Satellites, and also plans to start the preparation for the integration of elderly health services in phases in 2025-26, with a view to achieving greater synergy in the provision of services. Meanwhile, the Government is implementing the Healthy Mind Pilot Project at the Tuen Mun DHC, the Yau Tsim Mong DHCE and the Eastern DHCE to provide free mental health support services for the public on a trial basis. The Government is also preparing to roll out the Community Pharmacy Programme in phases starting from the fourth quarter of 2026 to provide drug dispensing and professional pharmacy services to patients of the Hospital Authority and participants of primary healthcare programmes.

(b) Further implementing prevention-oriented primary healthcare services

The PHCC actively promotes the concept of “Family Doctor for All”. Through collaboration between family doctors and primary healthcare professionals, the PHCC provides the public with preventive-oriented and holistic health management, including the formulation of personalised care plans, provision of vaccination services and screening for chronic diseases. In addition, the CDCC Pilot Scheme has been expanded to cover blood lipid testing starting from 28 March 2025 to allow for more comprehensive approach to assessment and proper management of cardiovascular disease risk factors, including the “three highs” (i.e. high blood pressure, high blood sugar and high cholesterol). A new programme will also be rolled out to subsidise risk-based hepatitis B screening for prevention of liver cancer, details of which are expected to be announced in 2025. Besides, the Government is repositioning General Out-patient Clinic services, with a view to prioritising care for the disadvantaged groups, especially low-income families and impoverished elderly, and providing them with comprehensive primary healthcare services.

(c) Strengthening training for primary healthcare professionals

The PHCC plans to incorporate sub-directories for physiotherapists and occupational therapists into the Primary Care Directory in mid-2025 and develop a sub-directory for pharmacists. It will also continue to collaborate with different academic/training institutions to design and provide relevant training for primary healthcare professionals, and explore incentives for attracting healthcare professionals to pursue their careers in primary healthcare.

(d) Setting up an overarching governance structure to formulate service standardisation

The PHCC is assisting the HHB in strengthening the regulatory framework of primary healthcare by empowering PHCC to set up quality assurance and monitoring mechanisms, which include defining primary healthcare service providers, auditing and monitoring the service quality of relevant personnel, setting relevant service standards applicable to private primary healthcare service providers and establishing a quality assurance mechanism, etc.

- End -

CONTROLLING OFFICER'S REPLY

HHB146

(Question Serial No. 1934)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Pilot Scheme for Direct Cross-boundary Ambulance Transfer in the Greater Bay Area was officially launched on 30 November 2024. Please advise on the following:

- (1) How many patients have been benefited so far? What are the relevant details?
- (2) Will the Administration consider expanding the Scheme? If yes, what are the details?

Asked by: Hon LI Sai-wing, Stanley (LegCo internal reference no.: 20)

Reply:

The study on the provision of land-based cross-boundary transfer for non-emergency and non-critically ill patients and the exploration of rolling out a pilot co-operation scheme for cross-boundary referral of patients between designated public hospitals were put forward in the Outline Development Plan for the Guangdong-Hong Kong-Macao Greater Bay Area (GBA). The Chief Executive of the Hong Kong Special Administration Region (SAR) also put forward in the 2023 Policy Address the initiative to explore cross-boundary ambulance transfer arrangements between hospitals in the GBA. With the staunch support and guidance of various national ministries, the Hong Kong SAR Government, in collaboration with the Guangdong Provincial Government, the Shenzhen Municipal Government and the Macao SAR Government, officially launched the one-year Pilot Scheme for Direct Cross-boundary Ambulance Transfer in the GBA (the Pilot Scheme).

The first phase of the Pilot Scheme starts by arranging direct cross-boundary ambulance transfer of patients from designated sending hospitals in Shenzhen and Macao (i.e. the University of Hong Kong - Shenzhen Hospital (HKU-SZH) and the Conde S. Januario Hospital (CHCSJ) of Macao) to designated public hospitals in Hong Kong.

Under the Pilot Scheme, upon assessment and agreement by the teams of designated cross-boundary collaborating hospitals, arrangements can be made for patients with specific clinical needs and suitable clinical conditions to be transferred directly to Hong Kong between designated hospitals in a point-to-point mode without the handover of patients between

ambulances at boundary control points, thus minimising risks posed to patients during transfer.

The direct cross-boundary ambulance transfer arrangement is not an ambulance call service, but a cross-boundary inter-hospital transfer arrangement made by the relevant medical teams according to the medical conditions of individual patients. Hence, the Pilot Scheme has a mechanism in place to avoid abuse while ensuring the safety of cross-boundary transfer. Since medical conditions and needs vary among patients, doctors at the sending hospital will assess, on a case-by-case basis, the need for the patient to have cross-boundary inter-hospital transfer for continuous treatment or recovery services, taking the patient's clinical diagnosis and actual conditions into consideration. The doctors at the sending hospital will communicate with the Major Incident Control Centre of the Hospital Authority (HA) for joint assessment, information exchange and co-ordination with the receiving hospital to decide whether the transfer mechanism should be activated. The sending and receiving hospitals will also ensure that the patient's relatives and/or the patient have given consent to the relevant arrangements and are informed of the risks involved in the transfer.

As at early April 2025, the HA received a total of 10 cases of cross-boundary ambulance transfer, of which 7 were referred by the HKU-SZH and 3 were referred by the CHCSJ of Macao. According to professional medical assessment, the conditions of the patients in the above cases are relatively stable, but are unable to return to Hong Kong on their own and are unsuitable for transfer to Hong Kong ambulances via the existing boundary control points. A patient as referred by HKU-SZH was considered not meeting the criteria for transfer after the joint assessment of the case by the medical teams of the two places, and hence, the mechanism of transfer arrangement was not activated.

The government departments of Guangdong, Hong Kong and Macao will review the effectiveness and operational experience of the Pilot Scheme in a timely manner to consider whether and how to expand the scheme, for example, by including more pilot hospitals and/or extending the scheme to a two-way arrangement.

- End -

CONTROLLING OFFICER'S REPLY**HHB147****(Question Serial No. 1947)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (3) Subvention: Hospital AuthorityControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

1. What are the expenses, the number of consultations, the average waiting time and the longest waiting time in relation to specialist outpatient (SOP) clinics in the past 5 years?
2. Regarding the median waiting time for first appointment at SOPs, the waiting time has increased from less than 1 week to 2 weeks for priority 1 cases, and from 5 weeks to 8 weeks for priority 2 cases. What are the reasons? What are the Government's solutions to shorten the waiting time?

Asked by: Hon LI Sai-wing, Stanley (LegCo internal reference no.: 33)Reply:

1.

The tables below set out the number of specialist out-patient (SOP) new cases triaged as Priority 1 (urgent), Priority 2 (semi-urgent) and Routine (stable) cases, and their respective median (50th percentile) and longest (90th percentile) waiting time in each hospital cluster of the Hospital Authority (HA) from 2020-21 to 2024-25 (up to 31 December 2024).

2020-21

Hospital Cluster	Specialty	Priority 1			Priority 2			Routine Cases		
		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)	
			50th	90th		50th	90th		50th	90th
			percentile			percentile			percentile	
HKEC	ENT	499	<1	<1	2 294	7	7	6 798	31	106
	MED	1 045	1	2	3 617	5	7	9 104	31	106

Hospital Cluster	Specialty	Priority 1			Priority 2			Routine Cases		
		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)	
			50th	90th		50th	90th		50th	90th
			percentile			percentile			percentile	
HKEC	GYN	695	<1	1	438	5	7	3 565	29	41
	OPH	4 449	<1	1	2 062	7	8	6 345	48	76
	ORT	1 240	1	1	1 587	5	7	7 885	51	117
	PAE	108	<1	1	565	3	7	122	8	15
	PSY	250	1	1	993	3	7	2 289	13	34
	SUR	972	1	2	3 477	7	8	9 897	52	75
HKWC	ENT	1 312	<1	1	2 155	6	7	3 299	26	86
	MED	2 437	<1	1	1 731	4	7	13 086	31	115
	GYN	1 236	<1	1	665	5	7	3 870	42	60
	OPH	3 263	1	2	1 461	6	8	4 391	55	60
	ORT	1 199	1	2	1 242	3	7	7 871	20	74
	PAE	105	<1	1	231	3	7	1 130	12	16
	PSY	467	1	1	1 063	4	7	2 041	26	73
	SUR	2 793	<1	2	2 479	4	7	9 569	26	99
KCC	ENT	1 642	<1	1	2 093	4	7	13 259	64	148
	MED	1 452	1	2	3 461	5	7	19 411	77	111
	GYN	987	<1	1	2 568	6	7	7 331	21	37
	OPH	7 269	<1	<1	5 364	3	5	12 328	124	134
	ORT	1 893	<1	1	2 004	4	7	11 165	48	139
	PAE	1 287	<1	1	985	3	6	2 116	9	17
	PSY	395	<1	1	1 213	4	7	1 244	14	34
	SUR	2 964	1	1	5 581	5	8	25 772	34	86
KEC	ENT	1 835	<1	1	2 569	7	8	7 719	84	97
	MED	1 603	1	1	4 784	6	8	18 338	67	149
	GYN	1 398	1	1	841	5	7	5 647	43	94
	OPH	5 233	<1	1	2 662	7	7	9 164	23	129
	ORT	2 969	<1	1	2 885	5	7	9 221	69	115
	PAE	758	<1	1	420	5	7	2 394	10	51
	PSY	253	1	2	2 269	3	7	5 137	46	94
	SUR	1 751	1	1	5 547	7	8	17 087	53	112

Hospital Cluster	Specialty	Priority 1			Priority 2			Routine Cases		
		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)	
			50th	90th		50th	90th		50th	90th
			percentile			percentile			percentile	
KWC	ENT	2 161	<1	1	2 009	5	8	10 841	83	106
	MED	1 670	1	2	5 521	6	8	14 467	84	114
	GYN	270	<1	2	1 528	6	7	7 095	35	63
	OPH	6 157	<1	<1	6 206	1	6	6 133	26	118
	ORT	1 784	1	1	2 605	3	7	11 992	56	103
	PAE	1 185	<1	1	887	3	7	1 915	10	18
	PSY	375	<1	1	1 048	4	7	12 101	16	80
	SUR	2 216	1	2	6 412	6	7	19 718	38	64
NTEC	ENT	3 243	<1	2	4 803	4	8	10 877	69	92
	MED	2 284	<1	1	3 134	6	8	22 322	87	133
	GYN	2 379	<1	1	1 021	5	7	7 979	49	83
	OPH	6 170	<1	1	3 349	4	8	13 152	36	76
	ORT	4 230	<1	1	1 552	5	7	13 722	58	121
	PAE	138	<1	2	328	5	8	2 992	10	26
	PSY	1 145	1	1	2 456	4	7	5 554	52	99
	SUR	2 335	1	2	3 563	5	8	25 113	34	79
NTWC	ENT	3 384	<1	1	1 610	4	7	9 293	40	79
	MED	915	<1	1	3 034	5	7	10 485	77	118
	GYN	1 328	<1	1	317	6	11	4 810	70	73
	OPH	9 487	<1	1	2 651	3	6	7 733	17	65
	ORT	1 816	<1	2	1 795	6	7	11 038	79	97
	PAE	231	<1	1	676	6	7	1 269	21	29
	PSY	492	1	1	1 595	3	7	5 045	33	64
	SUR	2 058	1	2	4 900	6	14	18 659	58	116
Overall HA	ENT	14 076	<1	1	17 533	5	7	62 086	60	102
	MED	11 406	<1	2	25 282	6	7	107 213	68	133
	GYN	8 293	<1	1	7 378	5	7	40 297	35	73
	OPH	42 028	<1	1	23 755	3	7	59 246	55	127
	ORT	15 131	<1	1	13 670	4	7	72 894	57	114
	PAE	3 812	<1	1	4 092	4	7	11 938	11	26
	PSY	3 377	1	1	10 637	3	7	33 411	27	89
	SUR	15 089	1	2	31 959	6	8	125 815	41	84

Hospital Cluster	Specialty	Priority 1			Priority 2			Routine Cases		
		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)	
			50th	90th		50th	90th		50th	90th
			percentile			percentile			percentile	
HKEC	ENT	445	<1	<1	3 249	6	7	5 684	26	99
	MED	1 006	1	2	3 798	5	8	11 449	36	100
	GYN	753	<1	1	579	5	7	3 939	25	32
	OPH	4 613	<1	1	2 488	7	8	7 501	62	90
	ORT	1 206	1	1	1 331	5	7	8 029	59	95
	PAE	69	1	1	770	5	8	295	9	17
	PSY	286	<1	1	912	3	7	2 989	16	45
	SUR	1 104	1	2	3 547	7	8	10 582	52	85
HKWC	ENT	1 240	<1	1	2 132	6	7	3 621	39	72
	MED	2 792	<1	2	1 855	4	7	13 789	49	138
	GYN	1 185	<1	1	765	5	7	4 137	41	54
	OPH	3 136	1	2	1 583	7	8	5 464	62	71
	ORT	1 025	1	2	1 758	4	7	8 093	19	80
	PAE	174	1	2	378	5	8	1 225	13	20
	PSY	386	1	2	827	4	7	2 099	50	83
	SUR	2 995	<1	2	2 900	4	6	10 761	31	103
KCC	ENT	2 225	<1	1	2 161	4	7	12 489	27	116
	MED	1 357	1	2	4 068	5	7	24 269	73	118
	GYN	944	<1	1	2 982	6	7	8 138	33	58
	OPH	6 689	<1	1	6 749	3	7	13 753	79	147
	ORT	1 881	<1	1	1 953	4	7	11 607	53	109
	PAE	1 270	<1	1	1 554	4	7	2 569	9	21
	PSY	284	<1	1	1 096	4	7	1 542	14	46
	SUR	2 884	1	1	5 609	5	12	28 874	43	104
KEC	ENT	1 669	<1	1	2 586	7	8	6 985	68	105
	MED	1 931	1	2	5 516	7	8	20 429	62	120
	GYN	1 603	<1	1	951	4	7	6 028	41	90
	OPH	5 448	<1	1	4 494	7	7	9 628	55	125
	ORT	3 041	<1	1	2 503	3	7	10 128	69	116
	PAE	765	<1	1	512	4	7	3 039	11	50
	PSY	302	1	1	2 452	4	7	5 212	59	97
	SUR	1 701	1	1	5 982	7	8	18 676	50	99

Hospital Cluster	Specialty	Priority 1			Priority 2			Routine Cases		
		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)	
			50th	90th		50th	90th		50th	90th
			percentile			percentile			percentile	
KWC	ENT	2 086	<1	1	2 168	5	8	11 721	94	105
	MED	2 054	1	2	6 292	7	8	16 773	83	114
	GYN	237	<1	1	1 667	6	7	7 975	40	77
	OPH	6 537	<1	<1	7 742	7	22	6 533	125	164
	ORT	1 792	1	2	3 110	4	7	13 254	61	83
	PAE	1 155	<1	1	1 108	4	7	2 724	10	17
	PSY	256	<1	1	794	5	7	13 361	24	90
	SUR	2 189	1	2	6 827	6	8	22 710	48	90
NTEC	ENT	2 876	<1	1	3 651	5	7	11 638	55	101
	MED	2 730	<1	1	3 506	7	8	25 143	79	134
	GYN	2 313	<1	1	939	5	8	8 510	56	87
	OPH	6 555	<1	2	3 147	4	8	15 656	63	93
	ORT	4 440	<1	1	1 625	5	7	14 848	46	97
	PAE	94	<1	2	385	6	8	3 521	12	28
	PSY	1 015	1	1	2 422	4	7	6 216	65	97
	SUR	2 254	<1	2	3 570	5	8	27 558	28	80
NTWC	ENT	3 654	<1	1	1 897	4	7	9 013	45	89
	MED	913	<1	1	2 464	6	7	12 434	26	84
	GYN	1 331	<1	1	345	6	11	5 211	70	72
	OPH	9 839	<1	1	4 966	4	8	7 401	50	81
	ORT	1 915	<1	2	1 989	6	7	11 439	60	91
	PAE	161	<1	1	939	6	7	1 728	20	27
	PSY	399	1	1	1 492	3	7	5 606	62	90
	SUR	2 112	1	2	5 029	4	7	20 529	51	78
Overall HA	ENT	14 195	<1	1	17 844	5	7	61 151	47	104
	MED	12 783	<1	2	27 499	6	8	124 286	59	122
	GYN	8 366	<1	1	8 228	6	7	43 938	38	77
	OPH	42 817	<1	1	31 169	6	9	65 936	68	139
	ORT	15 300	<1	1	14 269	4	7	77 398	52	97
	PAE	3 688	<1	1	5 646	4	7	15 101	12	26
	PSY	2 928	1	1	9 995	4	7	37 025	40	93
	SUR	15 239	1	2	33 464	5	8	139 690	48	96

Hospital Cluster	Specialty	Priority 1			Priority 2			Routine Cases		
		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)	
			50th	90th		50th	90th		50th	90th
			percentile			percentile			percentile	
HKEC	ENT	488	<1	<1	3 502	4	7	4 910	14	77
	MED	963	1	1	3 178	5	7	10 668	48	94
	GYN	695	<1	1	541	6	8	3 904	25	28
	OPH	4 482	<1	1	3 041	5	8	7 584	52	85
	ORT	1 311	1	1	1 293	5	7	6 688	55	92
	PAE	76	1	2	673	4	7	286	9	14
	PSY	302	<1	1	897	3	7	3 296	19	60
	SUR	999	1	2	3 168	7	8	10 867	46	84
HKWC	ENT	961	<1	1	2 085	7	7	3 605	65	83
	MED	1 802	<1	1	1 793	4	8	11 414	34	105
	GYN	1 244	<1	1	907	6	7	3 859	34	50
	OPH	2 454	1	2	1 777	4	8	6 669	55	75
	ORT	1 265	1	2	1 409	4	7	7 808	20	84
	PAE	103	<1	1	361	5	7	1 122	11	17
	PSY	363	1	2	687	4	7	1 920	41	87
	SUR	2 441	<1	2	2 999	4	7	10 716	26	86
KCC	ENT	1 985	<1	1	2 088	4	7	13 181	37	93
	MED	1 210	1	1	3 593	6	7	21 992	71	96
	GYN	934	<1	1	2 944	6	7	7 482	30	64
	OPH	6 983	<1	1	6 604	2	4	10 388	71	86
	ORT	1 978	1	1	1 977	4	7	11 819	51	98
	PAE	1 145	<1	1	1 605	4	7	2 748	10	25
	PSY	195	<1	1	1 318	4	7	2 347	18	55
	SUR	2 561	1	2	5 434	5	10	27 365	37	111
KEC	ENT	1 611	<1	1	2 606	6	7	6 742	86	92
	MED	1 804	1	2	4 788	6	8	19 030	58	108
	GYN	1 574	1	1	834	4	7	5 798	57	78
	OPH	5 520	<1	1	5 238	6	7	10 786	71	97
	ORT	2 975	<1	1	2 571	3	7	9 969	71	95
	PAE	731	<1	1	531	4	7	2 959	10	44
	PSY	265	1	2	2 322	3	7	5 238	52	95
	SUR	1 814	1	1	5 204	7	7	18 083	71	105

Hospital Cluster	Specialty	Priority 1			Priority 2			Routine Cases		
		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)	
			50th	90th		50th	90th		50th	90th
			percentile			percentile			percentile	
KWC	ENT	2 024	<1	1	2 303	5	7	10 662	62	97
	MED	1 752	1	2	5 585	6	8	15 897	72	95
	GYN	222	<1	2	1 595	6	7	7 468	46	88
	OPH	6 194	<1	<1	5 886	5	23	9 144	167	216
	ORT	1 860	<1	2	3 251	4	7	12 632	54	79
	PAE	1 334	<1	1	1 138	4	7	2 840	9	19
	PSY	232	<1	1	909	4	7	13 129	29	93
	SUR	1 874	1	2	5 953	5	7	21 840	52	100
NTEC	ENT	2 469	<1	1	3 040	4	7	12 300	50	89
	MED	2 407	<1	2	3 201	6	8	21 681	48	114
	GYN	2 216	<1	1	981	6	8	7 629	57	89
	OPH	6 635	<1	2	4 053	4	8	15 941	52	96
	ORT	4 524	<1	1	1 360	4	7	14 346	45	86
	PAE	107	<1	2	407	6	11	3 701	16	29
	PSY	828	1	2	2 427	4	7	6 342	64	93
	SUR	2 166	1	2	2 992	5	8	26 850	32	75
NTWC	ENT	3 808	<1	1	1 380	4	7	8 828	61	76
	MED	1 013	<1	1	2 404	6	7	9 591	38	80
	GYN	1 169	<1	1	353	6	8	4 814	62	66
	OPH	10 901	<1	1	3 449	4	7	8 243	59	88
	ORT	1 896	1	2	1 793	6	7	9 791	31	76
	PAE	265	<1	1	1 059	6	7	1 951	23	32
	PSY	377	1	1	1 459	3	7	6 027	55	87
	SUR	1 986	1	2	5 057	5	8	18 527	49	78
Overall HA	ENT	13 346	<1	1	17 004	5	7	60 228	50	93
	MED	10 951	1	2	24 542	6	7	110 273	54	102
	GYN	8 054	<1	1	8 155	6	7	40 954	39	80
	OPH	43 169	<1	1	30 048	4	8	68 755	55	100
	ORT	15 809	<1	1	13 654	4	7	73 053	48	91
	PAE	3 761	<1	1	5 774	4	7	15 607	12	29
	PSY	2 562	1	1	10 019	4	7	38 299	40	91
	SUR	13 841	1	2	30 807	5	8	134 248	46	101

Hospital Cluster	Specialty	Priority 1			Priority 2			Routine Cases		
		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)	
			50th	90th		50th	90th		50th	90th
			percentile			percentile			percentile	
HKEC	ENT	394	<1	<1	3 903	4	7	5 701	14	57
	MED	699	1	2	3 412	5	7	11 750	37	91
	GYN	662	<1	1	559	6	8	3 903	25	32
	OPH	4 817	<1	1	3 799	7	8	8 817	42	85
	ORT	1 247	1	1	1 314	5	7	6 329	51	87
	PAE	43	<1	2	834	6	8	522	12	19
	PSY	240	1	1	766	3	7	3 655	26	86
	SUR	878	1	2	3 078	7	8	11 116	44	85
HKWC	ENT	1 154	<1	1	2 466	7	7	3 802	26	58
	MED	1 776	<1	1	1 946	4	7	11 123	30	83
	GYN	1 431	<1	1	1 046	5	7	3 385	27	51
	OPH	2 433	1	2	1 714	6	8	6 607	61	66
	ORT	1 023	1	2	1 759	4	7	8 267	20	89
	PAE	96	1	1	306	4	7	1 444	16	19
	PSY	348	1	2	811	4	7	1 914	40	83
	SUR	2 570	<1	2	3 218	5	7	11 190	17	69
KCC	ENT	1 991	<1	1	2 218	4	8	13 327	38	85
	MED	1 451	1	1	4 220	6	7	24 333	57	94
	GYN	924	<1	1	2 885	6	7	8 097	35	78
	OPH	7 328	<1	1	6 380	2	4	13 655	85	101
	ORT	1 307	1	1	2 378	3	7	11 901	36	98
	PAE	1 090	<1	1	1 930	6	7	3 480	12	40
	PSY	271	<1	1	1 204	3	6	2 394	20	81
	SUR	2 369	1	2	5 907	5	8	29 556	33	111
KEC	ENT	1 996	<1	1	2 959	4	7	7 932	70	91
	MED	1 346	1	2	5 059	5	7	21 385	56	94
	GYN	1 465	1	1	905	5	7	5 447	36	81
	OPH	5 764	<1	1	5 464	6	7	12 707	84	102
	ORT	3 233	<1	1	2 147	4	7	11 351	57	75
	PAE	718	<1	1	545	4	7	3 544	12	59
	PSY	272	1	1	2 066	3	7	5 455	47	91
	SUR	1 953	1	1	5 616	6	7	19 290	59	106

Hospital Cluster	Specialty	Priority 1			Priority 2			Routine Cases		
		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)	
			50th	90th		50th	90th		50th	90th
			percentile			percentile			percentile	
KWC	ENT	2 517	<1	1	2 966	4	7	12 440	33	99
	MED	1 631	1	2	6 007	6	8	16 300	62	94
	GYN	181	<1	1	1 696	6	7	7 475	58	94
	OPH	6 357	<1	<1	4 887	5	12	7 961	74	180
	ORT	2 086	<1	2	2 672	3	7	13 386	50	92
	PAE	1 259	<1	1	1 167	6	7	3 199	11	22
	PSY	256	<1	1	795	3	7	12 947	26	95
	SUR	1 872	1	2	5 506	5	8	23 999	53	97
NTEC	ENT	2 404	<1	1	3 104	5	8	13 897	36	92
	MED	1 876	1	2	3 283	6	8	20 158	40	85
	GYN	2 057	<1	1	1 028	5	7	7 687	59	85
	OPH	7 005	<1	2	3 444	4	8	18 595	78	101
	ORT	4 632	<1	1	1 419	5	7	14 818	58	90
	PAE	93	<1	2	394	7	8	4 759	23	45
	PSY	829	1	2	2 310	4	8	6 701	73	97
	SUR	2 246	1	2	3 236	5	8	27 342	30	86
NTWC	ENT	4 317	<1	1	1 743	4	7	10 089	35	69
	MED	1 309	<1	1	2 517	6	7	10 474	27	65
	GYN	1 062	<1	1	314	5	8	5 030	60	62
	OPH	11 555	<1	1	6 686	3	7	8 051	82	93
	ORT	2 006	1	2	1 990	6	7	9 961	36	58
	PAE	210	1	1	1 052	6	7	2 929	21	26
	PSY	390	1	1	1 597	3	7	5 873	34	95
	SUR	1 947	1	1	4 625	5	8	19 741	35	91
Overall HA	ENT	14 773	<1	1	19 359	5	7	67 188	36	92
	MED	10 088	1	2	26 444	6	7	115 523	49	92
	GYN	7 782	<1	1	8 433	5	7	41 024	39	82
	OPH	45 259	<1	1	32 374	4	8	76 393	66	102
	ORT	15 534	<1	1	13 679	4	7	76 013	45	89
	PAE	3 509	<1	1	6 228	6	7	19 877	15	41
	PSY	2 606	1	1	9 549	3	7	38 939	40	93
	SUR	13 835	1	2	31 186	5	8	142 234	40	98

2024-25 (up to 31 December 2024)

Hospital Cluster	Specialty	Priority 1			Priority 2			Routine Cases		
		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)	
			50th	90th		50th	90th		50th	90th
			percentile			percentile			percentile	
HKEC	ENT	491	<1	1	2 568	5	7	4 519	26	51
	MED	586	1	2	2 496	5	7	9 484	29	91
	GYN	481	<1	1	366	7	8	3 091	25	33
	OPH	3 517	<1	1	2 718	7	8	6 270	30	90
	ORT	926	1	1	975	5	7	5 254	30	58
	PAE	40	<1	1	679	6	7	436	15	24
	PSY	106	1	1	437	3	6	3 037	39	84
	SUR	693	1	2	2 545	7	8	8 724	39	87
HKWC	ENT	929	<1	1	1 907	7	7	3 148	41	49
	MED	1 319	<1	2	1 729	4	7	8 581	30	79
	GYN	1 176	1	2	899	5	6	2 627	28	50
	OPH	2 040	1	2	1 229	6	8	4 086	61	65
	ORT	692	1	2	1 498	4	7	5 991	23	70
	PAE	59	1	2	207	4	7	1 185	20	23
	PSY	230	1	2	569	3	7	1 522	42	91
	SUR	1 916	<1	2	2 641	4	7	8 889	19	71
KCC	ENT	1 272	<1	1	1 388	4	7	10 035	40	71
	MED	1 002	1	1	3 190	6	7	18 566	61	94
	GYN	713	<1	1	2 295	6	7	6 464	31	90
	OPH	5 717	<1	1	4 759	3	5	10 007	91	100
	ORT	789	1	2	1 993	4	7	8 659	24	92
	PAE	869	<1	1	1 742	5	7	3 468	10	43
	PSY	212	<1	<1	925	3	4	1 813	21	90
	SUR	1 685	1	2	4 296	5	8	23 396	37	102
KEC	ENT	1 472	<1	1	1 993	4	7	7 131	80	81
	MED	922	1	2	3 331	6	8	15 866	47	91
	GYN	1 000	1	1	785	5	7	4 508	31	87
	OPH	4 738	<1	1	4 216	7	7	9 079	74	100
	ORT	2 324	<1	1	1 494	5	7	8 781	51	73
	PAE	498	<1	1	446	4	6	2 715	11	41
	PSY	197	1	1	1 353	3	5	4 520	45	84
	SUR	1 506	1	1	4 277	6	7	14 463	58	99

Hospital Cluster	Specialty	Priority 1			Priority 2			Routine Cases		
		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)		Number of new cases	Waiting Time (weeks)	
			50th	90th		50th	90th		50th	90th
			percentile			percentile			percentile	
KWC	ENT	2 523	<1	1	2 378	4	7	8 901	39	80
	MED	1 039	1	2	4 351	6	7	12 486	67	93
	GYN	149	<1	1	1 259	6	7	5 982	70	96
	OPH	4 820	<1	<1	3 807	8	16	7 815	35	185
	ORT	1 399	1	2	2 132	3	7	10 150	53	76
	PAE	781	<1	1	503	6	7	3 015	17	25
	PSY	158	<1	1	395	2	6	10 266	25	91
	SUR	1 303	1	2	3 931	5	8	19 591	58	101
NTEC	ENT	1 900	<1	1	2 570	5	7	10 775	31	74
	MED	1 407	1	2	2 778	6	7	16 953	49	86
	GYN	1 475	<1	1	689	5	7	6 066	61	87
	OPH	5 556	<1	2	2 815	6	8	13 958	74	114
	ORT	3 581	<1	1	1 493	5	8	10 716	29	73
	PAE	72	<1	1	293	6	8	3 502	36	50
	PSY	482	1	1	1 858	4	7	5 531	78	103
	SUR	2 147	1	2	2 767	5	8	20 216	32	90
NTWC	ENT	3 090	<1	1	981	5	7	8 872	52	54
	MED	1 158	<1	1	2 035	6	7	8 442	38	75
	GYN	318	<1	1	273	4	7	4 224	58	61
	OPH	9 555	<1	1	3 314	4	7	6 521	75	87
	ORT	1 551	1	2	1 491	6	7	8 425	33	64
	PAE	140	<1	1	892	5	7	2 016	28	31
	PSY	291	<1	1	1 398	2	7	4 566	39	81
	SUR	1 302	1	1	3 290	5	8	16 606	39	65
Overall HA	ENT	11 677	<1	1	13 785	5	7	53 381	40	79
	MED	7 433	1	2	19 910	6	7	90 378	48	91
	GYN	5 312	<1	1	6 566	6	7	32 962	36	87
	OPH	35 943	<1	1	22 858	5	8	57 736	64	108
	ORT	11 262	<1	1	11 076	4	7	57 976	35	73
	PAE	2 459	<1	1	4 762	5	7	16 337	17	43
	PSY	1 676	1	1	6 935	3	7	31 255	41	91
	SUR	10 552	1	2	23 747	6	8	111 885	40	96

Note:

- (1) The HA uses 90th percentile to denote the longest waiting time for SOP clinic (SOPC) services.
- (2) With effect from 1 October 2022, the waiting time for new case booking at integrated clinics has been incorporated in those at SOPCs.
- (3) In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA has adjusted its services to cope with the outbreak. This should be taken into consideration when comparing the service throughput of the HA in relevant years. With the cessation of anti-epidemic measures in early 2023, the services of HA have gradually returned to normalcy.

The table below sets out the costs of SOPC services provided by the HA from 2020-21 to 2024-25.

Year	Cost of SOPC Services (\$ million)
2020-21	16,186
2021-22	16,953
2022-23	17,925
2023-24	18,819
2024-25 (revised estimate)	19,725

Note:

- (1) The costs of SOPC services include direct staff costs (such as the expenditure related to doctors, nursing and allied health staff) for providing services to patients, expenditure incurred for various clinical support services (such as pharmacies, diagnostic radiology and pathology tests), and other operating costs (such as utility expenses, and repair and maintenance of medical equipment).
- (2) In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA has adjusted its services to cope with the outbreak. This should be taken into consideration when comparing the service throughput of the HA in relevant years. With the cessation of anti-epidemic measures in early 2023, the services of HA have gradually returned to normalcy. As the costing information for 2020-21 to 2022-23 has reflected the impact of the epidemic outbreak on costs (if any), the costing information for different years may not be directly comparable.

2.

The HA implements a triage system for new referrals to SOPCs to ensure that priority is given to treating patients in urgent conditions and requiring early intervention. Under the triage system, newly referred patients are usually screened by a nurse and then examined by a specialist doctor of the relevant department, before being classified into Priority 1 (urgent),

Priority 2 (semi-urgent) and Routine (stable) cases. The HA's target is to maintain the median waiting time for Priority 1 and Priority 2 cases within 2 weeks and 8 weeks respectively. The HA has been able to fulfil the pledge regarding the median waiting time for Priority 1 and Priority 2 cases, and will continue to implement this effective triage system to ensure timely treatment for patients in most urgent need.

Apart from implementing the triage system, the HA has been proactively taking measures to manage and improve the waiting time for SOPC patients, such as enhancing public primary healthcare services, strengthening manpower, optimising appointment booking and scheduling, and displaying the latest waiting time on HA's website and at SOPCs to help patients consider their treatment plans and options. Besides, under the strategy of "narrowing upstream, collaborating downstream, diverting midstream", the HA has introduced doctor-led multi-disciplinary integrated clinics, and will allocate more resources for new cases, streamline referral arrangements for cross-specialty cases, set up more integrated clinics to provide multi-disciplinary support, and enhance primary healthcare to follow up on patients in stable conditions.

The HA will review the effectiveness of these measures in a timely manner and implement appropriate supplementary measures as necessary to further shorten the waiting time of SOPCs.

Hong Kong's primary healthcare system operates on a dual-track system encompassing the public and private sectors. Primary healthcare is the first point of contact for individuals and families in disease prevention and treatment, and plays a gatekeeping role of primary healthcare in the public secondary healthcare system. To reduce the pressure on public healthcare services, the Government has been actively developing Community Health Centres in accordance with the Primary Healthcare Blueprint to provide patients with more comprehensive primary healthcare services, and strengthen community support for patients, especially chronic disease patients who are in stable conditions and require additional support, to reduce their need for hospitalisation. At the same time, the HA also provides Family Medicine Specialist Clinic (FMSC) services through its service points in hospitals and clinics. Attended by Family Medicine specialists, the FMSC service provides integrated disease management and support to patients who are in relatively complex conditions but are still suitable for treatment at primary healthcare level (such as patients who are in relatively stable conditions but still require specialist support) through a primary and secondary healthcare referral mechanism driven by an evidence-based, protocol-driven care pathway.

The Primary Healthcare Commission is actively strengthening the referral mechanism, including developing referral criteria in consultation with primary healthcare professionals and making reference to the experience of the existing referral mechanism in the public healthcare system, so as to establish a primary and secondary healthcare bi-directional referral mechanism driven by an evidence-based, protocol-driven care pathway, thereby facilitating patients to seek appropriate services at various levels of the healthcare system in an effective manner, to address the demand and waiting time for HA's SOPC services thereby promoting sustainability of the public hospital system. For example, the Government has established a bi-directional referral mechanism with the HA under the Chronic Disease Co-care Pilot Scheme. Family doctors can refer participants with clinical needs to receive a one-off specialist consultation at a designated Medicine SOPCs of the HA according to clinical diagnosis and pre-defined criteria and guidelines. This can support family doctors and enable

participants to receive continuous and comprehensive primary healthcare services in the community, so as to reduce non-essential referrals of new cases to SOPCs.

Abbreviations

Specialty

ENT – Ear, Nose & Throat

MED – Medicine

GYN – Gynaecology

OPH – Ophthalmology

ORT – Orthopaedics & Traumatology

PAE – Paediatrics

PSY – Psychiatry

SUR – Surgery

Cluster

HKEC – Hong Kong East Cluster

HKWC – Hong Kong West Cluster

KCC – Kowloon Central Cluster

KEC – Kowloon East Cluster

KWC – Kowloon West Cluster

NTEC – New Territories East Cluster

NTWC – New Territories West Cluster

- End -

CONTROLLING OFFICER'S REPLY

HHB148

(Question Serial No. 0782)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (1) Director of Bureau's Office

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Among Matters Requiring Special Attention in 2025-26 is the work with the Greater Bay Area International Clinical Trial Institute to establish the Greater Bay Area Clinical Trial Collaboration Platform with Shenzhen and set up the Real-World Study and Application Centre. On 21 November 2024, the Greater Bay Area International Clinical Trial Institute (GBAICTI) and the Greater Bay Area International Clinical Trials Center of the Shenzhen Municipality (the Center) were respectively commissioned in the Hong Kong Park and Shenzhen Park in the Loop, marking the first milestone in the strategic synergy between the 2 parks.

In this connection, please inform this Committee of:

- (1) the details of the manpower and expenditure of the GBAICTI wholly owned by the Government;
- (2) the specific timeline and work details for implementing projects of the GBAICTI, such as establishing the Hong Kong Clinical Trial Digital Portal and founding the Clinical Trial Academy; and
- (3) the work details on how the GBAICTI and the Center can achieve deep collaboration, strengthen co-ordination and accelerate the transformation and application of clinical trial outcomes.

Asked by: Hon LIAO Cheung-kong, Martin (LegCo internal reference no.: 18)

Reply:

The Chief Executive announced in the 2023 Policy Address that the Government would establish the Greater Bay Area International Clinical Trial Institute (GBAICTI) to provide a one-stop clinical trial support platform for medical research institutions. The GBAICTI would co-ordinate clinical trial resources in the public and private healthcare sectors in Hong Kong to promote the co-ordinated development of the Hong Kong and Shenzhen Parks.

In the fourth quarter of last year, the Li Ka Shing (LKS) Faculty of Medicine of the University of Hong Kong (HKU), renowned for its extensive global experience in clinical trials, was selected by the Government of Hong Kong Special Administrative Region through open tender to operate the GBAICTI. The LKS Faculty of Medicine of the HKU completed the appointment of the GBAICTI's Chief Executive Officer in February 2025, with the formation of the operation team in the pipeline. The Health Bureau (HHB) has set aside a total time-limited provision of \$140 million from 2024-25 to 2028-29 for meeting manpower and other operational expenses at the GBAICTI. Besides, the HHB will earmark an additional provision of around \$38 million to support the implementation of specific strategic initiatives by the GBAICTI in 2025-26, including those partnership projects launched by Phase 1 Clinical Trials Centres of the 2 medical schools.

The GBAICTI serves as a key hub for clinical trial network co-operation between Hong Kong and the Mainland, leveraging a population base of over 86 million in the Greater Bay Area (GBA) to support medical research organisations from both domestic and overseas markets, and co-ordinate multi-centre cross-boundary clinical trials that simultaneously meet national and international standards. In 2025, the GBAICTI will collaborate with the Shenzhen Municipal Government to establish the "GBA Clinical Trial Collaboration Platform", working with the Greater Bay Area International Clinical Trials Center located in the Shenzhen Park to provide consultation, matching, and referral services, etc. for medical research organisations conducting clinical trials in Hong Kong and the GBA. This includes co-ordinating the launch of multicentre cross-boundary clinical trials that can meet both national and international standards. In the future, the GBAICTI will move into one of the wet laboratory-enabled buildings in the Hong Kong Park (i.e. the Hong Kong-Shenzhen Innovation and Technology Park) to provide a platform with more diverse and comprehensive clinical trial facilities and services.

Furthermore, the GBAICTI will establish the collaboration mechanism within 2025 for different bureaux and departments, the Hospital Authority (HA) and relevant institutions to provide all-round support to research organisations and innovative medical enterprises to facilitate the conduct of research and development (R&D), clinical trials and application of advanced medical technology in Hong Kong. Meanwhile, multiple projects will be rolled out in phases, including establishing the "Hong Kong Clinical Trial Digital Portal", founding the "International Clinical Research Academy", and collaborating with the Department of Health and the HA to shorten the approval time for application of drugs to align with global competitors. On another front, the GBAICTI will also establish strategic partnerships with healthcare and biomedical institutions, including the Hong Kong Genome Institute, to leverage its genome database primarily acquired from the Southern Chinese population, spur the opening up of the HA's medical databases to support clinical trials, and attract enterprises of advanced biomedical technologies (e.g. gene therapy, cell therapy, radioligand therapy and new vaccine technology platforms, etc.) within and outside of Hong Kong to set up their operations in Hetao for R&D and translation.

- End -

CONTROLLING OFFICER'S REPLY

HHB149

(Question Serial No. 0078)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: Not Specified

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in paragraph 207 of the Budget Speech that the government will, taking into account the latest demographic structure, planning and development situation in Hong Kong, review the distribution, scale and priority of projects under the Second Hospital Development Plan (HDP), and will make the announcement in due course. In this connection, please inform this Committee of the following:

1. The population of Hong Kong is ageing continuously. The proportion of people aged 65 and over will increase from 20.5% in 2021 to 36.0% in 2046. With an imminent demand for healthcare services, and the general ageing of existing hospitals and clinics, there is a pressing need for the Second HDP. What are the details of the announcement and implementation regarding the HDP?
2. Since the launch of the First HDP in 2016, its projects are progressively implemented and completed. What experiences and innovative construction technologies will be drawn on by the Government with a view to expediting the construction of hospital facilities?
3. Chinese medicine (CM) is effective in “preventive treatment of disease” and recognised by the public. Will the Government strengthen the training for CM healthcare personnel and CM-related healthcare infrastructure under the Second HDP? If yes, what are the details; if no, what are the reasons?

Asked by: Hon LO Wai-kwok (LegCo internal reference no.: 23)

Reply:

1. To meet the increasing service demand, the Hospital Authority (HA) is properly upgrading and maintaining existing facilities on one hand, while the Government is constructing essential hospital facilities through the Hospital Development Plans (HDPs) on the other. As the works projects under the First HDP are being progressively implemented and completed, the Government is planning and preparing for the Second HDP.

With the changes in the population structure, planning and development situation of Hong Kong, the Health Bureau (HHB) and the HA are currently reviewing the Second HDP. Amongst others, in view of the territory-wide and regional planning and development strategies as announced by the Planning Department, including the Hong Kong 2030+: Towards a Planning Vision and Strategy Transcending 2030 and the Northern Metropolis Development Strategy, as well as the corresponding population projections of Hong Kong including the latest changes in overall population, its distribution and demographics, the HHB and the HA have to make reference to the latest future planning of the whole territory (including the development concepts of the Northern Metropolis), population statistics, projections of population distribution and demographics of various districts, and the population policy and talent attraction initiatives of the Government, etc, to adopt a planning horizon of up to 2040 and beyond for the Second HDP, and to project healthcare service demand and consider the supply and conditions of the land required, for optimising the Second HDP.

The Government also considers factors such as the needs for and cost-effectiveness of renovation, refurbishment, redevelopment or addition of facilities for individual hospitals, and the convenience of public access to healthcare services under various major transport infrastructure development plans for determining the distribution, scale and priority, etc. of various hospital development projects under the Second HDP. Upon completion of the review, the Government will announce the details of the Second HDP in due course.

On the maintenance of the existing facilities, the HA has been carrying out maintenance and modification works to ensure the smooth operation of public hospitals/healthcare institutions and clinics. The Finance Committee of the Legislative Council approved on 14 June 2024 a provision of \$8 billion to the HA under the Capital Works Reserve Fund Head 708 Subhead 8096MM to carry out minor works projects for about 5 years starting from 2024-25, including facility rejuvenation, capacity enhancement, safe engineering, infection control, energy conservation, scheduled maintenance, and general minor works and preparatory works for major capital works projects, etc. The HA expects that about 400 new works projects will be implemented in 2025-26.

2. Some of the works projects under the First HDP have adopted innovative construction technologies, including Modular Integrated Construction (MiC), Multi-trade Integrated Mechanical, Electrical and Plumbing (MiMEP), and Design for Manufacture and Assembly (DfMA), etc. The HA will consider the feasibility of applying these experiences and technologies in light of the specific needs and environment of hospitals, as well as the practical experiences gained from the works projects under the First HDP, and promote the wider application of these technologies under suitable conditions as far as practicable to make the works projects more cost-effective, ensuring that hospital facilities can be put into operation more quickly to meet the healthcare needs of the public in a timely manner.
3. To promote the development of Chinese Medicine (CM) and nurturing of talents in Hong Kong, the Government has set up Chinese Medicine Clinics cum Training and Research Centres (CMCTRs) in all 18 districts, with each CMCTR operated on a tripartite collaboration model involving the HA, a non-governmental organisation and a local university to provide the public with Government-subsidised and non-Government-

subsidised CM out-patient services at district level. The integrated Chinese-Western Medicine services are also provided by the public hospitals under the HA. The HA has all along been providing relevant training for CM professionals of various ranks in the 18 CMCTRs, including training programmes for Chinese medicine practitioners (CMP) trainees, scholarships at junior and advanced levels, training on the knowledge and practice of scientific research and commissioned training in Western medicine etc., with a view to nurturing more local CM talents. The HA also provides relevant training for CM drug professionals, including professional training programmes on CM drugs, programmes on fundamental knowledge of Western medicine, and online training platforms, with a view to enhancing the professional competence of CM drug professionals. To foster the cultivation of local backbone talents in CM clinical practice, the HA launched the Greater Bay Area (GBA) CM Visiting Scholars Programme and the CM Enhanced In-patient Training Programme with GBA in November 2022 and April 2024 respectively with the aim to enhance the clinical competency of local CMPs in providing CM in-patient services on all fronts.

In planning and implementing the Second HDP, the HA will proactively tie the projects in with the policy initiatives of the Government, including the development of CM and integrated Chinese-Western Medicine services, while providing better healthcare services to the public by reserving spaces in newly built hospital facilities to facilitate the development of various services, increasing resources as appropriate, optimising services and nurturing talents.

Furthermore, the Chinese Medicine Hospital of Hong Kong (CMHHK), planned and constructed by the Government and monitored by the HHB, will commence services in phases from December 2025 onwards. The CMHHK will undertake 5 key missions of development, i.e. provision of government-subsidised and market-oriented healthcare services, training and education, research, collaboration, and creation of health values. The CMHHK established a talent pool mechanism at end-2024 and registered healthcare professionals of the talent pool will be given priority in taking part in relevant training so as to enhance their competence and professional standard.

- End -

CONTROLLING OFFICER'S REPLY**HHB150****(Question Serial No. 2260)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (3) Subvention: Hospital AuthorityControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

In 2024-25, the Hospital Authority (HA) has a staff of over 93 000, including 7 140 doctors, 13 dentists, 28 580 nurses and 10 050 allied health professionals. Regarding the staffing establishment of doctors, will the Government advise this Committee on:

- (a) the number of doctors (full-time equivalents) and their ranks in each cluster in the past 3 years, with a breakdown by rank (including intern) and medical specialty;
- (b) the qualifications of full-time doctors, with a breakdown by medical specialty and length of service;
- (c) the government measures in place to retain, recruit and nurture doctors for medical specialties with manpower shortage (e.g. cardiothoracic surgery and neurosurgery); and
- (d) in view of the HA's demand in relation to establishment of doctors, whether the Government has any financial plans or budget adjustment measures to ensure that hospitals have sufficient funds to attract, retain and train doctors, especially those in medical specialties with manpower shortage?

Asked by: Hon LUK Chung-hung (LegCo internal reference no.: 21)Reply:

(a)

The numbers of doctors on full-time equivalent basis by cluster, specialty and rank group in 2022-23, 2023-24 and 2024-25 (as at 31 December 2024) are set out in the tables below:

2022-23 (as at 31 March 2023)

Cluster	Major Specialty	Rank Group		
		Consultant	Senior Medical Officer/Associate Consultant	Medical Officer/Resident
HKEC	Accident & Emergency	10	22	24
	Anaesthesia	7	13	19

Cluster	Major Specialty	Rank Group		
		Consultant	Senior Medical Officer/Associate Consultant	Medical Officer/Resident
	Family Medicine	3	13	39
	Intensive Care Unit	2	5	10
	Medicine	26	56	80
	Neurosurgery	4	3	7
	Obstetrics & Gynaecology	6	7	8
	Ophthalmology	7	6	11
	Orthopaedics & Traumatology	7	14	17
	Paediatrics	7	7	15
	Pathology	8	5	10
	Psychiatry	8	15	19
	Radiology	12	7	26
	Surgery	11	14	29
	Others	6	7	18
	Total	125	194	333
HKWC	Accident & Emergency	4	9	12
	Anaesthesia	17	23	26
	Cardiothoracic Surgery	6	4	3
	Family Medicine	3	19	23
	Intensive Care Unit	2	6	6
	Medicine	39	51	76
	Neurosurgery	5	2	6
	Obstetrics & Gynaecology	6	10	10
	Ophthalmology	2	3	10
	Orthopaedics & Traumatology	7	7	25
	Paediatrics	9	9	18
	Pathology	12	4	19
	Psychiatry	3	8	14
	Radiology	7	5	18
	Surgery	17	23	44
	Others	8	7	17
	Total	148	190	327
KCC	Accident & Emergency	10	29	46
	Anaesthesia	21	44	46
	Cardiothoracic Surgery	6	9	5
	Family Medicine	6	27	81
	Intensive Care Unit	7	7	9
	Medicine	49	108	137

Cluster	Major Specialty	Rank Group		
		Consultant	Senior Medical Officer/Associate Consultant	Medical Officer/Resident
	Neurosurgery	9	10	17
	Obstetrics & Gynaecology	12	17	26
	Ophthalmology	7	11	19
	Orthopaedics & Traumatology	16	20	30
	Paediatrics	37	62	79
	Pathology	21	20	19
	Psychiatry	7	13	22
	Radiology	27	22	37
	Surgery	28	37	58
	Others	16	17	23
	Total	276	452	655
KEC	Accident & Emergency	7	28	36
	Anaesthesia	9	18	27
	Family Medicine	6	27	64
	Intensive Care Unit	3	4	7
	Medicine	40	63	93
	Obstetrics & Gynaecology	10	11	12
	Ophthalmology	3	10	9
	Orthopaedics & Traumatology	11	13	34
	Paediatrics	7	17	21
	Pathology	13	5	13
	Psychiatry	5	20	19
	Radiology	12	9	15
	Surgery	11	22	30
	Others	4	16	13
	Total	141	262	392
KWC	Accident & Emergency	13	42	69
	Anaesthesia	12	25	31
	Family Medicine	6	32	81
	Intensive Care Unit	4	12	16
	Medicine	43	78	125
	Neurosurgery	2	5	8
	Obstetrics & Gynaecology	6	7	10
	Ophthalmology	4	10	11
	Orthopaedics & Traumatology	16	18	41
	Paediatrics	11	22	26
	Pathology	18	15	19

Cluster	Major Specialty	Rank Group		
		Consultant	Senior Medical Officer/Associate Consultant	Medical Officer/Resident
	Psychiatry	13	31	31
	Radiology	14	11	21
	Surgery	21	33	51
	Others	10	15	24
	Total	191	354	565
NTEC	Accident & Emergency	11	31	40
	Anaesthesia	13	19	31
	Cardiothoracic Surgery	3	3	7
	Family Medicine	5	35	66
	Intensive Care Unit	5	10	15
	Medicine	41	65	131
	Neurosurgery	3	2	8
	Obstetrics & Gynaecology	8	9	17
	Ophthalmology	4	6	17
	Orthopaedics & Traumatology	10	17	43
	Paediatrics	10	19	28
	Pathology	13	12	20
	Psychiatry	9	31	31
	Radiology	15	8	24
	Surgery	19	26	44
	Others	13	11	34
	Total	184	305	556
NTWC	Accident & Emergency	9	28	58
	Anaesthesia	9	18	31
	Cardiothoracic Surgery	1	1	0
	Family Medicine	5	24	60
	Intensive Care Unit	3	10	11
	Medicine	34	57	94
	Neurosurgery	3	3	7
	Obstetrics & Gynaecology	8	7	18
	Ophthalmology	5	8	14
	Orthopaedics & Traumatology	9	15	29
	Paediatrics	7	11	23
	Pathology	11	3	12
	Psychiatry	11	28	42
	Radiology	11	8	23
	Surgery	19	20	36

Cluster	Major Specialty	Rank Group		
		Consultant	Senior Medical Officer/Associate Consultant	Medical Officer/Resident
	Others	9	11	18
	Total	154	252	475
Cluster total		1 219	2 009	3 303

2023-24 (as at 31 March 2024)

Cluster	Major Specialty	Rank Group		
		Consultant	Senior Medical Officer/Associate Consultant	Medical Officer/Resident
HKEC	Accident & Emergency	11	22	29
	Anaesthesia	7	13	20
	Family Medicine	3	14	39
	Intensive Care Unit	2	5	14
	Medicine	29	55	92
	Neurosurgery	4	2	7
	Obstetrics & Gynaecology	6	7	10
	Ophthalmology	5	5	13
	Orthopaedics & Traumatology	7	14	17
	Paediatrics	7	8	16
	Pathology	9	6	8
	Psychiatry	9	14	21
	Radiology	12	9	27
	Surgery	12	11	30
	Others	6	8	18
	Total	129	193	361
HKWC	Accident & Emergency	5	10	19
	Anaesthesia	18	22	20
	Cardiothoracic Surgery	6	2	6
	Family Medicine	3	19	23
	Intensive Care Unit	2	6	8
	Medicine	37	50	81
	Neurosurgery	5	3	5
	Obstetrics & Gynaecology	6	10	14
	Ophthalmology	2	3	12
	Orthopaedics & Traumatology	6	9	20
	Paediatrics	8	9	20

Cluster	Major Specialty	Rank Group		
		Consultant	Senior Medical Officer/Associate Consultant	Medical Officer/Resident
	Pathology	12	7	15
	Psychiatry	3	9	15
	Radiology	10	4	24
	Surgery	16	24	46
	Others	8	5	20
	Total	148	192	347
KCC	Accident & Emergency	10	32	48
	Anaesthesia	22	44	47
	Cardiothoracic Surgery	7	7	5
	Family Medicine	6	26	89
	Intensive Care Unit	8	7	10
	Medicine	53	106	146
	Neurosurgery	9	9	19
	Obstetrics & Gynaecology	14	14	29
	Ophthalmology	7	14	20
	Orthopaedics & Traumatology	18	18	33
	Paediatrics	41	57	82
	Pathology	21	20	22
	Psychiatry	7	13	26
	Radiology	31	25	39
	Surgery	28	38	74
	Others	19	15	27
	Total	299	446	717
KEC	Accident & Emergency	9	26	38
	Anaesthesia	8	21	28
	Family Medicine	6	28	66
	Intensive Care Unit	3	5	6
	Medicine	40	63	98
	Obstetrics & Gynaecology	9	10	13
	Ophthalmology	3	9	10
	Orthopaedics & Traumatology	11	11	35
	Paediatrics	8	14	20
	Pathology	13	5	15
	Psychiatry	6	18	20
	Radiology	13	9	16
	Surgery	11	25	33
	Others	7	12	13

Cluster	Major Specialty	Rank Group		
		Consultant	Senior Medical Officer/Associate Consultant	Medical Officer/Resident
	Total	148	255	412
KWC	Accident & Emergency	12	45	74
	Anaesthesia	12	24	35
	Family Medicine	7	31	86
	Intensive Care Unit	4	12	17
	Medicine	48	77	126
	Neurosurgery	3	4	11
	Obstetrics & Gynaecology	6	8	15
	Ophthalmology	4	10	13
	Orthopaedics & Traumatology	17	22	36
	Paediatrics	10	22	24
	Pathology	20	14	20
	Psychiatry	14	29	35
	Radiology	17	9	24
	Surgery	22	31	46
	Others	11	12	26
	Total	208	350	588
NTEC	Accident & Emergency	12	31	47
	Anaesthesia	14	13	39
	Cardiothoracic Surgery	3	4	7
	Family Medicine	6	37	62
	Intensive Care Unit	6	9	12
	Medicine	43	65	135
	Neurosurgery	3	3	7
	Obstetrics & Gynaecology	8	8	18
	Ophthalmology	4	9	16
	Orthopaedics & Traumatology	13	17	40
	Paediatrics	11	17	27
	Pathology	13	13	17
	Psychiatry	9	29	31
	Radiology	15	11	28
	Surgery	23	21	57
	Others	14	15	31
	Total	197	302	573
NTWC	Accident & Emergency	9	27	52
	Anaesthesia	9	21	35
	Cardiothoracic Surgery	2	0	1

Cluster	Major Specialty	Rank Group		
		Consultant	Senior Medical Officer/Associate Consultant	Medical Officer/Resident
	Family Medicine	5	25	66
	Intensive Care Unit	3	11	11
	Medicine	37	55	99
	Neurosurgery	4	4	6
	Obstetrics & Gynaecology	10	6	18
	Ophthalmology	4	8	16
	Orthopaedics & Traumatology	10	15	30
	Paediatrics	10	9	20
	Pathology	14	2	13
	Psychiatry	14	25	49
	Radiology	12	9	26
	Surgery	20	20	40
	Others	8	13	24
	Total	172	250	506
Cluster total		1 301	1 988	3 504

2024-25 (as at 31 December 2024)

Cluster	Major Specialty	Rank Group		
		Consultant	Senior Medical Officer/Associate Consultant	Medical Officer/Resident
HKEC	Accident & Emergency	12	21	38
	Anaesthesia	7	14	22
	Clinical Oncology	6	3	14
	Ear, Nose & Throat	4	2	6
	Family Medicine	4	14	41
	Intensive Care Unit	3	4	12
	Medicine	31	52	112
	Neurosurgery	4	2	10
	Obstetrics & Gynaecology	6	6	10
	Ophthalmology	6	4	15
	Orthopaedics & Traumatology	7	12	20
	Paediatrics	6	9	13
	Pathology	9	5	10
	Psychiatry	9	15	26
	Radiology	12	7	32
	Surgery	12	13	33

Cluster	Major Specialty	Rank Group		
		Consultant	Senior Medical Officer/Associate Consultant	Medical Officer/Resident
	Others	0	1	0
	Total	137	184	415
HKWC	Accident & Emergency	6	8	20
	Anaesthesia	19	19	33
	Cardiothoracic Surgery	6	3	8
	Clinical Oncology	5	2	14
	Ear, Nose & Throat	3	4	9
	Family Medicine	3	19	24
	Intensive Care Unit	2	6	8
	Medicine	40	47	96
	Neurosurgery	5	2	7
	Obstetrics & Gynaecology	4	9	15
	Ophthalmology	4	2	13
	Orthopaedics & Traumatology	4	10	23
	Paediatrics	10	8	20
	Pathology	12	7	18
	Psychiatry	3	9	17
	Radiology	12	2	27
	Surgery	19	23	60
	Total	157	181	411
KCC	Accident & Emergency	11	31	52
	Anaesthesia	24	40	52
	Cardiothoracic Surgery	7	8	6
	Clinical Oncology	9	9	16
	Ear, Nose & Throat	7	3	9
	Family Medicine	6	29	87
	Intensive Care Unit	8	7	11
	Medicine	54	102	167
	Neurosurgery	9	10	23
	Obstetrics & Gynaecology	14	16	30
	Ophthalmology	8	11	27
	Orthopaedics & Traumatology	21	17	36
	Paediatrics	39	62	81
	Pathology	21	22	21
	Psychiatry	7	13	26
	Radiology	29	21	45
	Surgery	31	38	76

Cluster	Major Specialty	Rank Group		
		Consultant	Senior Medical Officer/Associate Consultant	Medical Officer/Resident
	Others	4	4	4
	Total	309	444	770
KEC	Accident & Emergency	10	25	43
	Anaesthesia	9	18	29
	Clinical Oncology	3	3	9
	Ear, Nose & Throat	3	6	4
	Family Medicine	6	27	70
	Intensive Care Unit	4	9	13
	Medicine	39	63	111
	Obstetrics & Gynaecology	8	10	14
	Ophthalmology	3	8	13
	Orthopaedics & Traumatology	11	14	32
	Paediatrics	9	15	20
	Pathology	15	5	13
	Psychiatry	6	18	22
	Radiology	15	6	19
	Surgery	13	25	38
	Others	2	3	0
	Total	154	254	449
KWC	Accident & Emergency	15	41	75
	Anaesthesia	14	27	35
	Clinical Oncology	8	6	15
	Ear, Nose & Throat	3	6	10
	Family Medicine	8	29	94
	Intensive Care Unit	5	12	19
	Medicine	51	77	137
	Neurosurgery	3	4	12
	Obstetrics & Gynaecology	7	8	14
	Ophthalmology	4	10	12
	Orthopaedics & Traumatology	18	21	38
	Paediatrics	12	21	24
	Pathology	19	14	21
	Psychiatry	15	27	36
	Radiology	15	9	25
	Surgery	22	33	57
	Others	1	0	0
	Total	219	345	625

Cluster	Major Specialty	Rank Group		
		Consultant	Senior Medical Officer/Associate Consultant	Medical Officer/Resident
NTEC	Accident & Emergency	11	34	50
	Anaesthesia	16	14	47
	Cardiothoracic Surgery	3	4	7
	Clinical Oncology	11	7	23
	Ear, Nose & Throat	4	4	11
	Family Medicine	6	36	70
	Intensive Care Unit	7	8	16
	Medicine	45	68	140
	Neurosurgery	4	4	7
	Obstetrics & Gynaecology	7	9	18
	Ophthalmology	5	7	19
	Orthopaedics & Traumatology	14	16	46
	Paediatrics	11	19	28
	Pathology	14	9	23
	Psychiatry	11	29	33
	Radiology	15	10	31
	Surgery	25	21	56
	Others	1	2	2
	Total	210	301	627
NTWC	Accident & Emergency	8	28	56
	Anaesthesia	9	21	39
	Cardiothoracic Surgery	2	0	1
	Clinical Oncology	5	6	18
	Ear, Nose & Throat	3	5	8
	Family Medicine	5	25	71
	Intensive Care Unit	4	8	12
	Medicine	38	54	113
	Neurosurgery	4	5	7
	Obstetrics & Gynaecology	9	7	18
	Ophthalmology	4	5	18
	Orthopaedics & Traumatology	11	15	32
	Paediatrics	10	9	21
	Pathology	13	2	14
	Psychiatry	15	24	53
	Radiology	12	6	30
	Surgery	23	16	53
	Others	1	0	0

Cluster	Major Specialty	Rank Group		
		Consultant	Senior Medical Officer/Associate Consultant	Medical Officer/Resident
	Total	177	236	564
Cluster total		1 363	1 945	3 861

Note:

- (1) The manpower figures above are calculated on full-time equivalent basis including permanent, contract and temporary staff in the Hospital Authority (HA). Individual figures may not add up to the total due to rounding.
- (2) Doctors exclude Interns and Dental Officers.
- (3) Starting from January 2024, full-time equivalent for temporary part-time staff is calculated based on their actual working hours. The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.
- (4) Starting from 2024-25, Ear, Nose & Throat and Clinical Oncology are no longer classified in the category of “Others”. The related figures of this category before 2024-25 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.

The numbers of Interns on full-time equivalent basis from 2022-23 to 2024-25 (as at 31 December 2024) are set out in the table below:

Cluster	2022-23 (as at 31 March 2023)	2023-24 (as at 31 March 2024)	2024-25 (as at 31 December 2024)
Intern	499	530	528

Note:

- (1) Interns employed by the HA are medical trainees. During the training period, they have to undergo a total of 2 six-month rotations in medicine and surgery, each consisting of 2 three-month postings.
- (2) The manpower figures above are calculated on full-time equivalent basis including permanent, contract and temporary staff in the HA. Individual figures may not add up to the total due to rounding.
- (3) Starting from January 2024, full-time equivalent for temporary part-time staff is calculated based on their actual working hours. The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.

(b)

The numbers of doctors by specialty and by year of service in 2024-25 (as at 31 December 2024) are set out in the table below:

Major Specialty	Year of Service	2024-25 (as at 31 December 2024)
Accident & Emergency	< 1 year	19
	1 - < 6 years	190
	6 - < 11 years	119
	11 - < 16 years	51
	16 - < 21 years	49
	21 - < 26 years	35
	26 - < 31 years	69
	31 years or above	27
Total		559
Anaesthesia	< 1 year	36
	1 - < 6 years	163
	6 - < 11 years	146
	11 - < 16 years	52
	16 - < 21 years	40
	21 - < 26 years	19
	26 - < 31 years	27
	31 years or above	10
Total		493
Cardiothoracic Surgery	< 1 year	4
	1 - < 6 years	15
	6 - < 11 years	10
	11 - < 16 years	9
	16 - < 21 years	7
	21 - < 26 years	4
	26 - < 31 years	4
Total		53
Clinical Oncology ⁽³⁾	< 1 year	5
	1 - < 6 years	71
	6 - < 11 years	48
	11 - < 16 years	22
	16 - < 21 years	18
	21 - < 26 years	7
	26 - < 31 years	4
	31 years or above	14
Total		189
Ear, Nose & Throat ⁽⁴⁾	< 1 year	4
	1 - < 6 years	37
	6 - < 11 years	33
	11 - < 16 years	17

Major Specialty	Year of Service	2024-25 (as at 31 December 2024)
	16 - < 21 years	7
	21 - < 26 years	6
	26 - < 31 years	3
	31 years or above	4
Total		111
Family Medicine	< 1 year	11
	1 - < 6 years	211
	6 - < 11 years	131
	11 - < 16 years	67
	16 - < 21 years	60
	21 - < 26 years	129
	26 - < 31 years	26
	31 years or above	6
Total		641
Intensive Care Unit	< 1 year	7
	1 - < 6 years	68
	6 - < 11 years	39
	11 - < 16 years	27
	16 - < 21 years	12
	21 - < 26 years	12
	26 - < 31 years	7
	31 years or above	4
Total		176
Medicine	< 1 year	54
	1 - < 6 years	510
	6 - < 11 years	339
	11 - < 16 years	227
	16 - < 21 years	139
	21 - < 26 years	111
	26 - < 31 years	123
	31 years or above	87
Total		1 590
Neurosurgery	< 1 year	3
	1 - < 6 years	54
	6 - < 11 years	17
	11 - < 16 years	16
	16 - < 21 years	13
	21 - < 26 years	5
	26 - < 31 years	6

Major Specialty	Year of Service	2024-25 (as at 31 December 2024)
	31 years or above	3
Total		117
Obstetrics & Gynaecology	< 1 year	6
	1 - < 6 years	75
	6 - < 11 years	74
	11 - < 16 years	20
	16 - < 21 years	26
	21 - < 26 years	11
	26 - < 31 years	10
	31 years or above	6
Total		228
Ophthalmology	< 1 year	17
	1 - < 6 years	70
	6 - < 11 years	65
	11 - < 16 years	16
	16 - < 21 years	11
	21 - < 26 years	2
	26 - < 31 years	8
	31 years or above	4
Total		193
Orthopaedics & Traumatology	< 1 year	13
	1 - < 6 years	116
	6 - < 11 years	125
	11 - < 16 years	64
	16 - < 21 years	29
	21 - < 26 years	13
	26 - < 31 years	33
	31 years or above	16
Total		409
Paediatrics	< 1 year	20
	1 - < 6 years	118
	6 - < 11 years	106
	11 - < 16 years	61
	16 - < 21 years	39
	21 - < 26 years	23
	26 - < 31 years	31
	31 years or above	24
Total		422
Pathology	< 1 year	12

Major Specialty	Year of Service	2024-25 (as at 31 December 2024)
	1 - < 6 years	93
	6 - < 11 years	68
	11 - < 16 years	30
	16 - < 21 years	24
	21 - < 26 years	18
	26 - < 31 years	17
	31 years or above	6
Total		268
Psychiatry	< 1 year	7
	1 - < 6 years	132
	6 - < 11 years	93
	11 - < 16 years	49
	16 - < 21 years	41
	21 - < 26 years	24
	26 - < 31 years	30
	31 years or above	17
Total		393
Radiology	< 1 year	19
	1 - < 6 years	146
	6 - < 11 years	112
	11 - < 16 years	31
	16 - < 21 years	22
	21 - < 26 years	9
	26 - < 31 years	12
	31 years or above	10
Total		361
Surgery	< 1 year	31
	1 - < 6 years	261
	6 - < 11 years	143
	11 - < 16 years	102
	16 - < 21 years	61
	21 - < 26 years	22
	26 - < 31 years	33
	31 years or above	16
Total		669
Others	< 1 year	7
	1 - < 6 years	10
	6 - < 11 years	4
	11 - < 16 years	2

Major Specialty	Year of Service	2024-25 (as at 31 December 2024)
	16 - < 21 years	5
	21 - < 26 years	1
	26 - < 31 years	6
	31 years or above	3
Total		38
Cluster total		6 910

Note:

- (1) The manpower figure is calculated on headcount basis including permanent, contract and temporary staff in the HA.
- (2) Doctors exclude Interns and Dental Officers.
- (3) Starting from 2024-25, Ear, Nose & Throat and Clinical Oncology are no longer classified in the category of “Others”. The related figures of this category before 2024-25 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.

(c) and (d)

Over the years, the HA has been closely monitoring its manpower situation and introduced a series of measures to attract, develop and retain talents. The HA has implemented ongoing measures within its overall budget, such as increasing the number of Resident Trainee posts to recruit local medical graduates, recruiting non-locally trained doctors to supplement local recruitment, improving promotion prospects to retain staff, hiring part-time healthcare staff by, for example, recruitment of locum staff, offering flexible full-time work arrangements, extending employment to suitable staff beyond retirement, enhancing the Home Loan Interest Subsidy Scheme, and providing better training opportunities for various grades by establishment of the HA Academy. The above measures have begun to bear fruits, as evidenced by an increase in the number of the HA’s doctors in the past 2 years and a fall from the peak attrition rate over the past 2 years.

The HA established a Task Group on Sustainability in December 2019 to review strategies for retaining staff. In line with the key directions recommended by the Task Group, the HA gradually rolled out further staff retention measures in 2023-24 and will continue with the relevant work in 2025-26, including:

- (a) creating opportunities for Associate Consultants (AC) to be promoted to Consultant rank with 400 AC posts upgraded to Consultant posts as at December 2024, so as to retain experienced medical personnel to address the service, manpower and training needs in the HA; and
- (b) sustaining efforts to implement the policy of Extending Employment Beyond Retirement (EER) to attract more retired staff who wish to stay after retirement. As at December 2024, there were 181 doctors working at the HA after retirement. Among all doctors retiring from 2024-25 to 2028-29, at least 338 doctors had indicated interest/agreed to take up full-time or part-time employment after retirement.

The additional financial provision for the 2 measures of creating opportunities for AC to be promoted to Consultant rank and implementing EER (for grades including doctors, nurses and allied health professionals) is around \$138 million in 2025-26. As the budget of the HA for 2025-26 is being worked out, information on the estimated expenditure for the medical grade is unavailable.

The HA will continue to closely monitor the manpower situation and actively adopt measures to attract, develop and retain talents for supporting the overall service demand and development in the HA.

Abbreviations

HKEC – Hong Kong East Cluster
HKWC – Hong Kong West Cluster
KCC – Kowloon Central Cluster
KEC – Kowloon East Cluster
KWC – Kowloon West Cluster
NTEC – New Territories East Cluster
NTWC – New Territories West Cluster

- End -

CONTROLLING OFFICER'S REPLY

HHB151

(Question Serial No. 2261)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Given that the Government will oversee the realignment of functions and responsibilities and transfer of services among the Hospital Authority, Department of Health and the Primary Healthcare Commission in 2025-26, will it inform this Committee of the following:

- (a) What is the provision for the integration of the above authorities? Is there an anticipated number of cases where suitable patients will be transferred to primary healthcare services? If so, what is it? What are the criteria adopted by the Health Bureau in deciding whether a transfer is suitable?
- (b) What are the changes to the manpower of the above 3 policy implementing authorities upon realignment of their functions? What are the estimated costs to be incurred for such changes?
- (c) How will the Government perform the gate-keeping role in overseeing the matter? Has it considered publicising the work progress regularly to keep the Legislative Council and the public informed?

Asked by: Hon LUK Chung-hung (LegCo internal reference no.: 22)

Reply:

As announced in the Chief Executive's 2024 Policy Address, to enhance the health of the people of Hong Kong, improve healthcare protection and quality, and capitalise on our healthcare professions' strengths, the Government is conducting a comprehensive review on the positioning and objectives of the healthcare system. The review covers a reform of the functions and division of work among the Hospital Authority (HA), the Department of Health (DH) and the Primary Healthcare Commission (PHCC), and among which a reform of the HA's governance efficiency, with a view to improving the standards and efficiency of its specialist and in-patient services is included. Meanwhile, the PHCC and the DH will enhance their work on health promotion and disease prevention, continuing to shift the emphasis of the healthcare system from treatment-oriented to prevention-focused, so as to address the existing problem of system imbalance. The DH will also strengthen its roles as

the Government's public health adviser and the regulatory authority by focusing on its public health functions. To this end, the DH is gradually transferring its specialist clinical and primary healthcare services to the HA and the PHCC respectively, including the following:

- (i) Transfer of the clinical genetic service to the HA was completed in early 2024;
- (ii) Woman health services will be integrated into the district health network, to be named as Women Wellness Satellites, of the PHCC under the Health Bureau (HHB) within 2025, forming a network with District Health Centres / District Health Centre Expresses in all 18 districts across Hong Kong to provide eligible women with prevention-based and more personalised primary healthcare services. In addition, to further develop the multi-disciplinary primary healthcare service network, the PHCC plans to prepare for the integration of services of the Elderly Health Centres under the DH into the district health network in phases, starting from 2025-26, with a view to enhancing service synergy and minimising service duplication. Details of the transitional arrangements will be announced upon discussion with the DH; and
- (iii) In 2025-26, hospital dental services will be integrated into those under the HA and there is a plan to gradually transfer services such as child assessment service and tuberculosis and chest service to the HA.

The manpower and expenditure involved in the integration of services into those under the HA and the PHCC is subsumed under the overall provision of the DH, and hence no breakdown is available.

The HHB takes a central role in steering and coordinating the reform of the functions and division of work among the HA, the DH and the PHCC. For the DH's services integrated into the HA and the PHCC, relevant organisations will, at an appropriate time, inform the public and the users of the original services about the arrangements of service transfer and the new service model after the integration.

- End -

CONTROLLING OFFICER'S REPLY

HHB152

(Question Serial No. 2149)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned under Matters Requiring Special Attention in 2025-26 that the Hospital Authority (HA) will open a total of around 330 additional hospital beds to relieve the pressure on existing healthcare facilities and increase its service capacity. However, opening additional hospital beds involves an injection of a large amount of resources, including the expenses on manpower, equipment, facility conversion and various areas. In this connection, will the Government inform this Committee:

- (a) of the estimated expenditure involved in opening 330 additional hospital beds, with details of the allocation and a breakdown by item (such as manpower resources, facility conversion, etc.);
- (b) of the specific locations for the additional hospital beds to be distributed, with justifications for the selected locations; and
- (c) upon provision of additional hospital beds, how the HA will ensure sufficient healthcare personnel (such as doctors, nurses and support staff) for service delivery, with details on the plans and arrangement for the relevant manpower resources?

Asked by: Hon NG Chau-pei, Stanley (LegCo internal reference no.: 27)

Reply:

(a)-(c)

In general, the Hospital Authority (HA) plans and develops various public healthcare services (including the supply of hospital beds) on a cluster basis, taking into account a number of factors, including the increase of service demand arising from population growth and demographic changes, rising prevalence of chronic diseases, technology advancement, manpower supply as well as service arrangements of the various clusters. The HA has earmarked about \$548 million in 2025-26 for provision of 342 additional hospital beds. The table below sets out the proposed number of additional hospital beds to be provided in 2025-26 by hospital cluster:

Hospital cluster	Proposed no. of additional hospital beds to be provided in 2025-26
HKEC	4
HKWC	16
KCC	84
KEC	77
KWC	52*
NTEC	65
NTWC	44
HA overall	342

* Including 13 additional hospital beds to be provided upon re-planning the existing spaces of Yan Chai Hospital by converting 20 inpatient beds to 33 day inpatient beds

As the HA is preparing the budget for 2025-26, breakdown relating to expenditure of hospital beds is thus unavailable.

The HA has been proactively implementing various human resources measures to recruit additional staff, such as the Special Retired and Rehire Scheme and recruiting non-locally trained doctors and nurses. The HA also encourages clusters to optimise the use of existing manpower and internal resources to strengthen the management of public hospital systems and enhance the overall efficiency of service delivery, so as to cope with the increasing service demand. Overall, it is estimated that the number of doctors, nurses and allied health professionals of the HA will increase by 290, 1 040 and 250 (on full-time equivalent basis) respectively in 2025-26 as compared with that in 2024-25.

The HA will continue to monitor the utilisation of various healthcare services and make proper planning on public healthcare services.

Abbreviations

HKEC – Hong Kong East Cluster
HKWC – Hong Kong West Cluster
KCC – Kowloon Central Cluster
KEC – Kowloon East Cluster
KWC – Kowloon West Cluster
NTEC – New Territories East Cluster
NTWC – New Territories West Cluster

- End -

CONTROLLING OFFICER'S REPLY

HHB153

(Question Serial No. 2159)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned under Matters Requiring Special Attention in 2025-26 that the Government will enhance the Chronic Disease Co-care Pilot Scheme (the Scheme). In this connection, please advise this Committee on the following:

- (a) How does the Government evaluate the current progress regarding the implementation effectiveness of the Scheme? In particular, considering the number of participants in excess of 100 000 citizens, what specific indicators does the Government use to measure the success of the Scheme?
- (b) What is the annual expenditure for each healthcare item covered by the Scheme? Please provide the specific spending data and total expenditure amount for each item.
- (c) Does the Government plan to expand the coverage of healthcare items under the Scheme? If so, what are the new items and related expenditures expected to be involved?
- (d) Has the Government considered raising the screening subsidy under the Scheme? If so, what increase is expected in expenditure?
- (e) What are the criteria for the Government's selection of service points during the implementation of the Scheme? Are there any specific standards or procedures?
- (f) What publicity channels has the Government used to promote the Scheme? What is the expenditure for the relevant publicity activities? What is the reach rate of the publicity content? Are there any statistics indicating through which channels the participants have learned about the Scheme?

Asked by: Hon NG Chau-pei, Stanley (LegCo internal reference no.: 37)

Reply:

(a) to (d)

The Government has launched the Chronic Disease Co-Care Pilot Scheme (CDCC Pilot Scheme) since 13 November 2023, which is the first major initiative under the Primary Healthcare Blueprint. The Scheme provides subsidised diabetes mellitus (DM) and hypertension (HT) screening services in the private healthcare sector to Hong Kong residents aged 45 or above with no known medical history of DM or HT, with a view to encouraging citizens to gain a better understanding of their own health status as early as possible through screening, so as to achieve the goals of “early prevention, early identification and early treatment”.

The Government expects that 200,000 people will participate in the CDCC Pilot Scheme within the three-year pilot period. The Scheme has been well received since its launch. As at 27 March 2025 [provisional figures], about 114 200 citizens and over 600 family doctors have joined the Scheme, of which around 65 000 participants (i.e. nearly 60%) have completed the screenings for DM and HT, and around 25 230 of them (i.e. nearly 40%) have been diagnosed with prediabetes ^{Note}, DM or HT. The latter patients can proceed to the treatment phase and will be subsidised by the Government to continue their treatment with self-selected family doctors, and subject to their health conditions, be prescribed medication, or referred to follow-up care at nurse clinics and allied health services. In addition, the Government has established a bi-directional referral mechanism with the HA under CDCC Pilot Scheme. Family doctors can refer participants with clinical needs to receive a one-off specialist consultation at a designated Medicine SOPC of the HA according to clinical diagnosis and pre-defined criteria and guidelines; 50 participants have received one-off specialist consultation at the HA through the mechanism.

With regard to the promotion of multidisciplinary care, in accordance with the Government's earlier announcement, the dedicated nurse clinic and allied health services (including optometrists, physiotherapists and dietitians) have been introduced to devise more comprehensive chronic disease management programmes for the CDCC Pilot Scheme participants since 20 January 2025. Since the introduction of the relevant services, as at 27 March 2025 [provisional figures], 504 participants have made reservations for relevant services and 417 of them have already received services. From 28 March 2025, the CDCC Pilot Scheme has been expanded to cover blood lipid testing for eligible participants, allowing a more comprehensive approach to the assessment and proper management of cardiovascular disease risk factors, including the “three highs” (high blood pressure, high blood sugar and high cholesterol). Starting from the same day, the Scheme will be expanded in phases to provide preventive screening and care services in GOPCs of the HA for the underprivileged group. The 2025-26 estimates cover the medical service expenditures required for the scheme expansion, including doctor consultations, laboratory tests, medications, nurse clinics, and allied health services.

As mentioned in the Primary Healthcare Blueprint, local studies have shown that the healthcare system can achieve savings in healthcare expenses and reduce the burden of disease through the provision of subsidised screening and management services for DM management to suitable patients. The CDCC Pilot Scheme is a pilot scheme that encourages eligible citizens to undergo screening for DM and HT, two common chronic diseases, so that hidden patients can be detected at an early stages and their complications can be treated and prevented as early as possible, thereby reducing the need for hospitalisation. In order to further examine the effectiveness of the CDCC Pilot Scheme, the Government commissioned a local university in the first quarter of 2024 to conduct a study to assess the extent to which

the objectives of the scheme are met and the overall performance, including the service quality and effectiveness, as well as the cost-effectiveness. The Government will review the service model and operational details of the CDCC Pilot Scheme in a timely manner and make enhancements as necessary to ensure its effectiveness, including considering whether to expand the service scope of the Scheme.

The expenditure of the CDCC Pilot Scheme for 2023-24 and the estimated expenditure for 2024-25 are provided below:

2023-24 Expenditure (\$ million)	2024-25 Estimated Expenditure (\$ million)
10	43.1

Note: Prediabetes with glycated haemoglobin level of 6.0 to 6.4 per cent or fasting plasma glucose level of 6.1 to 6.9 mmol/L.

(e)

When selecting service points, factors such as convenience of access, market availability and frequency of demand for services will be taken into account, with a view to allowing the people across Hong Kong easy access to such service points, thereby providing a comprehensive and consistent primary healthcare service network for participants.

As at 27 March 2025 [provisional figure], there are 714 family doctor service points under the CDCC Pilot Scheme and 15 dedicated nurse clinics in 18 districts covering Hong Kong Island, Kowloon and the New Territories, whereas allied health services mainly focus on addressing the needs of patients with specific clinical needs or complex medical conditions, and it is therefore not necessary to establish service points in all districts.

(f)

Since the launch of the CDCC Pilot Scheme, the Government has promoted the Scheme through various channels, among which the District Health Centres / District Health Centre Expresses (collectively DHCs) play an important role. In addition to inviting existing eligible members to participate in the CDCC Pilot Scheme, the DHCs also organise large-scale promotional activities in respective districts and strengthen connection with the public through community outreach activities, mobile outreach vehicles and promotional booths in community complexes. The DHCs have been actively co-operating with community service partners, such as district councillors and the District Services and Community Care Teams to organise community activities to recruit eligible individuals to become Scheme participants. In view of the relatively low proportion of male participants (as at 31 December 2024, about 67% of the participants were female and 33% were male), DHCs are enhancing their promotional efforts focusing on men, including stepping up promotional efforts targeting at practitioners of particular industries such as transport, construction and catering, and arranging promotional activities on non-working days, especially Sundays.

At the same time, the Government has also been carrying out other forms of publicity activities to promote the CDCC Pilot Scheme through various television and media channels, and providing the public and healthcare service providers with latest information of the CDCC

Pilot Scheme through various communication platforms, such as website, telephone hotline, posters and brochures, electronic newsletters and online briefings.

- End -

CONTROLLING OFFICER'S REPLY

HHB154

(Question Serial No. 0944)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Health Bureau will continue to co-ordinate policy measures relating to mental health in 2025-26. In recent years, public awareness of treatment-resistant depression (TRD) (i.e. depression that remains unresponsive to at least 2 types of antidepressants) has increased. Patients with TRD are more prone to suicidal tendencies compared to those with general depression. According to a study released by the Faculty of Medicine of the University of Hong Kong in November 2024, fewer than 20% of patients with depression are likely to develop TRD or associated comorbidities, but they represent 31% to 54% of total depression-related healthcare costs. In this connection, will the Government inform this Committee of the following:

1. Information on mental health services under the Hospital Authority (HA) in the past 5 financial years in table form: i. the number and age distribution of patients with mental illnesses (including but not limited to depression, anxiety-related disorders, bipolar affective disorders and severe mental illnesses) in each hospital cluster; ii. the number of patients with TRD in each hospital cluster, and the proportion of patients with TRD to the overall population of patients suffering from depression; iii. the number of persons hospitalised due to mental illnesses (including but not limited to depression, anxiety-related disorders, bipolar affective disorders and severe mental illnesses) and their average, longest and shortest length of stay in hospitals; and iv. the number of persons hospitalised due to TRD and their average, longest and shortest length of stay in hospitals;
2. Does the HA maintain or track data on attempted suicides among TRD patients receiving treatment in public hospitals? Has there been an estimation of the suicide rate or attempted suicide rate among TRD patients? Does the HA have targeted measures to support patients with TRD?
3. It is mentioned in the 2024 Policy Address that the Government will extend integrated services based on a medical-educational-social collaboration model to promote mental health. Will the Government formulate targeted policy measures to support patients with TRD?

4. Will the HA arrange for more patients diagnosed with TRD to adopt new treatment methods and medications, such as electroconvulsive therapy, repetitive transcranial magnetic stimulation and prescription of Esketamine? If yes, what are the details? If not, what are the reasons?

Asked by: Hon NGAN Man-yu (LegCo internal reference no.: 2)

Reply:

(1)(i)、(ii)、(iv) and (2)

The tables below set out the number of psychiatric patients receiving treatment in each hospital cluster under the Hospital Authority (HA) and diagnosed with anxiety-related disorders, bipolar affective disorder, schizophrenic spectrum disorder or depression by disease group and age group from 2020-21 to 2024-25 (projection as of 31 December 2024).

2020-2021

Age Group ³	Hospital Cluster	No. of Psychiatric Patients of HA ^{1,2,7}	Type of Disorder			
			Anxiety-related Disorders ²	Bipolar Affective Disorder ²	Schizophrenic Spectrum Disorder ^{2,6}	Depression ²
Aged 0-17	HKEC	300	100	<50	<50	100
	HKWC	7 900	300	<50	<50	200
	KCC	300	<50	<50	<50	100
	KEC	6 100	200	<50	<50	200
	KWC	10 900	300	<50	100	400
	NTEC	8 700	200	<50	100	200
	NTWC	6 200	300	<50	<50	300
	Overall⁵	40 100	1 300	100	300	1 300
Aged 18-64	HKEC	15 400	3 600	600	2 600	3 700
	HKWC	12 200	3 400	600	2 400	3 800
	KCC	13 500	3 700	800	3 900	3 800
	KEC	23 400	8 000	1 000	5 900	5 300
	KWC	44 800	13 700	1 900	12 600	11 200
	NTEC	30 300	8 500	2 000	6 700	8 200
	NTWC	29 000	8 600	1 100	7 000	7 800
	Overall⁵	164 900	49 000	7 600	39 800	43 300

Age Group ³	Hospital Cluster	No. of Psychiatric Patients of HA ^{1,2,7}	Type of Disorder			
			Anxiety-related Disorders ²	Bipolar Affective Disorder ²	Schizophrenic Spectrum Disorder ^{2,6}	Depression ²
Aged 65 or above	HKEC	8 200	2 000	100	800	1 700
	HKWC	5 100	1 800	100	600	1 400
	KCC	6 500	1 900	200	1 000	1 500
	KEC	9 100	3 000	100	1 500	1 800
	KWC	20 900	5 800	300	3 600	4 600
	NTEC	12 200	2 900	300	1 500	3 200
	NTWC	9 800	2 600	200	1 700	2 600
	Overall⁵	70 800	19 800	1 300	10 500	16 600
Total⁴		275 800	70 100	9 100	50 600	61 300

2021-2022

Age Group ³	Hospital Cluster	No. of Psychiatric Patients of HA ^{1,2,7}	Type of Disorder			
			Anxiety-related Disorders ²	Bipolar Affective Disorder ²	Schizophrenic Spectrum Disorder ^{2,6}	Depression ²
Aged 0-17	HKEC	600	100	<50	<50	100
	HKWC	7 700	300	<50	<50	200
	KCC	400	100	<50	<50	100
	KEC	6 600	200	<50	<50	200
	KWC	12 000	400	<50	100	500
	NTEC	9 400	200	100	100	200
	NTWC	7 000	400	<50	<50	400
	Overall⁵	43 300	1 600	200	300	1 700
Aged 18-64	HKEC	15 700	3 900	600	2 500	3 800
	HKWC	12 400	3 500	600	2 400	3 900
	KCC	13 900	4 000	800	3 900	4 000
	KEC	24 700	8 500	1 100	6 000	5 700
	KWC	46 000	14 300	1 900	12 700	11 600
	NTEC	31 100	8 800	2 000	6 700	8 400
	NTWC	29 700	8 900	1 100	6 900	8 100
	Overall⁵	169 600	51 200	7 800	39 700	44 800
Aged 65 or above	HKEC	8 700	2 200	100	900	1 900
	HKWC	5 400	1 900	100	700	1 600
	KCC	6 800	2 000	200	1 100	1 600
	KEC	10 100	3 500	200	1 600	2 000
	KWC	22 200	6 400	400	3 700	5 000
	NTEC	13 200	3 200	300	1 600	3 500
	NTWC	10 600	3 000	200	1 800	2 800
	Overall⁵	76 100	22 100	1 400	11 200	18 200
Total⁴		288 900	74 800	9 400	51 200	64 700

2022-2023

Age Group ³	Hospital Cluster	No. of Psychiatric Patients of HA ^{1,2,7}	Type of Disorder			
			Anxiety-related Disorders ²	Bipolar Affective Disorder ²	Schizophrenic Spectrum Disorder ^{2,6}	Depression ²
Aged 0-17	HKEC	1 100	100	<50	<50	100
	HKWC	7 300	300	<50	<50	200
	KCC	900	100	<50	<50	100
	KEC	6 800	300	<50	<50	200
	KWC	12 200	400	<50	100	500
	NTEC	10 100	300	100	100	300
	NTWC	7 200	300	<50	<50	400
	Overall⁵	45 100	1 800	200	300	1 800
Aged 18-64	HKEC	15 700	4 000	600	2 500	3 800
	HKWC	12 600	3 600	600	2 400	3 900
	KCC	14 000	4 000	800	3 900	4 100
	KEC	25 500	8 700	1 100	5 900	5 900
	KWC	46 500	14 400	1 900	12 600	11 800
	NTEC	31 500	9 000	2 000	6 600	8 500
	NTWC	29 500	8 900	1 100	6 700	8 100
	Overall⁵	171 300	52 000	8 000	39 200	45 400
Aged 65 or above	HKEC	9 000	2 400	100	900	2 000
	HKWC	5 900	2 100	100	700	1 700
	KCC	7 100	2 200	200	1 100	1 700
	KEC	10 800	3 800	200	1 700	2 200
	KWC	23 300	6 900	400	3 800	5 400
	NTEC	14 100	3 600	400	1 700	3 800
	NTWC	11 300	3 300	200	1 900	3 100
	Overall⁵	80 500	24 100	1 600	11 700	19 600
Total⁴		296 900	77 800	9 700	51 100	66 800

2023-2024

Age Group ³	Hospital Cluster	No. of Psychiatric Patients of HA ^{1,2,7}	Type of Disorder			
			Anxiety-related Disorders ²	Bipolar Affective Disorder ²	Schizophrenic Spectrum Disorder ^{2,6}	Depression ²
Aged 0-17	HKEC	1 800	200	<50	<50	200
	HKWC	7 000	300	<50	<50	200
	KCC	1 500	100	100	100	200
	KWC	7 200	300	<50	<50	200
	KEC	12 900	400	<50	100	500
	NTEC	10 500	300	100	100	300
	NTWC	8 100	400	<50	<50	400
	Overall⁵	48 400	2 100	300	300	2 100

Age Group ³	Hospital Cluster	No. of Psychiatric Patients of HA ^{1,2,7}	Type of Disorder			
			Anxiety-related Disorders ²	Bipolar Affective Disorder ²	Schizophrenic Spectrum Disorder ^{2,6}	Depression ²
Aged 18-64	HKEC	15 800	4 100	600	2 500	3 800
	HKWC	12 700	3 600	600	2 300	3 900
	KCC	14 300	4 200	900	3 900	4 100
	KEC	26 400	9 000	1 100	5 800	6 000
	KWC	47 000	14 700	2 000	12 400	12 100
	NTEC	31 900	9 100	2 100	6 500	8 500
	NTWC	30 400	9 300	1 200	6 700	8 300
	Overall⁵	174 400	53 300	8 200	38 700	46 100
Aged 65 or above	HKEC	9 600	2 600	100	900	2 100
	HKWC	6 300	2 300	100	800	1 800
	KCC	7 600	2 400	200	1 100	1 800
	KEC	11 600	4 200	200	1 800	2 300
	KWC	25 100	7 600	400	4 000	5 900
	NTEC	15 300	4 100	400	1 800	4 100
	NTWC	12 300	3 700	200	2 000	3 300
	Overall⁵	86 600	26 800	1 700	12 200	21 200
Total⁴		309 400	82 100	10 200	51 200	69 400

2024-2025 (projection as of 31 December 2024)

Age Group ³	Hospital Cluster	No. of Psychiatric Patients of HA ^{1,2,7}	Type of Disorder			
			Anxiety-related Disorders ²	Bipolar Affective Disorder ²	Schizophrenic Spectrum Disorder ^{2,6}	Depression ²
Aged 0-17	HKEC	2 400	200	<50	<50	200
	HKWC	6 800	300	<50	<50	200
	KCC	2 000	200	100	100	200
	KWC	7 300	400	<50	<50	300
	KEC	13 200	400	<50	100	500
	NTEC	10 900	300	100	100	300
	NTWC	8 500	500	<50	<50	500
	Overall⁵	50 500	2 200	300	300	2 100
Aged 18-64	HKEC	15 600	3 900	600	2 500	3 800
	HKWC	12 800	3 600	600	2 200	3 900
	KCC	14 300	4 200	900	3 700	4 100
	KEC	27 100	9 200	1 100	5 700	6 200
	KWC	47 800	14 800	2 100	12 200	12 300
	NTEC	32 500	9 400	2 000	6 400	8 500
	NTWC	30 900	9 400	1 200	6 600	8 500
	Overall⁵	176 600	53 700	8 300	37 900	46 500

Age Group ³	Hospital Cluster	No. of Psychiatric Patients of HA ^{1,2,7}	Type of Disorder			
			Anxiety-related Disorders ²	Bipolar Affective Disorder ²	Schizophrenic Spectrum Disorder ^{2,6}	Depression ²
Aged 65 or above	HKEC	10 200	2 900	100	900	2 300
	HKWC	6 700	2 500	200	800	1 900
	KCC	8 000	2 600	200	1 200	1 900
	KEC	12 400	4 600	200	1 900	2 500
	KWC	27 100	8 400	500	4 300	6 300
	NTEC	16 700	4 500	500	2 000	4 500
	NTWC	13 600	4 200	300	2 200	3 700
	Overall⁵	93 500	29 400	1 900	13 100	22 900
Total⁴		320 600	85 300	10 500	51 300	71 600

Note:

1. Including inpatients, patients at specialist outpatient clinics and day hospitals.
2. Figures are rounded to the nearest hundred.
3. Referring to the age of the patient as of 30 June of the respective year.
4. Individual figures may not add up to the total due to rounding and the inclusion of patients of unknown age.
5. The figures for each hospital cluster may not add up to the total as patients may be treated in more than one hospital cluster.
6. In the HA, patients with severe mental illness generally refer to psychiatric patients with schizophrenic spectrum disorder, and do not include severely mentally ill patients diagnosed with other disorders.
7. As the above table does not cover all types of disorder, the breakdown by type of disorder may not add up to the total number of psychiatric patients.

The HA does not maintain figures of psychiatric patients suffering from treatment-resistant depression (TRD) and the related statistics.

(1)(iii)

The table below sets out the numbers of discharges and deaths as well as the average, 25th and 90th percentile of length of stay of psychiatric inpatients from 2020-21 to 2024-25 (projection as of 31 December 2024).

Year	No. of Discharges and Deaths of Psychiatric Inpatients	Length of Stay of Inpatients (Day)		
		Average	25 th Percentile	90 th Percentile
2020-21	16 597	57.3	11	97
2021-22	16 816	51.4	11	93
2022-23	16 577	60.1	12	100
2023-24	19 161	55.5	11	98
2024-25 (as of 31 December 2024)	15 299	53.9	11	103

Note:

1. The HA uses the 25th percentile and 90th percentile to indicate the relatively short and long length of stay of inpatients respectively.
2. In the HA, day inpatients refer to those who are admitted to hospitals for non-emergency treatment and discharged within the same day. Inpatients are those who are admitted to hospitals via Accident & Emergency departments or those who have stayed for more than one day. The number of day patients are excluded from the calculation of the inpatients' length of stay on average and at the 25th percentile and 90th percentile.

(3)

The HA has been actively promoting a number of community mental health programmes to strengthen the community psychiatric services and collaborating with community partners and carers to support psychiatric patients (including TRD patients) living in the community. Community psychiatric services cover 3 levels of services, including the Intensive Care Team, Case Management Programme and Standard Community Psychiatric Service. Taking into account patients' medical conditions as well as clinical needs and risks, the multi-disciplinary teams provide them with appropriate community support. Through regular outreach or home visits, as well as close collaboration with community partners, case managers help persons in mental recovery set goals and draw up recovery plans to facilitate their re-integration into the community, and also offer appropriate support and advice to their carers and families while endeavouring to promote mental health in the community.

Patients in need of community psychiatric support services may be referred through various channels such as Integrated Community Centres for Mental Wellness subvented by the Social Welfare Department (SWD) or social workers to receive community psychiatric services. Moreover, the HA and SWD's medical social workers provide appropriate assistance for patients and their families in need, including financial/in-kind assistance, counselling services, connection with community resources, etc., in order to facilitate their recovery and re-integration into society.

(4)

The first antidepressant targeting the glutamate system, Esketamine, has been included in the HA Drug Formulary as a special drug since mid-2023. Special drugs are used under specified clinical application with specific specialist authorisation. These drugs are provided at standard fees and charges in public hospitals and clinics when prescribed under specific clinical conditions. Psychiatrists of the HA will prescribe HA patients suitable and an appropriate amount of medications (including Esketamine) based on professional diagnosis and the patients' clinical conditions to ensure that patients receive timely and appropriate treatment.

Apart from drug treatment, the HA also provides Electroconvulsive Therapy and Transcranial Magnetic Stimulation for the treatment of depression. Healthcare professionals will refer suitable patients to receive the above treatments according to their medical conditions and clinical needs.

Remark:

In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA adjusted its services to cope with the outbreak. This should therefore be taken into consideration when comparing the service capacity of the HA in the respective years. With the subsiding of local COVID-19 epidemic situation and cessation of anti-epidemic measures in early 2023, the HA has been gradually resuming provision of all of its public healthcare services to tie in with the Government's normalcy measures.

Abbreviations:

HKEC – Hong Kong East Cluster
HKWC – Hong Kong West Cluster
KCC – Kowloon Central Cluster
KEC – Kowloon East Cluster
KWC – Kowloon West Cluster
NTEC – New Territories East Cluster
NTWC – New Territories West Cluster

- End -

CONTROLLING OFFICER'S REPLY

HHB155

(Question Serial No. 0954)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

In a bid to shift the emphasis of the present healthcare system and people's mindset from treatment-oriented to prevention-focused, the Government has set up District Health Centres (DHCs) and interim District Health Centre Expresses (DHCEs) of a smaller scale in multiple districts, with a view to providing prevention-focused primary healthcare services across the 18 districts in Hong Kong. The DHCs and DHCEs, subsidised by the Government and run by non-governmental organisations, play a vital role in the healthcare system. In this connection, will the Government inform this Committee of the following:

1. Please give a brief account of the implementation of the DHC initiative, including the service commencement date, number of members, number of attendances, expenditure and staffing establishment;
2. It is understood that due to the lack of data interoperability between the current DHCs and the Government, users need to apply separately and provide relevant proof before they can be granted a full or partial waiver of the medical service fees under the present medical fee waiver mechanism of the Hospital Authority (HA). Will the Bureau consider promoting data sharing between DHCs and government or public institutions (e.g. Social Welfare Department and HA) with users' consent so as to streamline the procedure and save the time involved in data submission?
3. Please provide the timetable for upgrading DHCEs to DHCs, and the expenditure and staffing establishment involved; and
4. Under this Programme, it is stated that the Bureau will "continue to take forward and enhance the development of DHCs and DHCEs across the territory, and integrating the services of Woman Health Centres and Elderly Health Centres into DHC Network." Please provide details of the relevant plan and the work schedule.

Asked by: Hon NGAN Man-yu (LegCo internal reference no.: 12)

Reply:

(1)

The service commencement dates, cumulative numbers of members and attendances of DHCs and DHCEs are set out in the table below:

DHC/DHCE Service Commencement Date	Cumulative Number of Members^{Note 1} (as at 31 December 2024) [Provisional Figures]	Cumulative Number of Attendances^{Notes 1, 2, 3, 4} (as at 31 December 2024) [Provisional Figures]
<i>DHC</i>		
Kwai Tsing 24 September 2019	46 100	498 300
Sham Shui Po 30 June 2021	34 300	296 600
Tuen Mun 31 May 2022	38 100	344 100
Wong Tai Sin 30 June 2022	34 700	200 900
Southern 17 October 2022	23 900	175 300
Yuen Long 24 October 2022	42 500	255 000
Tsuen Wan 30 December 2022	26 000	175 700
<i>DHCE</i>		
Sai Kung 1 September 2021	10 600	84 900
Kowloon City 1 October 2021	11 300	57 300
Yau Tsim Mong 1 October 2021	9 600	48 500
Wan Chai 4 October 2021	6 800	53 000
North 18 October 2021	8 700	53 700
Islands 18 October 2021	6 400	35 900
Kwun Tong 21 October 2021	10 800	49 300
Tai Po 22 October 2021	7 800	45 000
Sha Tin 30 October 2021	13 300	71 400
Central and Western 30 October 2021	7 900	50 200
Eastern 30 October 2021	10 900	54 700

DHC/DHCE Service Commencement Date	Cumulative Number of Members^{Note 1} (as at 31 December 2024) [Provisional Figures]	Cumulative Number of Attendances^{Notes 1, 2, 3, 4} (as at 31 December 2024) [Provisional Figures]
Total	349 900	2 549 900

Note:

1. Figures are rounded to the nearest hundred.
2. The figures only include service figures captured from the DHC/DHCE information system, and do not include those relating to medical laboratory tests.
3. As different services are provided by the 11 DHCEs, the attendance figures are not directly comparable.
4. The service figures above have included services provided by DHCs/DHCEs for participants of the Chronic Disease Co-care Pilot Scheme which was launched on 13 November 2023.

The staff establishment (including healthcare professionals and other supporting staff) and revised estimate (including the provisions for service contracts, site maintenance and rental cost) of DHCs in Kwai Tsing, Sham Shui Po, Tuen Mun, Wong Tai Sin, Southern, Yuen Long and Tsuen Wan in 2024-25 are set out in the table below:

	DHC						
	Kwai Tsing	Sham Shui Po	Tuen Mun	Wong Tai Sin	Southern	Yuen Long	Tsuen Wan
Staff establishment^{Note 5}							
Executive Director	1	1	1	1	1	1	1
Medical Consultant ^{Note 6}	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Chief Care Coordinator	1	1	1	1	1	1	1
Care Coordinator/ Nurse	21	18.5	26	25	16	29	21
Physiotherapist	3.5	2	3	3	3	3	2
Occupational Therapist	1.5	2	2	2	3	3	2
Dietitian	1	1	1	2	1	2	2
Pharmacist	1	1	1	1	1	1	1
Social Worker, Administrative Staff and Supporting Staff	55	69	62	62	59	50	48
Total	85.5	96	97.5	97.5	85.5	90.5	78.5
2024-25 Revised Estimate (\$ million)	62	63	80	69	58	73	78

Note:

5. The staff establishment is proposed by DHC operators through tendering procedures according to the service demand in the community and manpower estimation, and is approved by the Government. The 0.5 staff establishment refers to a part-time position with half of the working hours of a full-time position. The actual number of staff may vary from time to time, depending on factors such as service demand and short-term manpower turnover, etc. The Government will continue to monitor the situation to ensure that services are not affected.
6. Medical Consultants are part-time or outsourced positions.

The staff establishment (including healthcare professionals and other supporting staff) and revised estimate (including the provisions for service contracts, site maintenance and rental cost) of all DHCEs in 2024-25 are set out in the table below:

	DHCE										
	Central and Western	Eastern	Islands	Kowloon City	Kwun Tong	North	Sai Kung	Sha Tin	Tai Po	Wan Chai	Yau Tsim Mong
Staff establishment Notes 7,8											
Project Coordinator	1	1	1	1	1	1	1	1	1	1	1
Medical Consultant Note 9	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Care Coordinator	3	3	3	1	2	1	2	5	5	5	1
Nurse	1	3		5	4	3	4				4
Physiotherapist	1	1	1	1	1	1	1	1	1	1	1
Occupational Therapist					1		1		0.5	1	
Pharmacist	0.5	0.5					1	1		1	
Dietitian				1	1	0.5	1		1		1
Social Worker, Administrative Staff and Supporting Staff	14	15	12	13	15.5	14.5	12	18	14	7.5	14
Total	21	24	17.5	22.5	26	21.5	23.5	26.5	23	17	22.5
2024-25 Revised Estimate (\$ million)	15	14	13	14	14	14	14	14	14	15	14

Note:

7. The staff establishment is proposed by DHCEs according to the service demand in the community and manpower estimation, and is reviewed and approved by the Government before entering into contracts with operators. The 0.5 staff establishment refers to a part-time position with half of the working hours of a full-time position. The actual number of staff may vary from time to time, depending on factors such as service demand and short-term manpower turnover, etc. The Government will continue to monitor the situation to ensure that services are not affected.
8. The staff establishment of each DHCE is dependent on the service demand and service delivery model of the district concerned, and so the figures are not directly comparable.
9. Medical Consultants are part-time or outsourced positions.

(2)

The Government is implementing a five-year development plan of eHealth+ to transform eHealth from a health record sharing system into a comprehensive healthcare information infrastructure that integrates multiple functions of data sharing, service delivery and care journey management, with a view to supporting healthcare reforms and implementation of various healthcare measures including primary healthcare. In July 2024, the Finance Committee of the Legislative Council approved a capital funding of \$1,395.8 million to support the eHealth+ development.

One of the strategic directions of eHealth+ development is “One Care Journey”, which calls for building an effective IT infrastructure that runs through the entire healthcare journey and links to different sectors and tiers of the healthcare system. eHealth+ will also facilitate citizens’ participation in different health programmes, including the services provided by DHC. DHC would access individual’s health records through eHealth with authorisation to assist citizens to obtain relevant district services, and act as citizens’ case manager to provide continuous chronic disease management and preventive care services in the community. At the same time, we will strengthen the interfacing, coordination and data sharing across the information systems of various government departments and public organisations. We are now building a one-stop “Strategic Health Service Operation Platform” in phases to support and standardise the workflow and documentation, both clinically and administratively, of all subsidised healthcare programmes and related public and private healthcare services (including DHCs and DHCEs). The platform will cover multiple layers of functions, including enrolment, attendance registration, subsidy reimbursement and participants’ co-payment management, etc. We will also consult other departments/organisations (such as the Department of Health (DH), Hospital Authority (HA) and the Social Welfare Department) on integrating the platform with information systems of relevant departments/organisations, including exploring the addition of eligibility checking features. This will allow healthcare providers, with citizens’ consent and in compliance with privacy protection laws, to electronically verify their eligibility for medical fee waiver in real-time, thereby enhancing the efficiency of related service processes.

(3)

The Government set up 7 DHCs and 11 smaller interim DHCEs in rented properties across the territory by 2022, thereby attaining the interim goal of covering all 18 districts of Hong

Kong. The Government will upgrade the three DHCEs in the Central and Western District, Eastern District, and Yau Tsim Mong District to DHCs within 2025. In April 2024, the Health Bureau launched a tender exercise for the operation of the Central and Western DHC and three women's health service points named Women Wellness Satellites located in Chai Wan, Lam Tin and Tuen Mun. A three-year operation service contract with a total value of approximately \$531.7 million was subsequently awarded in January 2025. The Central and Western DHC is expected to commence operation in the third quarter of this year. In July 2024, the Health Bureau conducted tender exercises for the operation of the Eastern and Yau Tsim Mong DHCs. The operation service contracts for these two DHCs are expected to be awarded this year.

Upon the upgrading of the three DHCEs to DHCs this year, the 11 existing DHCEs will gradually reduce to 8, while the number of DHCs will increase to 10. The estimated expenditure for DHCs and DHCEs (including provisions for service contracts, site maintenance and rental cost) for 2025-26 are \$1.083 billion and \$213 million respectively.

In addition, the funding proposals for the construction projects of Wan Chai, Kwun Tong, Sai Kung and North District DHCs were approved by the Finance Committee of the Legislative Council (LegCo) in January and October 2021, and in April and July 2024 respectively. These projects will be completed gradually in the next few years. To achieve the long-term development goal of having DHCs in all 18 districts as early as possible, the Government is actively taking forward the plan to establish DHCs in the remaining four districts and will seek LegCo's funding approval in due course. Before the remaining DHCs are set up, the Government will continue to subsidise non-governmental organisations to operate DHCEs in those districts. The services provided by DHCEs will be migrated as appropriate to DHCs in respective districts at a later stage. The PHCC will, together with the operators of DHCEs, draw up and implement transition plans for upgrading DHCEs to DHCs to ensure a smooth transition of services.

(4)

Integration of women and elderly health services under the Department of Health (DH) into the district health network of the PHCC aims to utilise resources more effectively, strengthening the prevention-oriented, district-based, and family-centric primary healthcare network.

The PHCC will commence the integration of women health services within this year in an orderly manner. The services, operated by non-governmental organisations engaged by open tender, will be rendered through three service points named Women Wellness Satellites (WWSs) to provide women primary healthcare services. The 3 WWSs in Chai Wan, Lam Tin and Tuen Mun will progressively start service in 2025 to replace the Woman Health Centres of the DH. The Chai Wan WWS will commence operation in the second quarter while the Lam Tin and Tuen Mun WWSs are expected to be open in the third quarter. DHCs and DHCEs across all 18 districts will enhance promotion and education on women's health, and provide new dedicated nurse clinics for women's health services to encourage and support members of the public to manage their own health. DHCs and DHCEs will also identify women in need through basic health assessments and individual consultations, and refer them to WWSs or General Out-patient Clinics of the Hospital Authority to receive women's health services.

Specifically, DHCs and DHCEs provide basic women health services, conduct initial assessments and arrange referrals to WWSs for services as necessary. WWSs will provide more personalised primary healthcare services for women. In addition to the existing services such as health assessments, breast cancer and cervical cancer screenings, WWSs will devise personalised preventive care or specific consultation services according to individual health risks and needs for members' selection to enhance prevention-oriented women's health services.

Moreover, to further expand the multidisciplinary primary healthcare service network, the PHCC plans to start the preparation for the integration of the services of Elderly Health Centres under the DH into the district health network in phases from 2025-26, with a view to enhancing service synergy and minimising service duplication. The detailed transitional arrangements will be announced after discussion with the DH.

- End -

CONTROLLING OFFICER'S REPLY

HHB156

(Question Serial No. 0955)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Chronic Disease Co-Care Pilot Scheme (CDCC Pilot Scheme) was officially launched on 13 November 2023. Starting from that day, Hong Kong residents aged 45 or above with no known medical history of diabetes mellitus (DM) or hypertension (HT) can enrol in the scheme at any District Health Centre (DHC) or DHC Express and pair up with a family doctor for DM and HT screening and long-term follow-up. Please advise this Committee of:

1. the respective number of doctors participating in the scheme, the completion rate of screening, the percentage of those diagnosed with prediabetes, DM or HT upon completion of screening, and the follow-up actions taken;
2. whether there are plans to review the CDCC Pilot Scheme, and the details of the review, including whether the scheme will be extended to cover different age groups; and
3. given it is noted that the Primary Healthcare Commission is planning to further extend the CDCC Pilot Scheme to cover blood lipid testing, please provide the details of such an extension, including the anticipated number of participants, number of doctors, types of screening items, follow-up actions for those diagnosed with hyperlipidemia upon completion of screening, and the estimated expenditure.

Asked by: Hon NGAN Man-yu (LegCo internal reference no.: 13)

Reply:

(1) to (3)

The Government has launched the three-year Chronic Disease Co-Care Pilot Scheme (CDCC Pilot Scheme) since 13 November 2023, which is the first major initiative under the Primary Healthcare Blueprint. The Scheme provides subsidised diabetes mellitus (DM) and hypertension (HT) screening services in the private healthcare sector to Hong Kong residents aged 45 or above with no known medical history of DM or HT, with a view to encouraging citizens to gain a better understanding of their own health status as early as possible through screening, so as to achieve the goals of “early prevention, early identification and early

treatment”. The Government aims to establish a family doctor regime and position District Health Centres (DHC) and DHC Expresses as hubs to foster expansion of the community healthcare network, so as to properly manage chronic diseases in the community through a multi-disciplinary approach, thereby alleviating the pressure on secondary and tertiary healthcare services, in particular the Specialist Out-patient Clinics (SOPCs) of the Hospital Authority (HA).

The Government expects that 200,000 people will participate in the CDCC Pilot Scheme within the three-year pilot period. The Scheme has been well received since its launch. As at 27 March 2025 [provisional figures], about 114 200 citizens and over 600 family doctors have joined the Scheme, of which around 65 000 participants (i.e. nearly 60%) have completed the screenings for DM and HT, and around 25 230 of them (i.e. nearly 40%) have been diagnosed with prediabetes^{Note}, DM or HT. The latter patients can proceed to the treatment phase and will be subsidised by the Government to continue their treatment with self-selected family doctors, and subject to their health conditions, be prescribed medication, or referred to follow-up care at nurse clinics and allied health services. In addition, the Government has established a bi-directional referral mechanism with the HA under CDCC Pilot Scheme. Family doctors can refer participants with clinical needs to receive a one-off specialist consultation at a designated Medicine SOPC of the HA according to clinical diagnosis and pre-defined criteria and guidelines; 50 participants have received one-off specialist consultation at the HA through the mechanism.

With regard to the promotion of multidisciplinary care, in accordance with the Government's earlier announcement, the dedicated nurse clinic and allied health services (including optometrists, physiotherapists and dietitians) have been introduced to devise more comprehensive chronic disease management programmes for the CDCC Pilot Scheme participants since 20 January 2025. From 28 March 2025, the CDCC Pilot Scheme has been expanded to cover blood lipid testing for eligible participants, allowing a more comprehensive approach to the assessment and proper management of cardiovascular disease risk factors, including the “three highs” (high blood pressure, high blood sugar and high cholesterol). Starting from the same day, the Scheme will be expanded in phases to provide preventive screening and care services in GOPCs of the HA for the underprivileged group. The 2025-26 estimates cover the medical service expenditures required for the scheme expansion, including doctor consultations, laboratory tests, medications, nurse clinics, and allied health services.

As mentioned in the Primary Healthcare Blueprint, local studies have shown that the healthcare system can achieve savings in healthcare expenses and reduce the burden of disease through the provision of subsidised screening and management services for DM management to suitable patients. The CDCC Pilot Scheme is a pilot scheme that encourages eligible citizens to undergo screening for DM and HT, two common chronic diseases, so that hidden patients can be detected at an early stages and their complications can be treated and prevented as early as possible, thereby reducing the need for hospitalisation. In order to further examine the effectiveness of the CDCC Pilot Scheme, the Government commissioned a local university in the first quarter of 2024 to conduct a study to assess the extent to which the objectives of the scheme are met and the overall performance, including the service quality and effectiveness, as well as the cost-effectiveness. The Government will review the service model and operational details of the CDCC Pilot Scheme in a timely manner and make

enhancements as necessary to ensure its effectiveness, including considering whether to expand the service scope of the Scheme.

^{Note} Prediabetes with glycated haemoglobin level of 6.0 to 6.4 per cent or fasting plasma glucose level of 6.1 to 6.9 mmol/L.

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CONTROLLING OFFICER'S REPLY

HHB157

(Question Serial No. 0959)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health, (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding medical services for children, please advise this Committee of the following:

1. Under the current healthcare system, how many public hospitals provide Paediatric specialist services, what is their proportion in the total number of public hospitals in Hong Kong, and what is their geographical distribution;
2. Please provide details of Paediatric specialist services in the past 3 years, including service categories, quotas, patient waiting times, as well as the expenditure and staff establishment involved;
3. It is reported that the services of the Ear, Nose & Throat (ENT) department of Hong Kong Children's Hospital at Kai Tak has been suspended due to doctor attrition, and is expected to gradually resume in the second half of 2025. According to the Health Bureau, the incident reflects the need for integration of such subspecialty services. Please provide details of the follow-up actions taken, and the integration plan for sub-specialty services and its progress;
4. Please provide the number of attendances of minors (under 18) receiving general outpatient consultation services over the past 3 years with the proportion in total service attendances. (Please list by the following categories: Newborns (0 to under 6 months); Infants (6 months to before 1 year); Toddlers (1-2 years); Preschool children (3-5 years); School-age children (6-12 years); Adolescents (13-18 years));
5. Please provide the number of underage individuals (below 18 years old) currently registered as users of eHealth and their proportion in total registrations. (Please provide a breakdown by the following categories: Newborns (0 to less than 6 months); Infants (6 months to before 1 year); Toddlers (1-2 years); Preschool children (3-5 years); School-age children (6-12 years); Adolescents (13-18 years)); and
6. It is reported that eHealth launches a new feature that allows parents to open eHealth account and build a personal lifelong electronic health record for their children, with the aim

of facilitating more coherent healthcare services throughout their growth. What measures will the Bureau take to promote this feature, such as setting up registration booths at community centres and schools? Is there any plan to extend the functionalities of eHealth in relation to children's health in the future?

Asked by: Hon NGAN Man-yu (LegCo internal reference no.: 17)

Reply:

1.

The Hospital Authority (HA) operates its paediatric services under a hub-and-spoke model since the Hong Kong Children's Hospital (HKCH) commenced its service by phases starting from December 2018. As a tertiary referral centre, HKCH focuses on handling severe, complex and uncommon paediatric cases requiring multi-disciplinary management, providing diagnosis, treatment and rehabilitation services for patients of the whole territory from birth to 18 years of age with relevant clinical needs. As for the paediatric departments in the 16 public hospitals in different regions, they are mainly responsible for secondary, emergency and community care services. The service distribution by hospital cluster is tabulated below:

Cluster	Hospital
Hong Kong East	Pamela Youde Nethersole Eastern Hospital
Hong Kong West	Queen Mary Hospital
	The Duchess of Kent Children's Hospital at Sandy Bay
Kowloon Central	Queen Elizabeth Hospital
	Kwong Wah Hospital
	Hong Kong Children's Hospital
Kowloon East	United Christian Hospital
	Tseung Kwan O Hospital
Kowloon West	Princess Margaret Hospital
	North Lantau Hospital
	Caritas Medical Centre
	Yan Chai Hospital
New Territories East	Prince of Wales Hospital
	Alice Ho Miu Ling Nethersole Hospital
	North District Hospital
New Territories West	Tuen Mun Hospital
	Pok Oi Hospital

2.

The details of the HA's Paediatric Services for the past 3 years are set out in Tables 1 to 5 below.

Table 1: Number of inpatient and day inpatient discharges and deaths at the Paediatric Services of the HA[#] from 2022-23 to 2024-25 (as at 31 December 2024)

Year	Number of inpatient and day inpatient discharges and deaths at the Paediatric Services [#]
2022-23	88 718
2023-24	132 467
2024-25 (as at 31 December 2024)	94 026

[#] The figures above include those for Paediatrics and Neonatology, where adolescents are included under Paediatrics.

Note: According to HA's classification, day inpatients refer to those who are admitted to hospital for non-emergency treatment and discharged within the same day. Inpatients are those who are admitted to hospital via the Accident & Emergency departments or hospitalised for more than 1 day. The calculation of the number of patient discharges and deaths includes the figures for both inpatients and day inpatients.

Table 2: Number of paediatric specialist out-patient (SOP) attendances in HA from 2022-23 to 2024-25 (as at 31 December 2024)

Year	Number of paediatric SOP attendance
2022-23	248 044
2023-24	267 837
2024-25 (as at 31 December 2024)	214 893

Table 3: Number of paediatric SOP new cases in HA and the median (50th percentile) waiting time from 2022-23 to 2024-25 (as at 31 December 2024)

Year	Priority 1 (Urgent) case		Priority 2 (Semi-urgent) case		Routine (Stable) case	
	Number of new case	Median waiting time (week)	Number of new case	Median waiting time (week)	Number of new case	Median waiting time (week)
2022-23	3 761	<1	5 774	4	15 607	12
2023-24	3 509	<1	6 228	6	19 877	15
2024-25 (as at 31 December 2024)	2 459	<1	4 762	5	16 337	17

Note: With effect from 1 October 2022, the waiting time for new case booking at SOP clinics include that of integrated clinics.

Table 4: Cost of paediatric[#] specialist services (including inpatient and SOP services) in HA in 2022-23 and 2023-24

Year	Cost of paediatric[#] specialist service (\$ million)
2022-23	5,270
2023-24	5,549

The figures above include those for Paediatrics and Neonatology, where adolescents are included under Paediatrics.

Note:

1. Service costs include direct staff expenses (e.g. on doctors, nurses and allied health professionals) for service provision to patients; expenditure incurred for clinical support services (e.g. anaesthetic and operating theatre, pharmacy, diagnostic radiology and pathology laboratory); and other operating expenditure (e.g. expenses on meals for patients, public utilities, and repair and maintenance of medical equipment).
2. Since the financial year of 2024-25 has not yet ended, cost information in respect of the financial year is not yet available.
3. In view of the emergence of the COVID-19 epidemic in Hong Kong in early 2020, the HA adjusted its services to cope with the epidemic. This should be taken into consideration when comparing the throughput of services provided by the HA across the years. With the cessation of anti-epidemic measures in early 2023, the HA services have gradually resumed to normalcy. With the impact (if any) of the COVID-19 epidemic on costs reflected in the 2022-23 costing information, the costing information across the years may not be directly comparable.

Table 5: Number of paediatricians and paediatric nurses in HA from 2022-23 to 2024-25 (as at 31 December 2024) calculated on a full-time equivalent basis

Staff group	2022-23	2023-24	2024-25 (as at 31 December 2024)
Paediatricians	444	440	447
Nurses	1 552	1 540	1 589

Note:

1. The manpower figures above are calculated on a full-time equivalent basis including permanent, contract and temporary staff in the HA.
2. The number of paediatricians above exclude interns and Dental Officers.
3. The number of nurses include Senior Nursing Officers, Department Operations Managers, Nurse Consultants, Associate Nurse Consultants, Ward Managers, Nursing Officers, Advanced Practice Nurses, Registered Nurses, Enrolled Nurses and Nursing Trainees.
4. Starting from January 2024, the full-time equivalent for temporary part-time staff is calculated based on their actual working hours. The figures prior to that month are for reference only and direct comparison with those derived using the revised calculation method is not appropriate.

3.

The Chief Executive set out in his 2024 Policy Address to integrate paediatric services across clusters to better utilise the functions of HKCH. The HA will take forward its work in this direction to integrate paediatric services for development at HKCH, this will cover not only paediatric ear, nose and throat (ENT), but also serious, complex, uncommon conditions requiring multidisciplinary management in HKCH with a view to enhancing the quality of paediatric care. HKCH and other regional hospitals will also work together to establish a coordinated and coherent paediatric service network to provide appropriate hospital and nursing care for all children in Hong Kong.

The ENT department of HKCH was originally staffed by 1 Associate Consultant, 1 Resident and 1 half-time Consultant. However, the ENT service of the hospital has been temporarily adjusted since November last year due to insufficient manpower for reasons including departure from work and personal health.

The HA Head Office is actively co-ordinating the transitional measures during this period, including deploying experienced ENT Associate Consultants to the Kowloon Central Cluster to strengthen the overall manpower. The HA will continue to improve the manpower situation through recruitment, and the provision of ENT services at HKCH, such as specialist out-patient services and inpatient consultation services, is expected to gradually resume in the second half of this year. When the manpower situation stabilises, other services, such as non-emergency surgeries and cross-specialty services, will be provided in a progressive manner, with service resumption expected by the end of this year.

4.

The table below sets out the number of attendances of general out-patient (GOP) service in the HA regarding persons aged below 18 and its percentage in the total number of attendances by age group from 2022-23 to 2024-25 (up to 31 December 2024).

Age group	2022-23		2023-24		2024-25 (up to 31 December 2024)	
	Number of GOP attendances	Percentage in the total number of GOP attendances	Number of GOP attendances	Percentage in the total number of GOP attendances	Number of GOP attendances	Percentage in the total number of GOP attendances
Aged 0 to under 6 months	550	<1%	1 320	<1%	1 250	<1%
Aged 6 months to under 1	1 080	<1%	2 270	<1%	1 610	<1%
Aged 1 to 2	6 590	<1%	15 060	<1%	9 440	<1%
Aged 3 to 5	19 450	<1%	40 390	<1%	24 370	<1%
Aged 6 to 12	31 400	<1%	72 510	1%	56 700	1%
Aged 13 to	23 150	<1%	45 070	<1%	32 970	<1%

17						
Total	82 230	2%	176 620	3%	126 340	3%

Note:

1. The age groups of patients are determined by their age as at 30 June of the respective years.
2. The GOP attendance figures are rounded to the nearest ten.
3. Individual figures may not add up to the total due to rounding.

In view of the emergence of the COVID-19 epidemic in Hong Kong in early 2020, the HA adjusted its services to cope with the epidemic. This should be taken into consideration when comparing the throughput of services provided by the HA across the years. With the cessation of anti-epidemic measures in early 2023, the HA services have gradually resumed to normalcy.

5. & 6.

The Electronic Health Record Sharing System (eHealth) is a territory-wide electronic platform launched by the Government in 2016 that enable citizens to authorise healthcare providers in the public and private sectors to view and share their electronic health records (eHRs) for healthcare purposes. Building on the strengths of the infrastructure of eHealth, the Government announced in the 2023 Policy Address the initiative to roll out a five-year development plan of eHealth+ to transform eHealth into a comprehensive healthcare information infrastructure that integrates multiple functions of data sharing, service delivery and care journey management. The Government is taking forward the eHealth+ plan in phases under the patient-centric principle and four strategic directions, namely, One Health Record, One Care Journey, One Digital Front Door to Empowering Tool and One Health Data Repository.

As at end-February 2025, over 6.1 million citizens have registered with eHealth, accounting for over 80% of the total population in Hong Kong. Nevertheless, the number of minors (below 18 years old) who have registered with eHealth is relatively low, accounting for approximately 50% of the population in that age group. Detailed statistics for each age group under 18 are tabulated below:

Age	Number of eHealth registrants	Percentage share in the total number of eHealth registrants	Percentage share in the population in the age group
Aged under 1 ^{Note}	3 555	0.1%	10.7%
Aged 1 to 2	14 198	0.2%	20.0%
Aged 3 to 5	56 984	0.9%	40.9%
Aged 6 to 12	239 777	3.9%	59.0%
Aged 13 to 18	146 622	2.4%	42.5%
Total	461 136	7.5%	46.4%

Note: The Government does not maintain a breakdown of the number of eHealth registrants aged 0 to 6 months and aged 6 months to 1.

Under the development strategy of One Health Record, we seek to consolidate the longitudinal eHRs of citizens that are spread across a multiple of healthcare processes into their personal eHealth accounts. As for children and toddlers, the Government has all along been taking various measures to encourage and make it more convenient for parents to register eHealth for their children, so as to enable children to build up their own lifelong personal eHRs from an early stage and to acquire coherent healthcare services as they grow up. For instance, the Government has launched a dedicated eHealth registration drive for students since the 2023/24 academic year, which enables students to register with eHealth when participating in vaccination programmes at school. Two years into the scheme, nearly 180 000 students have registered with eHealth. As for infants, the Maternal and Child Health Centres (MCHCs) of the Department of Health (DH) have put in place express registration for eHealth in the regular enrolment procedure, so as to assist parents in signing up for their newborns. Furthermore, we launched a new registration channel in February this year, which enables citizens to register eHealth for their children aged under 16 and verify their identities through the one-stop “My Family” function of the eHealth App. Moreover, various online and offline publicity means, including social media, parents’ groups on messaging apps, parenting websites, mobile registration teams and time-limited gift redemption campaigns, have been adopted to encourage parents to register eHealth for their children.

Under the development strategy of One Digital Front Door to Empowering Tool, we continue to enhance the functions of the eHealth App to help parents manage their children’s health. Currently, parents can easily access their children’s health records via the eHealth App, including all records of vaccination that their children have received at MCHCs since 2007 and at primary schools across the city since 2013 under the DH’s Hong Kong Childhood Immunisation Programme, as well as allergies or adverse drug reactions records. Moreover, the “Child Growth Record” function of the eHealth app has adopted the updated Hong Kong 2020 Growth References to help parents monitor the growth of their children. Through the eHealth App, parents can also manage their children’s participation in subsidised Government health programmes, such as their children’s consultation records under DH’s Primary Dental Co-care Pilot Scheme for Adolescents launched in March 2025. Later this year, they will also be able to access their children’s electronic oral health records and oral care advice from the dentists under the scheme, which will enable them to better understand and monitor their children’s dental health.

We also launched the new “e+Life” health challenge platform under eHealth in September 2024. The platform encourages parents and children to participate in different health challenges, including the “e+ Go to Park”, and accumulate health coins for gift redemption. This enables participants to work out while gaming, thus developing healthy habits.

- End -

CONTROLLING OFFICER'S REPLY

HHB158

(Question Serial No. 2766)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Lung cancer is the leading cause of cancer-related deaths in Hong Kong. Regarding the prevention and treatment of lung cancer, will the Government inform this Committee of the following:

1. Whether the Government will launch a Lung Cancer Screening Pilot Programme, following the example of the Breast Cancer Screening Pilot Programme, to provide lung cancer screening services, such as chest X-ray and low-dose computed tomography (CT) thorax scans, with reference to various high-risk factors for high-risk citizens? If so, what are the work plan, timetable, and expenditure involved? If not, what are the reasons?
2. Will the Government consider increasing subsidies for postoperative adjuvant treatment for patients with early-stage lung cancer to reduce recurrence rates, enhance patients' chances of complete recovery and reintegration into society, while also help alleviate the long-term burden on the public healthcare system?
3. Whether the Government will consider allocating additional resources for the Hospital Authority to hire more staff, enhance Cardiothoracic surgery services, provide more surgical quotas, and explore the possibility of adopting a public-private partnership model to strengthen surgical treatment for lung cancer patients by making use of the service capacity of the private healthcare sector; if so, what are the work plans and estimated expenditure involved; if not, what are the reasons?
4. Will the Government consider the possibility of purchasing services from Grade 3A hospitals in the Greater Bay Area to provide lung cancer screening services, such as chest X-ray and low-dose CT thorax scans, for high-risk citizens to reduce expenditure and enhance the survival rates of patients?

Asked by: Hon QUAT Elizabeth (LegCo internal reference no.: 37)

Reply:

1.

The Cancer Expert Working Group on Cancer Prevention and Screening (CEWG) under the Cancer Coordinating Committee chaired by the Secretary for Health regularly reviews local and international scientific evidence, with a view to making recommendations to the Government on formulating evidence-based measures for cancer prevention and screening programmes applicable to the local population. Based on the CEWG recommendations on cancer screening, the Government has rolled out the Cervical Screening Programme, the Colorectal Cancer Screening Programme and the Breast Cancer Screening Pilot Programme.

The Government will carefully assess various factors when considering the implementation of a screening programme for a specific cancer with reference to an evidence-based public health risk assessment and advice from relevant experts. These include local prevalence of the cancer concerned, accuracy and safety of the relevant screening tests, effectiveness in reducing incidence and mortality rates, feasibility of implementing a screening programme, taking into account the perspective of optimising the use of the healthcare resources to determine the priority. Excessive screening under public health programme not only wastes resources for the overall public health, but also runs out of resources that can be invested on other projects in greater need, and may pose unnecessary health risks to individuals, often causing more harm than good.

Primary prevention (i.e. reducing exposure to cancer risk factors) is the most important strategy for reducing the risk of developing cancer. The Department of Health (DH) has all along been encouraging members of the public to adopt a healthy lifestyle, including avoidance of smoking and alcohol, healthy diet, regular physical activity and maintenance of a healthy body weight and waist circumference, in order to reduce the risk of non-communicable diseases including cancer.

On lung cancer screening, the CEWG considers there is currently insufficient evidence to recommend population-based lung cancer screening in asymptomatic persons at average risk by the Government. As for asymptomatic persons at increased risk, the CEWG is of the view that, based on overseas literature, heavy smokers may benefit from low-dose computed tomography (LDCT) scans for lung cancer screening. However, current data is insufficient to make assessments for lung cancer screening strategies applicable to Hong Kong, such as target groups and the most cost-effective screening protocol.

According to the above evidence-based scientific recommendations, the Government will not implement a lung cancer screening programme at this stage. As announced in the Chief Executive's 2024 Policy Address, the Government will explore the strategies for lung cancer screening applicable to Hong Kong, and consider collaborating with universities to conduct researches in order to provide scientific evidence for formulating screening strategies in the local context, as well as assessing the feasibility of providing AI-aided LDCT scans for lung cancer screening for high-risk asymptomatic persons in Hong Kong. The DH is actively following up on this matter.

2.

The attending doctors of the Hospital Authority (HA) will, based on the patient's clinical conditions, make professional diagnoses to prescribe appropriate treatments and medications as postoperative adjuvant treatment of lung cancer, such as chemotherapy or radiotherapy, etc. Among which, radiotherapy is a standard fee-charging service highly subsidised by the Government, with a relatively low fee. Persons who have financial difficulties and cannot afford the relevant expenses can apply for a medical fee waiver. Regarding medications, other than those highly subsidised standard and special drugs, under the current mechanism, if a patient requires self-financed items covered by the safety net (including different medications for lung cancer treatment), meets the clinical criteria and has financial difficulty in affording the medication costs, can apply the Samaritan Fund or Community Care Fund for subsidy via the HA. Medical social worker will conduct a financial assessment to evaluate his/her eligibility and the amount of financial assistance.

The HA will pay close attention to the latest scientific and clinical evidence of different medications for treating various types of cancers, with a view to providing patients with cost-effective medications of proven safety and efficacy, as well as sustainable and appropriate support.

Furthermore, the Government and the HA will press ahead at full steam with the implementation of the fees and charges reform for public healthcare, by reforming the subsidisation structure, reducing waste and abuse and enhancing healthcare protection to guide the public to make optimal use of healthcare resources, and enhance healthcare protection for “poor, acute, serious, critical” patients on all fronts. Relevant measures include relaxing the application criteria in medical fee waiving mechanism and enhancing the protection for patients with serious or critical conditions in relation to drug and devices (especially for those cancer patients that currently using Self-financed Items). This is to ensure limited medical resources can be accurately used for patients most in need, hereby enhancing the sustainability of the healthcare system to cope with the challenges posed by an ageing population, inflation of healthcare costs, etc., and serve as a safety net for all.

3.

The HA delivers healthcare services through multi-disciplinary teams comprising doctors, nurses, allied health professionals and care-related support staff. The HA regularly monitors the manpower situation and flexibly deploys its staff having regard to the service and operational needs. The HA has been seeking to enhance the service capacity for cardiothoracic surgery through its annual plan, which includes increasing manpower and the number of surgery sessions, so as to address the continuous growth in service demand for public healthcare services. The HA has increased the operating theatre sessions for cardiothoracic surgery by 4 more sessions per week in 2021-2022 and 2022-23 respectively. In respect of manpower increase, the table below sets out the manpower strength of doctors working in the specialty of cardiothoracic surgery in 2022-23, 2023-24 and 2024-25 (as at 31 December 2024):

Specialty	2022-23	2023-24	2024-25 (as at 31 December 2024)
Cardiothoracic Surgery	48	50	54

Note:

1. The manpower figures above are calculated on a full-time equivalent basis including permanent, contract and temporary staff in the HA.
2. Doctors above exclude Interns and Dental Officers.
3. Starting from January 2024, the full-time equivalent for all temporary part-time staff is calculated based on their actual working hours. The relevant figures prior to that month are for reference only and cannot be directly compared with the figures obtained from the revised methodology currently adopted.

When exploring new public-private partnership (PPP) programmes, the HA will align with the Government's healthcare policies, including directions of primary healthcare development, apply the principle of strategic purchasing of healthcare services, and consider a number of factors including evolving service needs, will and affordability of the patients, potential risk and quality of the medical services and capacity and readiness of the private sector, as well as whether it would aggravate the loss in manpower in public healthcare sector and inflation in private healthcare charges, etc. The HA will explore the demand for and feasibility of introducing individual PPP programmes with the Strategic Purchasing Office established under the Government in order to meet the healthcare service needs of the general public.

4.

The Hong Kong Special Administrative Region (HKSAR) Government has been following the principles of complementarity and mutual benefits to enhance the cooperation with various cities of the Guangdong-Hong Kong-Macao Greater Bay Area (GBA), on the premise that the development of Hong Kong and the Mainland's healthcare system will be benefited. This is to promote the medical professional standard in the region in general and provide convenience for Hong Kong citizens travelling to and from the Mainland in terms of choices of medical services. Among which, in collaboration with designated collaborating healthcare institutions in the Mainland cities of the GBA, the Government gradually launched the Pilot Scheme for Supporting Patients of the Hospital Authority in the Guangdong-Hong Kong-Macao Greater Bay Area, the Elderly Health Care Voucher Greater Bay Area Pilot Scheme, the Pilot Scheme for Direct Cross-boundary Ambulance Transfer in Greater Bay Area, as well as the new functions under the five-year plan of eHealth+, which enables citizens to keep and use their personal medical records from within and outside Hong Kong across the boundary.

As a member of the GBA, the HKSAR Government, in formulating cross-boundary healthcare measures, will not only focus on meeting the needs of Hong Kong citizens, but will also consider the potential impact of the policies on the social resources and livelihood of citizens on the Mainland. The healthcare resources and needs, relevant laws and regulations, as well as regulatory regimes for healthcare professions are different in Hong Kong and the Mainland. Upholding the important role of protecting the health of Hong

Kong citizens, the HKSAR Government will continue to provide quality healthcare services to Hong Kong citizens. The Government will also explore cross-boundary healthcare measures under the premise that these measures are feasible and mutually beneficial. Meanwhile, the HKSAR Government is exploring the strategic purchase of healthcare services for Hong Kong citizens from suitable healthcare institutions in the GBA to alleviate the pressure on service demand of our public hospital services and shorten the waiting time of Hong Kong residents.

- End -

CONTROLLING OFFICER'S REPLY

HHB159

(Question Serial No. 0437)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the operation of the Hospital Authority Drug Formulary (HADF), please inform this Committee of the following:

- 1) the names of self-financed items (SFIs) covered by the Samaritan Fund (SF) and the Community Care Fund (CCF) Medical Assistance Programmes, the number of subsidy applications approved and the amount of subsidy granted in the past 5 years, broken down by drug class;
- 2) for SFIs covered by SF and CCF Medical Assistance Programmes, the dates on which they were first discussed by the Drug Advisory Committee and included in the HADF, and the effective dates on which they were included in the safety net in the past 5 years, broken down by drug class;
- 3) the annual estimates and balances (calculated as estimates minus actual expenditure) of the SF and the CCF Medical Assistance Programmes in the past 5 years;
- 4) the major sources of income (such as interest income) and main expenditures of the SF and CCF in the past 5 years;
- 5) the estimated expenditures of the SF and CCF Medical Assistance Programmes in the next 3 years; whether there is specific planning and percentage allocation for the expenditures on current and newly introduced drugs under the SF and CCF; and whether the 2 funds are sufficient to sustain operations for the next 3 years;
- 6) whether the Government will prioritise drugs previously excluded due to funding constraints for coverage under the SF and CCF Medical Assistance Programmes in the coming year; and the criteria and parameters used to determine which SFIs are covered by the SF and CCF;
- 7) the numbers of SFIs repositioned as Special drugs or General drugs, the expenditures involved, and the dates of including each SFI in the HADF and repositioning each SFI as a Special or/and General drug in the past 5 years, broken down by drug class;
- 8) the numbers of drugs and expenditures for each drug category in the HADF of HA, i.e. General drugs, Special drugs, SFIs with safety net coverage and SFIs without safety net coverage in the past 5 years;
- 9) the cost of SFIs borne by patients in the past 5 years, broken down by drug class;

- 10) the shortest, average, median and longest time taken from registration of drugs with the Department of Health to their inclusion in the DF since the implementation of DF in 2005;
- 11) the non-DF drugs used by HA, the numbers of prescription cases and the expenditures involved in the past 5 years;
- 12) whether applications for inclusion of the above items in the DF were made after prescription, and if so, the number of approvals and submissions before inclusion in the DF; and the number of rejections and submissions for each item;
- 13) the drug expenditures in Hong Kong, with respective public and private breakdowns, in the past 5 years; and the percentage share of drug expenditure in the total healthcare expenditure;
- 14) the recurrent healthcare expenditures by healthcare financing scheme in Hong Kong in the past 5 years, including government expenditure, medical insurance expenditure and household out-of-pocket payment;
- 15) whether the Government has set indicators and mechanisms to measure the effectiveness of the new mechanism of introducing new drugs given that the HA has optimised the process since the end of last year by simplifying some administrative procedures and establishing a “Cost Assessment Panel” to assess the cost-effectiveness of new drugs and their total cost impact.

Asked by: Hon SHIU Ka-fai (LegCo internal reference no.: 15)

Reply:

1)

The relevant figures on drug subsidies granted under the Samaritan Fund (SF) and the Community Care Fund (CCF) Medical Assistance Programmes in the past 5 years, i.e. 2020-21 to 2024-25 (up to 31 December 2024), are detailed at Annex 1.

2)

As at 31 December 2024, 100 and 39 self-financed items (SFIs) were covered by the SF and the CCF Medical Assistance Programmes respectively. The SFIs covered by the SF and the CCF Medical Assistance Programmes, the respective dates on which they were first discussed by the Hospital Authority (HA) Drug Advisory Committee (HADAC) and listed on the HA Drug Formulary (HADF), and the effective dates on which they were covered by the safety net in the past 5 years, i.e. 2020-21 to 2024-25 (as at 31 December 2024), are detailed at Annex 2.

3) & 4)

The financial resources of the SF mainly relies on government subvention¹, interest, and other income (including donations from charitable organisations and reimbursements from the Social Welfare Department, etc.). The major expenditures are those spent on subsidising eligible HA patients in purchasing designated SFIs and medical items. The interest and other income, expenditure, and balance of the SF from 2020-21 to 2023-24 are as follows²:

Year		Expenditure	

	Interest and other income (\$ million)	Drug items (\$ million)	Non-drug items (\$ million)	Total expenditure (\$ million)	Year-end fund balance (\$ million)
2020-21	393	578	266	844	9,980
2021-22	417	565	247	812	9,585
2022-23	480	613	230	843	9,222
2023-24	433	827	188	1,015	8,640

Note :

1. In 2012, the Government provided a \$10 billion grant to the SF to sustain its operation.
2. The actual expenditure for 2024-25, which is subject to various factors (such as the actual number of applicants for subsidies on newly-introduced drugs/items and the amount of subsidies involved, and the adjustments made to reflect the unspent subsidies brought back at year-end closing due to changes in patients' clinical conditions), will only be ascertained after completion of the audit by the independent auditor.

As for the CCF Medical Assistance Programmes, its income comes entirely from the funding of the CCF. Each year, the HA seeks approval from the Commission on Poverty on the indicative budgets for approved subsidies for each of the 3 medical assistance programmes, which will serve as the upper limit of the total amount of subsidy to be approved for patients under each programme in that year, subsidising eligible HA patients for the costs of purchasing designated SFIs and medical items. The indicative budgets for approved subsidies in the recent 5 years are as follows:

Year	Indicative Budget for Approved Subsidies (\$ million)			
	First Phase Programme of Medical Assistance Programmes	Subsidy for Eligible Patients to Purchase Ultra-expensive Drugs (Including Those for Treating Uncommon Disorders)	Subsidy for Eligible Patients of HA to Purchase Specified Implantable Medical Devices for Interventional Procedures	Total
2020-21	893	171	44	1,108
2021-22	1,379	303	50	1,732
2022-23	1,331	276	78	1,685
2023-24	1,330	385	73	1,788
2024-25	1,093	513	110	1,716

5) and 6)

Each year, the HA will project the growth rate in the subsidy amount based on the approved subsidies in previous years, taking into account new drugs/medical devices introduced, to estimate the expenditures of the SF and the CCF Medical Assistance Programmes for the coming year. The annual actual expenditure is subject to various factors, including the actual number of applicants, the amount of subsidy required by patients, etc. The annual balance of the SF will be used to support its future operation. As for the funding requirement of the CCF Medical Assistance Programmes, the HA will estimate the expenditure needs for each programme for the next quarter by the end of each quarter, which involves deducting the

balance of the quarter (or including the amount of insufficient funds for the quarter), and submit the funding requirement for the next quarter to the CCF to support the operational need.

As the major provider of publicly-funded public healthcare services, the HA attaches great importance to providing optimal treatment for all patients while ensuring patients have equitable access to cost-effective drugs of proven safety and efficacy under the highly subsidised public healthcare system.

The HA will review the coverage of the HADF and the safety net (including SF and the CCF Medical Assistance Programmes) continuously to enhance patient protection. The review process follows an evidence-based approach, having regard to the safety, efficacy and cost-effectiveness of drugs and other relevant considerations, including international recommendations and practices as well as professional views, so as to ensure equitable and effective use of public resources in providing optimal treatment for patients.

Besides, the Government and the HA will press ahead with the implementation of the fees and charges reform for public healthcare announced recently, which aims to guide the public to make optimal use of healthcare resources through 3 aspects, namely reforming the subsidisation structure, reducing wastage and abuse, and enhancing healthcare protection. It also seeks to strengthen the healthcare protection on all fronts for patients who are “poor, acute, serious or critical”, with a view to ensuring that the limited healthcare resources can be directed in a more targeted manner to assist those patients most in need, thereby enhancing the sustainability of the healthcare system so as to cope with the challenges posed by an ageing population, inflation of healthcare cost, etc., and serve as a safety net for all. One of the healthcare protection measures under the fees and charges reform is to utilise part of the additional resources generated from the reform to support patients with serious illnesses. By making use of the SF mechanism, more patients who need to pay for costly self-financed items will be provided with subsidies at rates higher than the current levels, thereby reducing the risk of citizens falling into poverty due to serious illnesses.

7)

The SFIs repositioned as Special or General drugs, the respective dates of listing on the HADF and repositioning as Special or General drugs in the past 5 years, i.e. 2020-21 to 2024-25, are set out at [Annex 3](#). The numbers of SFIs involved are as follows:

	2020-21	2021-22	2022-23	2023-24	2024-25
Number of SFIs repositioned as Special or General drugs	5	2	7	3	0

The HA does not maintain statistics on the expenditure involved in the repositioning of SFIs as Special or General drugs on the HADF.

8)

In line with the Government’s public healthcare policy to ensure that citizens are not denied adequate medical care due to lack of means, the HA provides heavily subsidised healthcare

services and drugs or medical items to patients based on their clinical needs and in accordance with the HA's treatment guidelines. The numbers of General drugs, Special drugs, SFIs without safety net coverage, SFIs covered by the safety net provided through the SF and CCF Medical Assistance Programmes, listed on the HADF in the past 5 years, i.e. 2020-21 to 2024-25, are set out in the table below ³:

Drug Category	Number of Drugs				
	January 2021	January 2022	January 2023	January 2024	January 2025
General drug	886	899	897	904	900
Special drug	415	413	418	415	425
SFI without safety net coverage	67	72	65	71	79
SFI covered by the SF	51	59	72	89	100
SFI covered by the CCF Medical Assistance Programmes	37	41	41	42	41
Total	1 456	1 484	1 493	1 521	1 545

Note :

3. A drug may fall into more than one category (General drug, Special drug, SFI, SFI with safety net) on the HADF due to different therapeutic indications or dose presentations. The figures are gross summation of drugs in all categories on the HADF.

The drug expenditures on General and Special drugs on the HADF (i.e. the expenditures on General and Special drugs prescribed to patients at standard fees) in the past 5 years, i.e. 2020-21 to 2024-25, are set out in the table below:

	2020-21	2021-22	2022-23	2023-24	2024-25
Drug expenditure on General and Special drugs on the HADF (\$ million) ⁴	6,474	7,026	9,213	9,392	9,147 ⁵

Note :

4. Including drug expenditures on drugs for treating the Coronavirus Disease 2019 (COVID-19).
5. Projection based on the expenditure figure as at 31 December 2024.

9)

As drugs may have various clinical indications and may fall into different categories (General drug, Special drug, SFI, SFI with safety net) on the HADF due to different therapeutic indications or dose presentations, the HA is unable to provide breakdown on the expenditure for each SFI. Expenditures incurred by public hospital patients for purchasing SFIs (including those under the SF and the CCF Medical Assistance Programmes) in the past 5 years, i.e. 2020-21 to 2024-25, are provided below:

	2020-21	2021-22	2022-23	2023-24	2024-25 ⁶
Expenditure incurred by public hospital patients for	2,716	3,048	3,156	3,446	2,892

purchasing SFIs (including those under the SF and the CCF Medical Assistance Programmes) (\$ million)					

Note :

6. Figure up to 31 December 2024.

10)

The HA has an established mechanism to regularly evaluate new drugs and review the existing drugs on the HADF with the support of 21 expert panels. The process follows an evidence-based approach, having regard to the principles of safety, efficacy and cost-effectiveness of drugs; and taking into account various factors, including international recommendations and practices, latest development in technology, the state of the disease, patient compliance, quality of life, actual experience in the usage of drugs and views of professionals and patient groups.

As per the existing mechanism, the HADAC meets regularly to evaluate the new drug applications submitted by doctors or pharmaceutical companies. Evaluation of new drugs is an on-going process which has to be driven by evolving medical evidence, the latest clinical developments and market dynamics. The HA does not maintain statistics on the time taken from registration of new drugs with the Pharmacy and Poisons Board of Hong Kong to their listing on the HADF.

11)

Drugs listed on the HADF are intended for HA-wide use in order to cater for the needs of the local community as a whole. Drugs outside the HADF, on the other hand, are used under exceptional circumstances to cater for the clinical needs of individual patients. The use of drugs outside the HADF is an integral part of providing optimal healthcare services for patients, balancing the needs of the general public and individuals while ensuring that patients are provided with optimal clinical care. Clinicians will prescribe appropriate medical treatments based on their clinical expertise and professional judgment, taking into consideration the clinical conditions of individual patients.

The numbers of drug items outside the HADF used in the HA from 2020-21 to 2024-25 (as at 31 December 2024) and the corresponding drug expenditures involved are set out in the table below:

	2020-21	2021-22	2022-23	2023-24	2024-25 ⁸
Number of drugs items outside the HADF used ⁷	204	216	227	261	246
Expenditure on using drugs outside the HADF (\$ million) ⁷	131	306	1,967	122	108

Note :

7. Including the number of drugs for treating COVID-19 and the relevant drug expenditures.

8. Figures up to 31 December 2024.

12)

The HADAC only considers the applications for listing on the HADF of drugs that are registered in Hong Kong. The numbers of registered drugs approved and not approved for listing on the HADF, and the numbers of times for which those drugs were submitted to the HADAC for evaluation of listing on the HADF in the past 5 years, i.e. 2020-21 to 2024-25, are set out in the table below:

	Total number	Number of times submitted for evaluation			
		1	2	3	4 or above
Number of drugs approved by the HADAC for listing on the HADF	115	86	20	9	0
Number of drugs not approved by the HADAC for listing on the HADF	50	35	9	6	0

13)

The expenditures on procurement of drugs for the HA and the Department of Health (DH) over the past 5 years are set out in the table below:

	2020-21	2021-22	2022-23	2023-24	2024-25 (Projected figure)
Expenditure on procurement of drugs for HA ⁹ (\$ million)	8,685	9,642	12,451	13,127	12,951
Expenditure on procurement of drugs for DH (\$ million)	678	612	681.1	648.9	623.5

Note :

9. Including the expenditure on drugs charged at standard fees and SFI. Excluding other expenditures (such as storage and re-packaging).

The Government does not maintain statistics related to the private drug expenditure.

14)

According to the latest estimates based on the data collected in Hong Kong's Domestic Health Accounts, the recurrent healthcare expenditures in Hong Kong by financing scheme over the past 5 years are as follows:

Financial year	Government Schemes (\$ million)	Insurance Schemes¹² (\$ million)	Household Out-of-pocket Payment (\$ million)	Others¹³ (\$ million)	Recurrent Healthcare Expenditure¹⁴ (\$ million)
2018-19 ¹⁰	92,085	29,028	61,097	1,227	183,438
2019-20 ¹¹	101,226	32,023	59,318	1,424	193,991
2020-21 ¹¹	107,440	34,351	55,579	2,568	199,939
2021-22 ¹¹	111,577	36,258	62,756	2,059	212,650
2022-23 ¹¹	117,451	37,964	68,506	2,390	226,311

Source: Hong Kong's Domestic Health Accounts

Note :

10. There are no COVID-19-related expenditures in 2018-19.
11. Excluding COVID-19-related expenditures.
12. Including employer-based insurance schemes and privately purchased insurance schemes.
13. Including non-profit institutions serving households financing schemes and enterprise financing schemes.
14. As the figures for each category have been rounded off, the summation of figures of all categories may not equal the total number.

15)

The HA has been continuously striving to streamline the process of introduction of drugs through various measures and actively evaluate new drugs, including those approved for registration under the “1+” mechanism, in order to shorten the time required for new drugs to be listed on the HADF and facilitate good drugs for use in Hong Kong. The HA initiated the enhancement on the process of introduction of drugs at the end of last year. In addition to applications from doctors, the HADAC started accepting direct submission of drug listing applications from pharmaceutical companies. “Health economists” are also included in the HADAC for seeking expert advice during the discussion phase of introducing new drugs, and such advice will be considered together with the safety, efficacy, and cost-effectiveness of the drugs. At the same time, the functions of the HADAC will also be strengthened. Apart from evaluating new drugs, it will also advise on the priority of SFIs to be covered under the safety net for confirmation by the Drug Management Committee, so as to streamline administrative processes. The HA expects that the time for new drugs to be covered in the HADF and the safety net will be significantly reduced by half, thereby accelerating the introduction of new drugs and providing doctors and patients with more treatment options.

Moreover, the HA has also established the “Cost Assessment Panel” in 2024 to evaluate drugs against systematic and objective assessment standards, and conduct price negotiation with pharmaceutical companies with a view to reducing the costs and prices of introducing new drugs while ensuring that the quality and safety requirements of the drugs are met. For example, not only has the procurement cost of 2 new drugs for treating metastatic colorectal cancer been reduced by nearly 30% after successful price negotiation, but they have also been listed in the “Special Drug” category of the HADF. Patients are only required to pay the standard fee if they are prescribed these two drugs under specified clinical indications, greatly alleviating their financial burden. It is expected that nearly 300 cancer patients will benefit

each year. For another new drug for treating paroxysmal nocturnal haemoglobinuria, price negotiation has not only reduced the procurement cost by 30%, but also triggered a voluntary price reduction of 37% for a similar drug to control the costs of introducing new drugs effectively.

The HA will continue to review the progress and effectiveness of the above measures to ensure the sustainability of the new drug introduction process. The HA expects to introduce more new drugs from around the world that meet local healthcare needs for application in public hospitals, bringing new hopes of treatment to patients and enhancing the quality of healthcare services.

Annex 1

Information on drug subsidies granted under the Samaritan Fund (SF) and the Community Care Fund (CCF) Medical Assistance Programmes in the past 5 years

	2020-21		2021-22		2022-2023		2023-24		2024-25 (up to 31 December 2024)	
Drug Item	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)
SF										
Abatacept	58	5.22	66	6.63	75	7.75	73	7.53	51	5.49
Abemaciclib	-	-	-	-	-	-	23	3.00	59	7.19
Abemaciclib and Fulvestrant	-	-	-	-	-	-	22	5.34	18	2.88
Abiraterone	-	-	-	-	13	1.88	30	4.16	33	4.35
Abrocitinib	-	-	-	-	-	-	-	-	6	0.31
Acalabrutinib	-	-	-	-	11	2.92	21	6.82	32	10.01
Adalimumab	206	21.53	230	19.31	265	19.16	248	16.28	186	11.99
Afatinib	93	10.93	77	9.31	96	11.78	91	11.63	65	8.31
Aflibercept	-	-	-	-	178	8.17	854	38.00	572	23.51
Alectinib	114	42.21	153	58.36	144	56.37	120	43.76	92	36.01
Anifrolumab	-	-	-	-	-	-	-	-	6	0.48
Apalutamide	-	-	-	-	-	-	22	4.60	73	17.05
Atezolizumab	-	-	-	-	-	-	26	9.34	53	13.10
Axitinib	-	-	-	-	11	0.82	27	1.71	25	1.66
Alemtuzumab	4	0.97	-	-	-	-	-	-	-	-
Azacitidine	106	8.90	113	5.30	73	3.61	68	2.97	47	1.77
Baricitinib	51	3.16	72	4.50	65	3.99	60	3.85	46	2.97
Belimumab	3	0.32	25	2.42	35	3.45	57	5.87	45	5.01
Bendamustine	-	-	-	-	5	0.56	5	0.53	6	0.24

	2020-21		2021-22		2022-2023		2023-24		2024-25 (up to 31 December 2024)	
Drug Item	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)
Benralizumab	5	0.60	25	2.87	33	3.47	54	5.54	62	6.67
Bevacizumab	-	-	-	-	-	-	-	-	1	0.26
Bortezomib	186	38.21	183	42.56	135	9.72	84	6.02	33	1.91
Brentuximab Vedotin	-	-	-	-	1	0.20	14	3.55	11	3.30
Brigatinib	-	-	-	-	5	1.83	14	6.75	16	4.94
Canakinumab	4	1.49	4	1.66	3	1.30	6	3.31	5	2.79
Carfilzomib	44	16.05	44	14.15	52	18.67	40	17.18	13	5.69
Ceritinib	-	-	-	-	1	0.33	2	0.20	-	-
Certolizumab Pegol	42	3.18	57	4.12	61	4.37	53	3.78	35	2.50
Cetuximab	246	71.67	236	69.37	209	63.20	166	53.04	145	44.57
Cladribine	-	-	-	-	-	-	-	-	-	-
Crizotinib	29	7.35	30	7.00	25	5.01	19	4.14	14	3.26
Dabrafenib and Trametinib	-	-	-	-	-	-	-	-	2	0.40
Daratumumab and Bortezom	-	-	-	-	-	-	3	2.29	9	4.18
Dasatinib	134	27.53	139	29.97	125	27.16	151	31.03	116	25.26
Dexamethasone	-	-	-	-	-	-	-	-	-	-
Dupilumab	-	-	3	0.34	28	2.63	65	6.26	84	7.36
Durvalumab	-	-	-	-	-	-	34	11.35	54	15.69
Eculizumab	9	32.60	11	42.62	10	39.60	8	18.93	-	-
Eltrombopag	114	10.15	160	15.53	150	13.82	176	16.63	148	16.15
Enzalutamide	-	-	-	-	51	8.30	175	24.80	214	37.22
Etanercept	195	17.88	184	17.09	188	17.27	155	14.52	115	10.92

	2020-21		2021-22		2022-2023		2023-24		2024-25 (up to 31 December 2024)	
Drug Item	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)
Everolimus	8	1.43	-	-	-	-	19	2.62	16	2.05
Faricimab	-	-	-	-	-	-	-	-	81	4.47
Gefitinib	277	22.60	171	15.49	145	13.32	123	11.75	73	4.03
Gemtuzumab Ozogamicin	-	-	-	-	-	-	-	-	1	0.20
Gilteritinib	-	-	-	-	-	-	2	1.16	9	2.74
Golimumab	216	19.38	215	19.62	234	21.74	213	19.80	148	13.76
Growth Hormone	-	-	-	-	-	-	-	-	-	-
Guselkumab	10	0.98	13	1.35	29	3.04	26	2.64	34	3.45
Ibrutinib	32	11.10	42	18.28	42	12.48	20	6.37	7	1.77
Icatibant	-	-	-	-	-	-	-	-	-	-
Imatinib	284	46.65	284	46.97	146	5.65	-	-	-	-
Infliximab	33	2.80	34	2.78	35	2.53	26	2.08	22	1.94
Inotuzumab Ozogamicin	-	-	-	-	-	-	-	-	3	0.70
Interferon	1	0.27	1	0.27	-	-	-	-	-	-
Ixekizumab	-	-	3	0.29	7	0.55	15	1.17	16	1.30
Lenalidomide	67	7.34	32	3.15	37	4.45	93	15.56	86	13.10
Lenalidomide and Bortezomib	-	-	-	-	-	-	-	-	45	9.47
Lenvatinib	-	-	-	-	-	-	36	6.04	74	11.61
Letermovir	-	-	-	-	25	4.59	39	7.27	17	3.78
Lorlatinib	-	-	-	-	-	-	-	-	-	-
Luspatercept	-	-	-	-	-	-	-	-	-	-
Mepolizumab	47	5.20	41	4.82	54	6.02	78	9.53	56	7.26

	2020-21		2021-22		2022-2023		2023-24		2024-25 (up to 31 December 2024)	
Drug Item	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)
Midostaurin	28	15.67	20	10.23	21	11.15	20	10.15	13	7.97
Natalizumab	-	-	2	0.49	2	0.49	1	0.25	1	0.25
Nilotinib	137	34.38	136	33.70	130	34.26	127	33.08	100	27.00
Nintedanib (Ofev)	54	9.24	65	10.69	69	11.51	78	13.13	93	10.90
Nivolumab	-	-	-	-	-	-	34	8.72	86	19.67
Nivolumab and Ipilimumab	-	-	-	-	-	-	-	-	5	2.60
Obinutuzumab	60	9.23	79	9.63	61	9.53	101	13.73	66	7.09
Olaparib							-	-	33	8.52
Omalizumab	9	0.81	10	0.92	18	1.61	25	1.99	13	1.00
Osimertinib	-	-	-	-	185	39.38	213	42.84	417	88.89
Onasemnogene A Aspartate Albumin	-	-	-	-	-	-	-	-	41	5.71
Palbociclib	-	-	-	-	-	-	92	10.15	59	7.62
Panitumumab	70	15.81	87	19.44	141	29.02	177	35.91	148	32.23
Pazopanib	-	-	-	-	72	9.64	68	9.46	51	6.90
Pembrolizumab	-	-	-	-	-	-	85	48.88	241	130.21
Pertuzumab and Trastuzumab	-	-	193	41.34	406	97.09	399	93.18	300	66.05
Plerixafor	44	2.48	41	1.90	39	1.66	46	2.61	43	2.70
Pomalidomide	-	-	50	16.31	39	15.08	31	9.31	6	1.45
Ponatinib	-	-	21	5.95	27	7.72	38	10.95	24	7.19
Ranibizumab	-	-	-	-	8	0.42	50	2.91	26	1.63
Ribociclib	-	-	-	-	-	-	168	27.47	218	28.97
Ribociclib and Fulvestrant	-	-	-	-	-	-	48	9.07	58	10.74

	2020-21		2021-22		2022-2023		2023-24		2024-25 (up to 31 December 2024)	
Drug Item	Number of subsidy cases	Amount of subsidies granted (\$ million)	Number of subsidy cases	Amount of subsidies granted (\$ million)	Number of subsidy cases	Amount of subsidies granted (\$ million)	Number of subsidy cases	Amount of subsidies granted (\$ million)	Number of subsidy cases	Amount of subsidies granted (\$ million)
Risankizumab	-	-	4	0.39	20	2.10	34	3.25	33	3.00
Rituximab	283	24.49	243	12.35	219	9.50	221	9.23	151	7.45
Ruxolitinib	72	36.26	71	37.66	92	49.27	102	55.61	118	59.17
Sarilumab	17	1.37	41	3.07	35	2.75	55	4.43	47	3.83
Secukinumab	127	11.02	142	13.09	177	16.44	176	15.79	138	11.83
Siltuximab	-	-	-	-	-	-	5	2.52	11	5.62
Siponimod	-	-	-	-	1	0.18	2	0.34	1	0.16
Sorafenib	30	1.24	90	5.62	60	2.90	78	2.68	-	-
Sunitinib	-	-	10	1.24	40	4.95	45	5.52	28	3.67
Temozolomide	29	0.49	20	0.37	18	0.32	12	0.24	8	0.12
Tocilizumab	154	10.23	159	10.61	190	13.15	189	13.13	134	9.14
Tofacitinib	174	9.93	120	6.66	102	6.47	84	5.52	58	3.89
Tolvaptan (Jinarc)	9	0.96	11	1.11	19	2.13	27	3.02	15	1.89
Trastuzumab	488	96.31	251	29.42	191	18.30	43	8.97	28	6.07
Trastuzumab Deruxtecan	-	-	-	-	-	-	-	-	6	2.90
Trastuzumab emtansine (T-DM1)	-	-	58	12.91	61	13.86	130	36.72	121	32.63
Upadacitinib	-	-	9	0.56	46	2.80	76	4.70	74	4.91
Ustekinumab	8	0.86	10	0.85	8	0.88	10	0.99	6	0.56
Venetoclax and Azacitidine	-	-	-	-	-	-	46	15.03	63	13.27
Vedolizumab	5	0.34	5	0.34	8	0.41	-	-	-	-
Zanubrutinib	-	-	-	-	-	-	-	-	7	1.87
First Phase Programme of the CCF Medical Assistance Programmes										
Abemaciclib	6	0.95	48	8.15	117	18.07	72	9.17	-	-

	2020-21		2021-22		2022-2023		2023-24		2024-25 (up to 31 December 2024)	
Drug Item	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)
Abiraterone	111	15.00	99	14.06	68	9.22	35	4.67	5	0.54
Acalabrutinib	-	-	-	-	2	0.73	4	0.90	9	2.87
Alectinib	13	3.46	10	3.15	2	0.70	-	-	-	-
Atezolizumab	57	19.46	125	26.64	105	24.77	90	17.34	7	2.32
Atezolizumab and Bevacizumab	-	-	-	-	36	12.44	142	37.78	156	43.22
Avelumab	-	-	-	-	-	-	6	2.18	13	4.50
Axitinib	37	2.49	34	2.13	21	1.27	-	-	-	-
Bendamustine	11	1.48	10	1.21	3	0.15	-	-	-	-
Bevacizumab	456	62.30	439	98.64	437	60.64	467	61.15	331	46.14
Daratumumab and Lenalidomide	-	-	-	-	-	-	-	-	39	24.73
Brentuximab Vedotin	9	4.50	12	4.72	9	4.13	1	0.44	-	-
Brigatinib	3	1.33	5	1.77	2	0.72	1	0.44	-	-
Ceritinib	10	0.85	3	0.15	3	0.15	-	-	-	-
Dabrafenib and Trametinib	7	2.52	4	1.69	10	4.11	-	-	-	-
Daratumumab and Bortezomib	-	-	-	-	-	-	59	22.75	41	14.48
Durvalumab	62	17.63	59	17.99	64	18.51	44	13.24	-	-
Enzalutamide	103	14.27	146	19.57	124	16.45	-	-	-	-
Everolimus	36	4.75	29	3.86	18	2.36	3	0.35	-	-
Gemtuzumab Ozogamicin	-	-	8	1.29	17	2.49	20	3.21	13	2.26
Inotuzumab Ozogamicin	2	0.52	6	2.46	4	1.49	2	0.40	-	-
Ibrutinib	-	-	-	-	-	-	6	4.40	3	1.87
Isatuximab and Pomalidomide	-	-	-	-	-	-	31	17.98	46	26.81

	2020-21		2021-22		2022-2023		2023-24		2024-25 (up to 31 December 2024)	
Drug Item	Number of subsidy cases	Amount of subsidies granted (\$ million)	Number of subsidy cases	Amount of subsidies granted (\$ million)	Number of subsidy cases	Amount of subsidies granted (\$ million)	Number of subsidy cases	Amount of subsidies granted (\$ million)	Number of subsidy cases	Amount of subsidies granted (\$ million)
Ixazomib and Lenalidomide	94	36.98	112	36.34	110	35.15	130	45.40	57	15.59
Lapatinib	28	1.88	20	1.26	14	0.94	15	0.86	15	1.10
Lenvatinib	190	16.67	225	19.02	219	29.29	106	16.94	14	5.67
Lenvatinib and Pembrolizumab	-	-	-	-	-	-	-	-	27	22.29
Lorlatinib	-	-	-	-	34	14.14	80	34.30	72	31.96
Neratinib	-	-	-	-	8	1.06	20	2.12	24	2.58
Niraparib	-	-	-	-	-	-	22	7.48	27	9.57
Nivolumab	52	17.89	146	39.58	175	53.54	118	24.68	42	8.83
Nivolumab and Ipilimumab	-	-	16	10.20	56	29.18	85	34.63	78	31.57
Obinutuzumab	7	0.57	8	0.67	4	0.30	-	-	-	-
Olaparib	-	-	22	7.87	52	14.00	56	13.81	5	1.52
Osimertinib	371	116.44	524	112.68	462	95.58	436	88.65	176	45.44
Palbociclib	223	35.06	240	39.57	200	26.15	22	2.00	-	-
Pazopanib	89	12.44	108	15.27	24	2.51	-	-	-	-
Pegylated Liposomal Doxorubicin	64	4.06	52	2.93	58	3.93	66	4.01	53	1.19
Pembrolizumab	219	114.61	318	156.63	356	184.66	379	180.36	187	99.97
Pertuzumab	218	84.45	140	45.70	-	-	-	-	-	-
Polatuzumab Vedotin and Rituximab	-	-	-	-	-	-	-	-	25	3.20
Polatuzumab Vedotin and Rituximab and Bendamustine	-	-	-	-	16	3.83	48	7.80	29	4.19
Ribociclib	67	10.01	99	14.86	119	14.68	20	3.29	-	-
Selumetinib	-	-	-	-	-	-	-	-	8	6.05

	2020-21		2021-22		2022-2023		2023-24		2024-25 (up to 31 December 2024)	
Drug Item	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)	number of subsidy cases	amount of subsidies granted (\$ million)
Sorafenib	153	4.09	-	-	-	-	-	-	-	-
Sunitinib	64	6.73	38	3.57	11	1.04	11	1.45	12	1.45
Trastuzumab	20	3.85	15	1.21	8	0.91	1	0.25	1	0.25
umab emtansine	87	25.35	96	28.22	67	20.95	9	1.51	-	-
Vemurafenib	-	-	-	-	-	-	-	-	-	-
Zanubrutinib	-	-	-	-	-	-	-	-	7	1.92
“Subsidy for Eligible Patients to Purchase Ultra-expensive Drugs (Including Those for Treating Uncommon Disorders)” under the CCF										
Burosumab	-	-	-	-	-	-	1	2.85	3	4.46
Dinutuximab Beta	7	10.10	2	5.33	4	5.76	3	3.78	5	10.12
Eculizumab	5	20.41	2	6.27	1	5.18	-	-	2	2.95
Nusinersen	18	45.86	14	26.45	18	37.60	13	24.24	10	19.92
Onasemnogene abeparvovec	-	-	-	-	-	-	-	-	1	12.87
Ravulizumab	-	-	-	-	-	-	12	39.16	8	26.43
Risdiplam	-	-	-	-	18	29.10	29	45.09	11	16.42
Tafamidis Meglumine	1	0.84	1	0.37	-	-	-	-	-	-
Tafamidis	-	-	3	2.63	3	2.53	4	3.55	7	6.27
Tisagenlecleucel	-	-	21	40.32	20	51.82	38	84.15	20	49.90

Self-financed items (SFIs) covered by the Samaritan Fund and the Community Care Fund (CCF) Medical Assistance Programmes, the respective dates on which they were first discussed by the Hospital Authority Drug Advisory Committee (HADAC) and listed on the Hospital Authority Drug Formulary (HADF), and the effective dates on which they were covered by the safety net in the past 5 years

SFI covered by the safety net	Date on which the SFI was first discussed by the HADAC	Date on which the SFI was listed on the HADF	Effective date on which the SFI was covered by the safety net
Abemaciclib and Fulvestrant	14 October 2022	14 January 2023	26 May 2023
Onasemnogene abeparvovec*	14 April 2023	30 December 2023	30 December 2023
Acalabrutinib	09 July 2021	09 October 2021	28 May 2022
Aflibercept	10 January 2014	12 April 2014	17 December 2022
Apalutamide	08 October 2021	08 January 2022	16 December 2023
Atezolizumab and Bevacizumab	17 April 2020	11 July 2020	17 December 2022
Avelumab	11 October 2019	07 April 2023	16 December 2023
Abrocitinib	13 October 2023	13 January 2024	25 May 2024
Anifrolumab	13 October 2023	13 January 2024	25 May 2024
Atezolizumab	13 July 2018	13 October 2018	29 December 2020
Brentuximab Vedotin	08 April 2016	11 January 2020	23 May 2020
Brigatinib	12 July 2019	12 October 2019	23 May 2020
Belimumab	14 January 2013	11 July 2020	29 December 2020
Benralizumab	10 January 2020	10 April 2020	29 December 2020
Burosumab*	08 October 2021	26 May 2023	26 May 2023
Cladribine	11 October 2019	10 April 2021	04 December 2021
Daratumumab and Bortezomib	11 October 2019	22 August 2022	26 May 2023
Daratumumab and Lenalidomide	09 July 2021	08 January 2022	25 May 2024
Dinutuximab Beta	29 December 2020	29 December 2020	29 December 2020
Dupilumab	11 October 2019	10 April 2020	04 December 2021
Durvalumab	11 October 2019	11 January 2020	23 May 2020
Dexamethasone	13 January 2012	14 July 2012	14 December 2024

SFI covered by the safety net	Date on which the SFI was first discussed by the HADAC	Date on which the SFI was listed on the HADF	Effective date on which the SFI was covered by the safety net
Everolimus	12 January 2019	13 April 2019	23 May 2020
Faricimab	14 April 2023	14 October 2023	25 May 2024
Gilteritinib	14 October 2022	07 April 2023	16 December 2023
Gemtuzumab Ozogamicin	08 January 2021	10 July 2021	04 December 2021
Guselkumab	11 October 2019	11 January 2020	23 May 2020
Icatibant	09 July 2021	09 October 2021	17 December 2022
Inotuzumab Ozogamicin	10 January 2020	11 July 2020	29 December 2020
Isatuximab and Pomalidomide	14 October 2022	08 July 2023	16 December 2023
Ixazomib and Lenalidomide	13 July 2018	13 October 2018	23 May 2020
Ixekizumab	17 April 2020	10 October 2020	04 December 2021
Lenalidomide and Bortezomib	13 October 2023	13 January 2024	25 May 2024
Letermovir	10 January 2020	10 October 2020	28 May 2022
Lenvatinib	20 April 2018	14 July 2018	23 May 2020
Lenvatinib and Pembrolizumab	08 April 2022	14 October 2023	25 May 2024
Lorlatinib	14 January 2022	09 July 2022	17 December 2022
Luspatercept	14 October 2022	14 October 2023	14 December 2024
Midostaurin	12 April 2019	12 October 2019	23 May 2020
Niraparib	11 October 2019	09 April 2022	26 May 2023
Neratinib	09 October 2020	09 January 2021	17 December 2022
Nivolumab and Ipilimumab	10 January 2020	10 October 2020	04 December 2021
Olaparib	12 July 2019	09 January 2021	22 May 2021
Paclitaxel Albumin	08 January 2016	14 October 2023	25 May 2024
Polatuzumab Vedotin and Rituximab	08 January 2021	08 January 2022	25 May 2024
Pembrolizumab	10 July 2016	08 April 2017	23 May 2020

SFI covered by the safety net	Date on which the SFI was first discussed by the HADAC	Date on which the SFI was listed on the HADF	Effective date on which the SFI was covered by the safety net
Polatuzumab Vedotin and Rituximab and Bendamustine	08 January 2021	08 January 2022	17 December 2022
Pomalidomide	12 January 2019	13 April 2019	22 May 2021
Ponatinib	10 January 2020	23 May 2020	22 May 2021
Ranibizumab	11 January 2008	11 October 2008	17 December 2022
Risdiplam*	08 April 2022	17 December 2022	17 December 2022
Risankizumab	09 October 2020	09 January 2021	22 May 2021
Ribociclib and Fulvestrant	11 October 2019	09 October 2021	26 May 2023
Ravulizumab*	14 October 2022	08 July 2023	11 November 2023
Ruxolitinib	11 October 2013	12 October 2019	23 May 2020
Tolvaptan (Jinarc)	12 July 2019	11 January 2020	23 May 2020
Selumetinib	08 July 2022	13 January 2024	25 May 2024
Siltuximab	08 April 2022	08 July 2023	16 December 2023
Siponimod	09 April 2021	10 July 2021	28 May 2022
Tafamidis*	09 April 2021	04 December 2021	04 December 2021
Tisagenlecleucel*	10 July 2020	10 April 2021	10 April 2021
Trastuzumab Deruxtecan	14 October 2022	14 October 2023	14 December 2024
Upadacitinib	09 April 2021	10 July 2021	04 December 2021
Venetoclax and Azacitidine	08 April 2022	09 July 2022	16 December 2023
Zanubrutinib	14 July 2023	14 October 2023	25 May 2024

* SFIs covered by the “Subsidy for Eligible Patients to Purchase Ultra-expensive Drugs (Including Those for Treating Uncommon Disorders)” under the CCF.

**Self-financed items (SFIs) repositioned as Special or General drugs,
and respective dates of listing on the Hospital Authority Drug Formulary (HADF) and
repositioning as Special or General drugs in the past 5 years from 2020-21 to 2024-25**

SFI repositioned as Special or General drug	Date of listing on the HADF	Date of repositioning as Special or General drug
Eribulin	April 2018	April 2020
Goserelin	July 2005	April 2020
Leuprorelin	July 2005	April 2020
Triptorelin	July 2005	April 2020
Sacubitril/Valsartan	January 2018	April 2020
Alirocumab	April 2018	April 2021
Evolocumab	July 2017	April 2021
Rivaroxaban	April 2013	April 2022
Ticagrelor	April 2020	April 2022
Dulaglutide	April 2019	April 2022
Exenatide	January 2016	April 2022
Liraglutide	October 2016	April 2022
Lixisenatide	January 2016	April 2022
Semaglutide	January 2021	April 2022
Tofacitinib	April 2022	April 2023
Riociguat	April 2022	April 2023
Topotecan	October 2010	April 2023

- End -

CONTROLLING OFFICER'S REPLY

HHB160

(Question Serial No. 0439)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the Chronic Diseases Co-Care Pilot Scheme (CDCC Pilot Scheme) and Public-Private Partnership (PPP) programmes, will the Government advise this Committee on the following:

1. What has been the number of participants requiring follow-up drug treatment since the launch of the CDCC Pilot Scheme and its percentage in the total number of participants?
2. Further to the above question, what is the number of the cases requiring the use of drugs that are not on the drug list of the CDCC Pilot Scheme and its percentage in the total number of cases requiring follow-up drug treatment?
3. It is noted that participants with hypertension and/or diabetes will receive up to 6 subsidised consultation visits per year from family doctors, while those with prediabetes will be offered up to 4 subsidised consultation visits per year, with prescribed medicines for both groups of patients. How many subsidised consultation visits have the eligible participants received on average since the launch of the CDCC Pilot Scheme? How many patients have continued to make follow-up visits to the same family doctor at their own expense for management of hypertension and/or diabetes after using up the quota of subsidised consultation visits?
4. It was recommended in the Budget Speech that about \$62 billion from 6 endowment funds would be brought back to the Government's accounts in 2025-26 after setting aside the expenses required for the sustainable operation of the funds for the next 5 years. It is noted that the Hospital Authority PPP Fund is one of such endowment funds. What are the details of the actual measures for bringing back the remaining balance from the PPP Fund? Will such a move lead to a reduction in the expenditure related to the sustainable operation of the PPP programmes?

Asked by: Hon SHIU Ka-fai (LegCo internal reference no.: 17)

Reply:

(1) to (3)

The Government has launched the Chronic Disease Co-Care Pilot Scheme (CDCC Pilot Scheme) since 13 November 2023, which is the first major initiative under the Primary Healthcare Blueprint released at end-2022. The Scheme provides subsidised diabetes mellitus (DM) and hypertension (HT) screening services in the private healthcare sector to Hong Kong residents aged 45 or above with no known medical history of DM or HT, with a view to encouraging citizens to gain a better understanding of their own health status as early as possible through screening, so as to achieve the goals of “early prevention, early identification and early treatment”.

The Government expects that 200,000 people will participate in the CDCC Pilot Scheme within the three-year pilot period. The scheme has been well received since its launch. As at 27 March 2025 [provisional figures], about 114 200 citizens and over 600 family doctors have joined the scheme, of which around 65 000 participants (i.e. nearly 60%) have completed the screenings for DM and HT, and around 25 230 of them (i.e. nearly 40%) have been diagnosed with prediabetes^{Note}, DM or HT. The latter patients can proceed to the treatment phase and will be subsidised by the Government to continue their treatment with self-selected family doctors, and subject to their health conditions, be prescribed medication, or referred to follow-up care at nurse clinics and allied health services. In addition, the Government has established a bi-directional referral mechanism with the Hospital Authority (HA) under the CDCC Pilot Scheme. Family doctors can refer participants with clinical needs to receive a one-off specialist consultation at a designated Medicine Specialist Out-patient Clinic of the HA according to clinical diagnosis and pre-defined criteria and guidelines. 50 participants have received one-off specialist consultation at the HA through the mechanism.

As at 31 December 2024, the number of participants requiring follow-up drug treatment under the treatment phase of the scheme and the respective percentages are tabulated below:

Cumulative number of participants of the CDCC Pilot Scheme ^{Note 1}	92 999
Number of the scheme’s participants completed the screenings for DM and HT	52 507
Number of the scheme’s participants diagnosed with prediabetes ^{Note 2} , DM or HT	20 710
Number of the scheme’s participants entered treatment phase	19 959
Number of the scheme’s participants requiring follow-up drug treatment under the treatment phase	9 322
[Percentage in the total number of participants]	[10.0%]
[Percentage in the number of participants under the treatment phase]	[46.7%]
Number of the scheme’s participants prescribed with drugs that are not on the scheme’s list	1 355
[Percentage in the number of the scheme’s participants requiring follow-up drug treatment under the treatment phase]	[14.5%]

Note:

1. The figure refers to citizens who have been assessed by the nurses of the District Health Centers/District Health Centre Expresses, successfully paired up with family doctors and enrolled in the CDCC Pilot Scheme.
2. Prediabetes with glycated haemoglobin level of 6.0 to 6.4 per cent or fasting plasma glucose level of 6.1 to 6.9 mmol/L.

(4)

The Health Bureau has reviewed the latest financial status of the fund having regard to the past expenditure and scheduled projects of the fund. After taking into account the cash flow requirements of the HA Public-Private Partnership Fund in the next 5 years, the fund will retain \$1.8 billion and transfer about \$8.7 billion of unspent balance back to the Government's accounts. The policy objective, mode of operation, as well as management and supervision of the fund will remain unchanged after the transfer.

- End -

CONTROLLING OFFICER'S REPLY

HHB161

(Question Serial No. 0526)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (-) Not Specified

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Within 2025-26, the Department of Health will take forward the next phase of tobacco control measures and step up enforcement of the Smoking (Public Health) Ordinance (Cap. 371) and the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600). Will the Government advise on the contents of the plan, implementation timetable and estimated breakdown of expenditure involved in the next phase of tobacco control measures?

Asked by: Hon SHIU Ka-fai (LegCo internal reference no.: 23)

Reply:

The Government's tobacco control policy seeks to safeguard public health by discouraging smoking, containing the proliferation of tobacco use and minimising the impact of passive smoking on public. To this end, the Government adopts a progressive and multi-pronged approach comprising legislation, enforcement, publicity, education, smoking cessation services and taxation.

The Health Bureau (HHB) introduced in June 2024 the new tobacco control strategy, outlining the short, medium and long-term measures to further reduce smoking prevalence incrementally through various measures, with a view to minimising the harmful effects of tobacco products on the community and safeguarding public health through a multi-pronged approach. These measures are formulated around four directions under the tobacco control strategy, namely, reducing the demand for and supply of tobacco products, minimising the attractiveness of tobacco products, protecting the public from the hazard of second-hand smoke and strengthening the provision of smoking cessation services, aiming to take forward the tobacco control process incrementally. The HHB plans to introduce the proposed legislative amendments for the next-phase tobacco control measures to the Legislative Council for scrutiny by the end of this month. The 10 tobacco control measures to be rolled out in short-term are –

- (1) To implement a duty stamp system for cigarettes
- (2) To increase penalties for duty-not-paid cigarettes
- (3) To prohibit the possession of alternative smoking products

- (4) To implement plain packaging requirement
- (5) To prohibit smoking while queuing
- (6) To extend statutory no-smoking areas (NSAs) and increase the fixed penalty for doing a smoking act in statutory NSAs to \$3,000
- (7) To prohibit the provision of tobacco products to persons aged below 18
- (8) To ban flavoured tobacco products
- (9) To continuously review the effectiveness of increasing tobacco duty and the pace of future adjustments (ongoing)
- (10) To strengthen smoking cessation services as well as publicity and education (ongoing)

The revised estimate and estimate in respect of the tobacco control initiatives undertaken by the Department of Health's Tobacco and Alcohol Control Office (TACO) by work category from 2024-25 to 2025-26 are at **Annex**. Expenditure on individual implementation programmes of the next-phase tobacco control measures by the TACO cannot be separately identified.

Revised Estimate/ Estimate for
the Department of Health's Tobacco and Alcohol Control Office

	2024-25 Revised Estimate (\$ million)	2025-26 Estimate (\$ million)
<u>Enforcement</u>		
Programme 1: Statutory Functions	167.4	174.8
Health Education and Smoking Cessation		
Programme 3: Health Promotion	170.5	180.9
(a) <u>General Health Education and Promotion of Smoking Cessation</u>		
TACO	88.2	87.0
Subvention to Hong Kong Council on Smoking and Health (COSH)	27.9	27.3
<i>Sub-total</i>	<u>116.1</u>	<u>114.3</u>
(b) <u>Revised Estimate / Estimate for Smoking Cessation and Related Services by Non-Governmental Organisations</u>		
Subvention to Tung Wah Group of Hospitals	14.0	17.8
Subvention to Pok Oi Hospital	17.9	20.9
Subvention to Lok Sin Tong	3.6	3.6
Subvention to United Christian Nethersole Community Health Service	8.9	13.8
Subvention to Life Education Activity Programme	3.0	3.0
Subvention to Christian Family Service Centre	7.0	4.5
Subvention to The University of Hong Kong	-	3.0
<i>Sub-total</i>	<u>54.4</u>	<u>66.6</u>
Total	<u>337.9</u>	<u>355.7</u>

- End -

CONTROLLING OFFICER'S REPLY

HHB162

(Question Serial No. 3286)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: Not Specified

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

To assist bureaux and departments in reducing expenditure and ensure the proper use of public money, the relevant bureaux will review the expenditures on social welfare, healthcare and education. Will the Government specify the measures to reduce healthcare expenditure and the amount of savings involved?

Asked by: Hon SHIU Ka-fai (LegCo internal reference no.: 41)

Reply:

In 2025-26, the estimated recurrent expenditure of the Policy Area Group (PAG): Health is \$115.3 billion.

It has also taken into account the continued increase in recurrent funding for the Hospital Authority (HA) according to the projected service demand, based on the triennium funding arrangement in 2017. The recurrent provision for the HA in 2025-26 is \$99 billion, representing an increase of 3.7% over the 2024-25 revised estimate. Details of the expenditures related to other major initiatives of the Health Bureau (HHB) and the Department of Health under the PAG: Health can be found in Appendix 2 of the Budget Media Sheets (https://www.budget.gov.hk/2025/eng/pdf/2025-26_Media_Sheet.pdf).

The HHB will continue to review the healthcare-related expenditures to ensure more accurate and efficient use of resources, amongst which, in March 2025, the Government implemented the fees and charges reform for public healthcare which aims to guide the public to make optimal use of healthcare resources, reduce wastage and abuse, and enhance healthcare protection for “poor, acute, serious, critical” patients on all fronts, thereby enhancing the sustainability of the healthcare system as well as on the financial aspects.

- End -

CONTROLLING OFFICER'S REPLY**HHB163****(Question Serial No. 1600)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): (000) Operational expensesProgramme: Not SpecifiedControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

(1)

It is mentioned in paragraph 208 of the Budget Speech that the Government and the Hospital Authority are reviewing the structure and levels of subsidisation for public healthcare, with a view to strengthening the financial sustainability of public healthcare services. Over the past 3 years, what were the costs of public specialist outpatient clinic services and, in particular, of the specialty of Medicine?

(2)

Regarding the Chronic Disease Co-Care Pilot Scheme implemented since 2023, please provide a detailed breakdown of the expenditure of the scheme so far; the number of participants having had subsidised consultations with family doctors and their proportion to the total number of participants; and the number of participants whose subsidised consultations have exceeded their maximum number allowed.

Asked by: Hon SO Cheung-wing (LegCo internal reference no.: 2)Reply:

(1)

The table below sets out the costs of specialist outpatient services provided by the Hospital Authority (HA) in 2022-23 to 2024-25:

Year	Cost of specialist outpatient services (\$ million)
2022-23	17,925
2023-24	18,819
2024-25 (revised estimate)	19,725

The table below sets out the costs of specialist outpatient services in medicine specialty provided by the HA in 2022-23 to 2023-24. As the 2024-25 financial year has just ended,

cost information of the medicine specialist outpatient services corresponding to the financial year is not yet available.

Year	Cost of medicine specialist outpatient services (\$ million)
2022-23	6,945
2023-24	7,368

The cost of specialist outpatient services includes the direct staff expenses (such as doctors, nurses and allied health staff) for providing services to patients; expenditure incurred for various clinical support services (such as pharmacy, diagnostic radiology and pathology tests), and other operating expenditure (such as utility expenses, and repair and maintenance of medical equipment).

In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA adjusted its services to cope with the outbreak. This should be taken into consideration when comparing the service capacity of the HA in relevant years. With the subsiding of local COVID-19 epidemic situation and cessation of anti-epidemic measures in early 2023, the HA has been gradually resuming provision of all of its public healthcare services to tie in with the Government's normalcy measures. As the costing information for 2022-23 has reflected the impact of the epidemic outbreak (if any), the costing information for different years may not be directly comparable.

(2)

The Government has launched the three-year Chronic Disease Co-Care Pilot Scheme (CDCC Pilot Scheme) since 13 November 2023, which is the first major initiative under the Primary Healthcare Blueprint. The Scheme provides subsidised diabetes mellitus (DM) and hypertension (HT) screening services in the private healthcare sector to Hong Kong residents aged 45 or above with no known medical history of DM or HT, with a view to encouraging citizens to gain a better understanding of their own health status as early as possible through screening, so as to achieve the goals of “early prevention, early identification and early treatment”.

As at 27 March 2025 [provisional figures], about 114 200 citizens and over 600 family doctors have joined the Scheme, of which around 65 000 participants (i.e. nearly 60%) have completed the screenings for DM and HT, and around 25 230 of them (i.e. nearly 40%) have been diagnosed with prediabetes^{Note}, DM or HT. The latter patients can proceed to the treatment phase and will be subsidised by the Government to continue their treatment with self-selected family doctors, and subject to their health conditions, be prescribed medication, or referred to follow-up care at nurse clinics and allied health services. In addition, the Government has established a bi-directional referral mechanism with the HA under CDCC Pilot Scheme. Family doctors can refer participants with clinical needs to receive a one-off specialist consultation at a designated Medicine SOPC of the HA according to clinical diagnosis and pre-defined criteria and guidelines; 50 participants have received one-off specialist consultation at the HA through the mechanism.

With regard to the promotion of multidisciplinary care, in accordance with the Government's earlier announcement, the dedicated nurse clinic and allied health services (including optometrists, physiotherapists and dietitians) have been introduced to devise more comprehensive chronic disease management programmes for the CDCC Pilot Scheme participants since 20 January 2025. Since the introduction of the relevant services, as at 27 March 2025 [provisional figures], 504 participants have made reservations for relevant services and 417 of them have already received services. From 28 March 2025, the CDCC Pilot Scheme has been expanded to cover blood lipid testing for eligible participants, allowing a more comprehensive approach to the assessment and proper management of cardiovascular disease risk factors, including the “three highs” (high blood pressure, high blood sugar and high cholesterol). Starting from the same day, the Scheme will be expanded in phases to provide preventive screening and care services in GOPCs of the HA for the underprivileged group. The 2025-26 estimates cover the medical service expenditures required for the scheme expansion, including doctor consultations, laboratory tests, medications, nurse clinics, and allied health services.

The expenditure of the CDCC Pilot Scheme for 2023-24 and the estimated expenditure for 2024-25 are provided below:

2023-24 Expenditure (\$ million)	2024-25 Estimated Expenditure (\$ million)
10	43.1

As mentioned in the Primary Healthcare Blueprint, local studies have shown that the healthcare system can achieve savings in healthcare expenses and reduce the burden of disease through the provision of subsidised screening and management services for DM management to suitable patients. The CDCC Pilot Scheme is a pilot scheme that encourages eligible citizens to undergo screening for DM and HT, two common chronic diseases, so that hidden patients can be detected at an early stages and their complications can be treated and prevented as early as possible, thereby reducing the need for hospitalisation. In order to further examine the effectiveness of the CDCC Pilot Scheme, the Government commissioned a local university in the first quarter of 2024 to conduct a study to assess the extent to which the objectives of the scheme are met and the overall performance, including the service quality and effectiveness, as well as the cost-effectiveness. The Government will review the service model and operational details of the CDCC Pilot Scheme in a timely manner and make enhancements as necessary to ensure its effectiveness, including considering whether to expand the service scope of the Scheme.

Note: Prediabetes with glycated haemoglobin level of 6.0 to 6.4 % or fasting plasma glucose level of 6.1 to 6.9 mmol/L.

- End -

CONTROLLING OFFICER'S REPLY

HHB164

(Question Serial No. 1601)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Paragraph 229 of the Budget Speech mentions that the expenditure on healthcare should be reviewed, emphasising that the “user pays” and the “affordable users pay” principles should be upheld as far as practicable whilst increasing revenue. The “co-payment” and “family doctor” models will not only reduce healthcare expenditure but also ease the pressure on public healthcare. Therefore, in the review of healthcare expenditure, does the Government have any plan to allocate a portion of the expenditure for expanding the scope of Chronic Disease Co-Care Pilot Scheme so as to promote the “co-payment” and “family doctor” models?

Asked by: Hon SO Cheung-wing (LegCo internal reference no.: 3)

Reply:

The Government has launched the three-year Chronic Disease Co-Care Pilot Scheme (CDCC Pilot Scheme) since 13 November 2023, which is the first major initiative under the Primary Healthcare Blueprint. The Scheme provides subsidised diabetes mellitus (DM) and hypertension (HT) screening services in the private healthcare sector to Hong Kong residents aged 45 or above with no known medical history of DM or HT, with a view to encouraging citizens to gain a better understanding of their own health status as early as possible through screening, so as to achieve the goals of “early prevention, early identification and early treatment”. The Government aims to establish a family doctor regime and position District Health Centres (DHC) and DHC Expresses as hubs to foster expansion of the community healthcare network, so as to properly manage chronic diseases in the community through a multi-disciplinary approach, thereby alleviating the pressure on secondary and tertiary healthcare services, in particular the Specialist Out-patient Clinics (SOPCs) of the Hospital Authority (HA).

The Government expects that 200,000 people will participate in the CDCC Pilot Scheme within the three-year pilot period. The Scheme has been well received since its launch. As at 27 March 2025 [provisional figures], about 114 200 citizens and over 600 family doctors have joined the Scheme, of which around 65 000 participants (i.e. nearly 60%) have completed the screenings for DM and HT, and around 25 230 of them (i.e. nearly 40%) have

been diagnosed with prediabetes ^{Note}, DM or HT. The latter patients can proceed to the treatment phase and will be subsidised by the Government to continue their treatment with self-selected family doctors, and subject to their health conditions, be prescribed medication, or referred to follow-up care at nurse clinics and allied health services. In addition, the Government has established a bi-directional referral mechanism with the HA under CDCC Pilot Scheme. Family doctors can refer participants with clinical needs to receive a one-off specialist consultation at a designated Medicine SOPC of the HA according to clinical diagnosis and pre-defined criteria and guidelines; 50 participants have received one-off specialist consultation at the HA through the mechanism.

With regard to the promotion of multidisciplinary care, in accordance with the Government's earlier announcement, the dedicated nurse clinic and allied health services (including optometrists, physiotherapists and dietitians) have been introduced to devise more comprehensive chronic disease management programmes for the CDCC Pilot Scheme participants since 20 January 2025. Since the introduction of the relevant services, as at 27 March 2025 [provisional figures], 504 participants have made reservations for relevant services and 417 of them have already received services. From 28 March 2025, the CDCC Pilot Scheme has been expanded to cover blood lipid testing for eligible participants, allowing a more comprehensive approach to the assessment and proper management of cardiovascular disease risk factors, including the “three highs” (high blood pressure, high blood sugar and high cholesterol). Starting from the same day, the Scheme will be expanded in phases to provide preventive screening and care services in GOPCs of the HA for the underprivileged group.

In determining the subsidy rate under the CDCC Pilot Scheme, the Government has taken a host of factors including the market price, affordability of the public, the need for and options of services and attractiveness of the Scheme into account, so that participants can have access to personalised, convenient and time-saving primary healthcare services in a better environment. As mentioned in the Primary Healthcare Blueprint, local studies have shown that the healthcare system can achieve savings in healthcare expenses and reduce the burden of disease through the provision of subsidised screening and management services for DM management to suitable patients. The CDCC Pilot Scheme is a pilot scheme that encourages eligible citizens to undergo screening for DM and HT, two common chronic diseases, so that hidden patients can be detected at an early stages and their complications can be treated and prevented as early as possible, thereby reducing the need for hospitalisation. In order to further examine the effectiveness of the CDCC Pilot Scheme, the Government commissioned a local university in the first quarter of 2024 to conduct a study to assess the extent to which the objectives of the scheme are met and the overall performance, including the service quality and effectiveness, as well as the cost-effectiveness. The Government will review the service model and operational details of the CDCC Pilot Scheme in a timely manner and make enhancements as necessary to ensure its effectiveness, including considering whether to expand the service scope of the Scheme.

Note: Prediabetes with glycated haemoglobin level of 6.0 to 6.4 % or fasting plasma glucose level of 6.1 to 6.9 mmol/L.

- End -

CONTROLLING OFFICER'S REPLY

HHB165

(Question Serial No. 1612)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: Not Specified

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The progress of the First Hospital Development Plan was reported in the paragraph 207 of the Budget Speech. It was also mentioned there that the Government would review the priority of projects under the Second Hospital Development Plan. It is noted that up to now the Government has, by and large, expanded the hospital hardware through such 2 plans in response to the ever-growing demand. As regards review of resources, are there any plans for the Government to fine tune the hospital development plans for the repositioning of healthcare institutions and enhanced utilisation of resources?

Asked by: Hon SO Cheung-wing (LegCo internal reference no.: 13)

Reply:

The Hospital Authority (HA) plans and develops public healthcare services on a cluster basis. Service catchment areas are correspondingly delineated based on the location and function(s) of each hospital (mainly acute hospitals) within a cluster to facilitate the effective planning of capital works and services. At the same time, the roles of the hospitals within each cluster are examined and defined to enhance collaboration and co-ordination among hospitals, avoid duplication of services by hospitals, and ensure that the hospital developments of each cluster is comprehensively planned and well-coordinated.

With the changes in the planning and development situation of Hong Kong, the Health Bureau and the HA are currently reviewing the Second Hospital Development Plan (HDP). Amongst others, in view of the territory-wide and regional planning and development strategies as announced by the Planning Department (including the “Hong Kong 2030+: Towards a Planning Vision and Strategy Transcending 2030” and the “Northern Metropolis Development Strategy”), the corresponding population projections of Hong Kong including the latest changes in overall population, its distribution and demographics, as well as the population policy and talent attraction initiatives of the Government, etc., the Health Bureau and the HA have to adopt a planning horizon of up to 2040 and beyond for the Second HDP, and to project healthcare service demand and consider the supply and conditions of the land required, thereby optimising the Second HDP.

The Government also considers factors such as the needs for and cost-effectiveness of renovation, refurbishment, redevelopment or addition of facilities for individual hospitals, and the convenience of public access to healthcare services under various major transport infrastructure development plans for determining the distribution, scale and priority, etc. of various hospital development projects under the Second HDP.

The HA will continue to review and plan the service provision of the clusters from time to time based on the Government's population projections which are regularly updated, as well as making timely adjustments to its cluster delineation and setup in light of the social needs and demographic changes. It will also make corresponding manpower and resource allocations as well as service arrangements; and make prudent and optimal use of the limited healthcare resources, thereby maximising service effectiveness. When reviewing the future HDP projects, the Health Bureau and the HA will strategically determine the project types, scales and priorities based on the latest service provisions of the clusters, with a view to developing the hospital infrastructure facilities in the most cost-effective manner, while keeping in line with the development of hospital services for serving the general public.

- End -

CONTROLLING OFFICER'S REPLY

HHB166

(Question Serial No. 1613)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: Not Specified

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in paragraph 206 of the Budget Speech that to develop primary healthcare, the Government will upgrade the District Health Centre Expresses (DHCEs) in Central and Western District, Eastern District, and Yau Tsim Mong District to District Health Centres (DHCs) within this year. In this regard, will the Government please advise this Committee on the criteria for upgrading DHCEs to DHCs, and whether it has any plans to upgrade all existing DHCEs to DHCs?

Asked by: Hon SO Cheung-wing (LegCo internal reference no.: 14)

Reply:

The Government set up 7 District Health Centres (DHCs) and 11 smaller interim District Health Centre Expresses (DHCEs) in rented properties across the territory by 2022, thereby attaining the interim goal of covering all 18 districts of Hong Kong. The Government will upgrade the 3 DHCEs in the Central and Western District, Eastern District, and Yau Tsim Mong District to DHCs within 2025. In April 2024, the Health Bureau (HHB) launched a tender exercise for the operation of the Central and Western DHC and three women's health service points named Women Wellness Satellites located in Chai Wan, Lam Tin and Tuen Mun. A 3-year operation service contract with a total value of approximately \$531.7 million was subsequently awarded in January 2025. The Central and Western DHC is expected to commence operation in the third quarter of this year. In July 2024, the HHB conducted tender exercises for the operation of the Eastern and Yau Tsim Mong DHCs. The operation service contracts for these 2 DHCs are expected to be awarded this year.

Upon the upgrading of the 3 DHCEs to DHCs this year, the 11 existing DHCEs will gradually reduce to 8, while the number of DHCs will increase to 10. The estimated expenditure for DHCs and DHCEs (including provisions for service contracts, site maintenance and rental cost) for 2025-26 are \$1.083 billion and \$213 million respectively.

In addition, the funding proposals for the construction projects of Wan Chai, Kwun Tong, Sai Kung and North District DHCs were approved by the Finance Committee of the Legislative Council (LegCo) in January and October 2021, and in April and July 2024 respectively.

These projects will be completed gradually in the next few years. To achieve the long-term development goal of having DHCs in all 18 districts as early as possible, the Government is actively taking forward the plan to establish DHCs in the remaining 4 districts and will seek LegCo's funding approval in due course. Before the remaining DHCs are set up, the Government will continue to subsidise non-governmental organisations to operate DHCEs in those districts. The services provided by DHCEs will be migrated as appropriate to DHCs in respective districts at a later stage. The PHCC will, together with the operators of DHCEs, draw up and implement transition plans for upgrading DHCEs to DHCs to ensure a smooth transition of services.

- End -

CONTROLLING OFFICER'S REPLY

HHB167

(Question Serial No. 2611)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in the Budget Speech that the Government is progressively implementing and completing the 16 works projects, which entail a total of about \$190 billion, under the First Hospital Development Plan. Taking into account the latest demographic structure, planning and development situation in Hong Kong, it will review the distribution, scale and priority of projects under the Second Hospital Development Plan, and will make the announcement in due course. In this regard, will the Government inform this Committee of:

- (1) the specific titles of the 16 works projects under the First Hospital Development Plan, their progress and expenditures involved in table form;
- (2) whether an effectiveness evaluation has been made on the projects under the First Hospital Development Plan; if yes, the findings; if no, the reasons for that;
- (3) whether more factors such as integrated Chinese-Western medicine, mental health, healthcare manpower projections and the Government's financial situation, apart from demographic structure, planning and development situation, will be considered under the Second Hospital Development Plan?

Asked by: Hon TAN Yueheng (LegCo internal reference no.: 18)

Reply:

(1) and (2)

In 2016, the Government and the Hospital Authority (HA) commenced the implementation of the First Hospital Development Plan (HDP) which encompasses a total of 16 projects, covering the redevelopment and expansion of 11 hospitals, the construction of a new acute hospital, 3 community health centres and 1 supporting services centre. It is aimed that upon completion of the First HDP, a total of 6 557 additional bed spaces (Note) and 94 operating theatres will be provided, along with the creation of more room for increasing service quotas of specialist and general out-patient clinics.

Up till now, 15 out of those 16 projects under the First HDP have been upgraded to Category A. The completed or substantially completed projects include the expansion of Haven of Hope Hospital, the extension of Operating Theatre Block for Tuen Mun Hospital (New Block), the redevelopment of Kwong Wah Hospital (Phase 1), the North District Community Health Centre, the HA Supporting Services Centre, and the redevelopment of Queen Mary Hospital (Phase 1). Other projects the main works of which are currently underway include the redevelopment of Kwai Chung Hospital (Phases 2 and 3), the construction of a new acute hospital at Kai Tak Development Area, the redevelopment of Grantham Hospital (Phase 1), the redevelopment of Our Lady of Maryknoll Hospital, the expansion of Lai King Building in Princess Margaret Hospital, the redevelopment of Prince of Wales Hospital, Phase 2 (Stage 1), the expansion of United Christian Hospital, the redevelopment of Kwong Wah Hospital (Phase 2), and the expansion of North District Hospital. As for the redevelopment of Shek Kip Mei Health Centre, which has recently been upgraded to a Category A project, the construction works are expected to commence in the second quarter of 2025. The remaining Category B project, namely the development of a community health centre building at On Sau Road, Kwun Tong, is currently in the planning stage.

Since some of the projects under the First HDP remain underway while some other are pending commencement, there is currently no complete information on the assessment of its effectiveness.

(3)

When planning and implementing the Second HDP, the HA will take into account the latest territory-wide and regional planning and development strategies, demographic statistics, projections of population distribution and demographics of various districts, government population policies and talent attraction initiatives, etc. In addition, the HA will proactively tie in with various government policies and initiatives, including the development of primary healthcare services, mental health services, Chinese medicine services and integrated Chinese-Western medicine services, while providing the most appropriate healthcare services to the public by reserving space in newly constructed hospital facilities to accommodate various service developments, increasing resources as appropriate, optimising existing services and introducing various new service models, etc. In the course of planning, the HA will forecast future service demand and corresponding healthcare manpower requirements, and make corresponding assessments and planning, with a view to flexibly deploying manpower and recruit additional staff in a timely manner according to service plans during the commissioning of new hospital facilities and phased introduction of services to meet service demands.

The HA will continue to take service provisions of its clusters as the basis for consideration while strategically determining project types, scale and priorities, and making prudent and optimal use of the limited healthcare resources, with a view to developing hospital infrastructure facilities in the most cost-effective manner for serving the public.

Note: The figures include the additional beds at Kai Tak New Acute Hospital, which are provided for the relocation of the services from Queen Elizabeth Hospital (QEH). Currently,

QEH has around 1 940 beds and the reprovisioning of these beds will depend on the reallocation or redevelopment plan of its vacated buildings after its service relocation.

- End -

CONTROLLING OFFICER'S REPLY

HHB168

(Question Serial No. 2612)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It was mentioned in the Budget Speech that the Government would upgrade the District Health Centre Expresses (DHCEs) in Central and Western District, Eastern District and Yau Tsim Mong District into District Health Centres (DHCs) this year, with a view to strengthening the community healthcare system. It was also mentioned in Matters Requiring Special Attention in 2025–26 that the Government would continue to take forward and enhance the development of DHCs and DHCEs across the territory, and integrating the services of Woman Health Centres and Elderly Health Centres into DHC Network. In this connection, please advise this Committee of:

- 1) the cumulative numbers of members, numbers of beneficiaries and estimated expenses of each of the current DHCs and DHCEs across Hong Kong;
- 2) the staffing establishment, actual staff numbers and remuneration expenses of each of the current DHCs; and
- 3) the numbers of Woman Health Centres and Elderly Health Centres across Hong Kong, their geographical distribution and anticipated effectiveness of operations upon integration.

Asked by: Hon TAN Yueheng (LegCo internal reference no.: 19)

Reply:

(1) and (2)

The cumulative numbers of members and attendances of District Health Centres (DHCs) and District Health Centre Expresses (DHCEs) (collectively referred to as DHCs) are set out in the table below:

DHC/DHCE Service Commencement Date	Cumulative Number of Members ^{Note 1} (as at 31 December 2024) [Provisional Figures]	Cumulative Number of Attendances ^{Notes 1, 2, 3, 4} (as at 31 December 2024) [Provisional Figures]
<i>DHC</i>		
Kwai Tsing 24 September 2019	46 100	498 300
Sham Shui Po 30 June 2021	34 300	296 600
Tuen Mun 31 May 2022	38 100	344 100
Wong Tai Sin 30 June 2022	34 700	200 900
Southern 17 October 2022	23 900	175 300
Yuen Long 24 October 2022	42 500	255 000
Tsuen Wan 30 December 2022	26 000	175 700
<i>DHCE</i>		
Sai Kung 1 September 2021	10 600	84 900
Kowloon City 1 October 2021	11 300	57 300
Yau Tsim Mong 1 October 2021	9 600	48 500
Wan Chai 4 October 2021	6 800	53 000
North 18 October 2021	8 700	53 700
Islands 18 October 2021	6 400	35 900
Kwun Tong 21 October 2021	10 800	49 300
Tai Po 22 October 2021	7 800	45 000
Sha Tin 30 October 2021	13 300	71 400
Central and Western 30 October 2021	7 900	50 200
Eastern 30 October 2021	10 900	54 700
Total	349 900	2 549 900

Note:

1. Figures are rounded to the nearest hundred.

2. The figures only include service figures captured from the DHC/DHCE information system, and do not include those relating to medical laboratory tests.
3. As different services are provided by the 11 DHCEs, the attendance figures are not directly comparable.
4. The service figures above have included services provided by DHCs/DHCEs for participants of the Chronic Disease Co-care Pilot Scheme which was launched on 13 November 2023.

The staff establishment (including healthcare professionals and other supporting staff) and revised estimate (including the provisions for service contracts, site maintenance and rental cost) of DHCs in Kwai Tsing, Sham Shui Po, Tuen Mun, Wong Tai Sin, Southern, Yuen Long and Tsuen Wan in 2024-25 are set out in the table below:

	DHC						
	Kwai Tsing	Sham Shui Po	Tuen Mun	Wong Tai Sin	Southern	Yuen Long	Tsuen Wan
Staff establishment Note 5							
Executive Director	1	1	1	1	1	1	1
Medical Consultant Note 6	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Chief Care Coordinator	1	1	1	1	1	1	1
Care Coordinator/ Nurse	21	18.5	26	25	16	29	21
Physiotherapist	3.5	2	3	3	3	3	2
Occupational Therapist	1.5	2	2	2	3	3	2
Dietitian	1	1	1	2	1	2	2
Pharmacist	1	1	1	1	1	1	1
Social Worker, Administrative Staff and Supporting Staff	55	69	62	62	59	50	48
Total	85.5	96	97.5	97.5	85.5	90.5	78.5
2024-25 Revised Estimate (\$ million)	62	63	80	69	58	73	78

Note:

5. The staff establishment is proposed by DHC operators through tendering procedures according to the service demand in the community and manpower estimation, and is approved by the Government. The 0.5 staff establishment refers to a part-time position with half of the working hours of a full-time position. The actual number of staff may vary from time to time, depending on factors such as service demand and short-term manpower turnover, etc. The Government will continue to monitor the situation to ensure that services are not affected.
6. Medical Consultants are part-time or outsourced positions.

The staff establishment (including healthcare professionals and other supporting staff) and revised estimate (including the provisions for service contracts, site maintenance and rental cost) of all DHCEs in 2024-25 are set out in the table below:

	DHCE										
	Central and Western	Eastern	Islands	Kowloon City	Kwun Tong	North	Sai Kung	Sha Tin	Tai Po	Wan Chai	Yau Tsim Mong
Staff establishment Notes 7,8											
Project Coordinator	1	1	1	1	1	1	1	1	1	1	1
Medical Consultant Note 9	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Care Coordinator	3	3	3	1	2	1	2	5	5	5	1
Nurse	1	3		5	4	3	4				4
Physiotherapist	1	1	1	1	1	1	1	1	1	1	1
Occupational Therapist					1		1		0.5	1	
Pharmacist	0.5	0.5					1	1		1	
Dietitian				1	1	0.5	1		1		1
Social Worker, Administrative Staff and Supporting Staff	14	15	12	13	15.5	14.5	12	18	14	7.5	14
Total	21	24	17.5	22.5	26	21.5	23.5	26.5	23	17	22.5
2024-25 Revised Estimate (\$ million)	15	14	13	14	14	14	14	14	14	15	14

Note:

7. The staff establishment is proposed by DHCEs according to the service demand in the community and manpower estimation, and is reviewed and approved by the Government before entering into contracts with operators. The 0.5 staff establishment refers to a part-time position with half of the working hours of a full-time position. The actual number of staff may vary from time to time, depending on factors such as service demand and short-term manpower turnover, etc. The Government will continue to monitor the situation to ensure that services are not affected.
8. The staff establishment of each DHCE is dependent on the service demand and service delivery model of the district concerned, and so the figures are not directly comparable.
9. Medical Consultants are part-time or outsourced positions.

Upon the upgrading of the 3 DHCEs in the Central and Western District, Eastern District and Yau Tsim Mong District to DHCs this year, the 11 existing DHCEs will gradually reduce to 8, while the number of DHCs will increase to 10. The estimated expenditure for DHCs and DHCEs (including provisions for service contracts, site maintenance and rental cost) for 2025-26 are \$1.083 billion and \$213 million respectively.

(3)

Integration of women and elderly health services under the Department of Health (DH) into the district health network of the Primary Healthcare Commission (PHCC) aims to utilise resources more effectively, strengthening the prevention-oriented, district-based, and family-centric primary healthcare network.

The PHCC will commence the integration of women health services within this year in an orderly manner. The services, operated by non-governmental organisations engaged by open tender, will be rendered through three service points named Women Wellness Satellites (WWSs) to provide primary healthcare services for women. The 3 WWSs in Chai Wan, Lam Tin and Tuen Mun will progressively start service in 2025 to replace the Woman Health Centres of the DH. The Chai Wan WWS will commence operation in the second quarter while the Lam Tin and Tuen Mun WWSs are expected to be open in the third quarter. DHCs across all 18 districts will enhance promotion and education on women's health, and provide new dedicated nurse clinics for women's health services to encourage and support members of the public to manage their own health. DHCs will also identify women in need through basic health assessments and individual consultations, and refer them to WWSs or General Out-patient Clinics of the Hospital Authority to receive women's health services.

Specifically, DHCs provide basic women health services, conduct initial assessments and arrange referrals to WWSs for services as necessary. WWSs will provide more personalised primary healthcare services for women. In addition to the existing services such as health assessments, breast cancer and cervical cancer screenings, WWSs will devise personalised preventive care or specific consultation services according to individual health risks and needs for members' selection to enhance prevention-oriented women's health services.

Moreover, to further expand the multidisciplinary primary healthcare service network, the PHCC plans to start the preparation for the integration of the services of Elderly Health Centres under the DH into the district health network in phases from 2025-26, with a view to enhancing service synergy and minimising service duplication. The detailed transitional arrangements will be announced after discussion with the DH.

- End -

CONTROLLING OFFICER'S REPLY

HHB169

(Question Serial No. 2200)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: Not Specified

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

To develop primary healthcare, the Government will upgrade the District Health Centre Expresses (DHCEs) in Central and Western District, Eastern District, and Yau Tsim Mong District into District Health Centres (DHCs) this year, with a view to strengthening the community healthcare system. However, upgrading the scale and functions of DHCEs involves substantial resources, including human resources and service planning. In this connection, will the Government inform this Committee of the following:

- (a) What are the respective estimated expenditures for upgrading the DHCEs in Central and Western District, Eastern District and Yau Tsim Mong District into DHCs? Please provide a detailed breakdown of costs by district.
- (b) What are the numbers of users and attendances of each DHC in each of the past 3 years? Please provide the information by each of the 18 districts, with explanations of the trends and reasons for the changes in service capacity.
- (c) What is the average cost per treatment? Please provide the information by type of service; and
- (d) What is the civil service establishment involved in the proposed upgrade of the DHCEs? Please provide detailed information on the number, ranks and duties of the new positions, and the related human resource planning.

Asked by: Hon TANG Ka-piu (LegCo internal reference no.: 35)

Reply:

(a)

In April 2024, the Health Bureau (HHB) launched a tender exercise for the operation of the Central and Western District Health Centre (DHC) and 3 women's health service points named Women Wellness Satellites located in Chai Wan, Lam Tin and Tuen Mun. A three-year operation service contract with a total value of approximately \$531.7 million was

subsequently awarded in January 2025. The Central and Western DHC is expected to commence operation in the third quarter of this year.

In July 2024, the HHB conducted tender exercises for the operation of the Eastern and Yau Tsim Mong DHCs. The operation service contracts for these 2 DHCs are expected to be awarded this year.

Upon the upgrading of the 3 District Health Centre Expresses (DHCEs) to DHCs this year, the 11 existing DHCEs will gradually reduce to 8, while the number of DHCs will increase to 10. The estimated expenditure for DHCs and DHCEs (including provisions for service contracts, site maintenance and rental cost) for 2025-26 are \$1.083 billion and \$213 million respectively.

(b)

The annual numbers of service users and attendances of DHCs/DHCEs across the 18 districts in Hong Kong have continued to rise. As at 31 December 2024, the cumulative number of members of DHCs/DHCEs is about 349 900, with cumulative attendances of around 2 549 900.

The cumulative numbers of members and attendances of DHCs and DHCEs are set out in the table below:

DHC/DHCE Service Commencement Date	Cumulative Number of Members Note 1 (as at 31 December 2024) [Provisional Figures]	Cumulative number of attendances Notes 1, 2, 3, 4 (as at 31 December 2024) [Provisional Figures]
<i>DHC</i>		
Kwai Tsing 24 September 2019	46 100	498 300
Sham Shui Po 30 June 2021	34 300	296 600
Tuen Mun 31 May 2022	38 100	344 100
Wong Tai Sin 30 June 2022	34 700	200 900
Southern 17 October 2022	23 900	175 300
Yuen Long 24 October 2022	42 500	255 000
Tsuen Wan 30 December 2022	26 000	175 700
<i>DHCE</i>		
Sai Kung 1 September 2021	10 600	84 900
Kowloon City 1 October 2021	11 300	57 300
Yau Tsim Mong 1 October 2021	9 600	48 500

DHC/DHCE Service Commencement Date	Cumulative Number of Members ^{Note 1} (as at 31 December 2024) [Provisional Figures]	Cumulative number of attendances ^{Notes 1, 2, 3, 4} (as at 31 December 2024) [Provisional Figures]
Wan Chai 4 October 2021	6 800	53 000
North 18 October 2021	8 700	53 700
Islands 18 October 2021	6 400	35 900
Kwun Tong 21 October 2021	10 800	49 300
Tai Po 22 October 2021	7 800	45 000
Sha Tin 30 October 2021	13 300	71 400
Central and Western 30 October 2021	7 900	50 200
Eastern 30 October 2021	10 900	54 700
Total	349 900	2 549 900

Note:

1. Figures are rounded to the nearest hundred.
2. The figures only include service figures captured from the DHC/DHCE information system, and do not include those relating to medical laboratory tests.
3. As different services are provided by the 11 DHCEs, the attendance figures are not directly comparable.
4. The service figures above have included services provided by DHCs/DHCEs for participants of the Chronic Disease Co-care Pilot Scheme which was launched on 13 November 2023.

(c)

The Primary Healthcare Commission (PHCC) is progressively enhancing the performance monitoring mechanism of the DHCs by regularly reviewing a number of quantitative and qualitatively related aspects, including service volume, operational effectiveness and health-related outcomes, etc., to assess the performance of the DHCs, and to make timely recommendations to the operators for improvement. The PHCC will take into account the relevant assessment results when renewing the operating service contracts.

(d)

The upgrading of DHCEs is carried out by the PHCC as part of its overall functions, and there is no separate staff establishment. Therefore, information on the expenditure and staff establishment involved in the related work is not available.

- End -

CONTROLLING OFFICER'S REPLY

HHB170

(Question Serial No. 2201)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned under Matters Requiring Special Attention in 2025-26 that the Government will expand the Elderly Health Care Voucher Greater Bay Area (GBA) Pilot Scheme. With the integrated development between the GBA and Hong Kong, more and more elderly persons from Hong Kong choose to live or take up short-term residence in Mainland cities. To promote the sharing and collaboration of medical resources within the GBA, will the Government inform this Committee of the following:

- (a) What were the numbers of beneficiaries of the Elderly Health Care Voucher Scheme and the related total expenditures in each of the past 5 years? How many of them used the vouchers in the GBA and what was the amount of money involved?
- (b) What is the specific scope for expanding the Elderly Health Care Voucher GBA Pilot Scheme? Please provide the new pilot cities to be included in the Pilot Scheme and the justifications for selecting the related locations.
- (c) What are the publicity strategies and channels adopted by the Government and what was the expenditure in publicity in the past 5 years?

Asked by: Hon TANG Ka-piu (LegCo internal reference no.: 36)

Reply:

(a)

In the past 5 years, the numbers of eligible elderly persons who had used their Elderly Health Care Vouchers (EHCVs), as well as the total number of EHCV claim transactions made at medical institutions in the Greater Bay Area (GBA)^{Note 1} and the amount claimed are set out in the table below:

	2020	2021	2022	2023	2024 ^{Note 2}
Cumulative number of elderly persons who had used their EHCVs as at the end of the year	1 350 000	1 424 000	1 492 000	1 610 000	1 714 000
Total number of EHCV claim transactions made at medical institutions in the GBA	18 962	35 953	32 356	38 462	77 918
Total amount of EHCVs claimed for services at medical institutions in the GBA (HK\$'000)	5,507	12,103	10,949	11,883	39,339

The actual/estimated expenditures on the Elderly Health Care Voucher Scheme (EHVS) for the financial years from 2020-21 to 2024-25 are as follows:

Year	Actual/estimated expenditure on the EHVS (\$ million)
2020-21	2,150 (Actual)
2021-22	2,550 (Actual)
2022-23	2,790 (Actual)
2023-24	3,330 (Actual)
2024-25	3,450 (Revised estimate)

Note 1 : Including the University of Hong Kong-Shenzhen Hospital (HKU-SZH) and its offsite medical institution, i.e. the Huawei Li Zhi Yuan Community Health Service Centre, as well as the 7 pilot medical institutions under the Elderly Health Care Voucher Greater Bay Area Pilot Scheme (Pilot Scheme).

Note 2 : The Pilot Scheme was launched in 2024.

(b)

The Government launched the Elderly Health Care Voucher Greater Bay Area Pilot Scheme (Pilot Scheme) in 2024 to extend the coverage of EHCVs to suitable medical institutions in the GBA. As at September 2024, the coverage of EHCVs has been extended to 7 integrated medical/dental institutions in the GBA. Together with the 2 existing service points operated by the HKU-SZH, eligible elderly persons can use their EHCVs to pay for outpatient healthcare services provided by the designated departments at 9 service points in the GBA, located at Guangzhou, Zhongshan, Dongguan and Shenzhen, offering more convenience and flexibility for eligible Hong Kong elderly persons residing in Mainland cities in the GBA by providing more service points for them to better use their EHCVs on primary healthcare services for improving their health. The Chief Executive's 2024 Policy Address announced the extension of the Pilot Scheme to cover the 9 Mainland cities in the GBA. The Health Bureau and the Department of Health (DH) are actively taking forward the related work. The initial plan is to commence the relevant arrangements under the Pilot Scheme at the locations concerned by the 4th quarter of 2025.

(c)

The DH promotes the EHVS through various publicity campaigns and public education activities, including disseminating the latest information on the Scheme through the websites of the DH and the EHVS (hcv.gov.hk) as well as via social media; broadcasting television and radio Announcements in the Public Interest (APIs); displaying advertisements for the EHVS and points to note when using EHCVs on public transport and at shopping centres in public housing estates; broadcasting APIs and distributing leaflets and posters at elderly health centres, Home Affairs Enquiry Centres, etc.; and distributing leaflets at neighbourhood elderly centres, district elderly community centres, hospitals and clinics under the Hospital Authority, estate management offices, etc. The DH also mobilises its Visiting Health Teams to organise health talks for elderly persons and Senior Police Call members of the Hong Kong Police Force in various districts, with a view to promoting the EHVS together with the Pilot Scheme.

The EHVS is administered by the Health Care Voucher Division (HCVD) of the DH. The actual/estimated administrative expenses incurred by the HCVD for administering the EHVS (including its publicity and promotion work) for the financial years from 2020-21 to 2024-25 are as follows:

Year	Administrative expense (\$ million)
2020-21	43.6 (Actual)
2021-22	41.4 (Actual)
2022-23	42.2 (Actual)
2023-24	50.6 (Actual)
2024-25	54.7 (Revised estimate)

The expenses involved in the above publicity and public education work cannot be separately quantified.

- End -

CONTROLLING OFFICER'S REPLY

HHB171

(Question Serial No. 2202)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is announced in the Chief Executive's 2024 Policy Address that the Government will map out a community pharmacy programme and commence the work on developing a community drug formulary. In this connection, will the Government inform this Committee:

- (a) of the expenditures on developing a community drug formulary and the number of drug types expected to be included therein, and whether there is overlapping of drug types with those listed in the existing Drug Formulary of the Hospital Authority;
- (b) of the overall budget for mapping out and launching the community pharmacy programme, including the expenditures on the research, co-ordination, commencement and implementation of the community drug formulary, and any specific progress made thus far that can be revealed;
- (c) in view that there are community pharmacies of various sizes in all districts across the territory, how the Government will co-ordinate the individuals or organisations concerned to join or support the programme to be launched, and whether the Government has considered incorporating these community pharmacies into the future service networks;
- (d) how the Government will assess the effectiveness of the community drug formulary on promoting the development of primary healthcare;
- (e) whether any other financial expenses or arrangements are also involved in the operation of the community pharmacy programme, such as the costs on daily expenditures, rent and human resources of the community pharmacies, and whether the Government has any corresponding subsidy or assistance schemes.

Asked by: Hon TANG Ka-piu (LegCo internal reference no.: 37)

Reply:

(a)

The community drug formulary (the Formulary) will be expanded in phases according to patient needs starting from the end of 2025, with the number of drugs covered to exceed 100 at the commencement stage. The Formulary will include various designated drugs (primarily generic drugs) and specified patented drugs. To address the clinical needs of

primary healthcare patients, we will establish an expert panel to advise on the listing of drugs in the Formulary.

(b) and (c)

The Government will launch the community pharmacy programme (the Programme) by phases starting from the fourth quarter of 2026. Currently, the Government is developing the service model plan, drug supply methods and related information systems. To solicit feedback from the industry and assess the market's acceptance level, the Government conducted a market consultation in November 2024. The Government plans to extend the services of the Programme across all 18 districts of Hong Kong, with at least 4 to 5 community pharmacies in each district.

(d)

Under the Programme, community pharmacies will arrange more frequent drug dispensing to reduce medication waste and ensure accurate drug dispensing meeting the clinical needs of patients, thereby improving their use of medication. Meanwhile, citizens participating in various primary healthcare programmes (such as the Chronic Disease Co-Care Pilot Scheme) can more conveniently obtain affordable primary healthcare drugs, and therefore reduce their overreliance on the public healthcare system.

(e)

Regarding the Programme, the Government will, through a competitive process, select service providers that meet the set requirements and cost-effectiveness standard, and encourage citizens to use the services of community pharmacies by providing more convenient and affordable services.

- End -

CONTROLLING OFFICER'S REPLY

HHB172

(Question Serial No. 2015)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Hospital Authority manages and develops the public medical service system, and provides adequate, efficient and effective public hospital services of the highest standard recognised internationally within the resources available. In this connection, will the Government inform this Committee of the following in the past 3 financial years in table form:

- (a) the number and the total number of each type of medical staff (including specialists, non-specialists, interns and dentists) in each hospital cluster;
- (b) the number and the total number of each type of medical staff (including specialists, non-specialists, interns and dentists) in each public hospital;
- (c) the number and the total number of each type of nursing staff (including nurses and trainees) in each hospital cluster;
- (d) the number and the total number of each type of nursing staff (including nurses and trainees) in each public hospital;
- (e) the number of allied health staff in each hospital cluster;
- (f) the number of allied health staff in each public hospital.

Asked by: Hon TIEN Puk-sun, Michael (LegCo internal reference no.: 2)

Reply:

The Hospital Authority (HA) organises and provides its services on a cluster basis, and manpower is deployed and rotated flexibly among various hospitals within each hospital cluster. As such, information by cluster provides a better picture of the manpower situation than that by hospital.

(a) and (b)

The numbers of doctors on a full-time equivalent basis by cluster and by rank group from 2022-23 to 2024-25 (as at 31 December 2024) are set out in the table below:

Cluster	Rank Group	2022-23 (as at 31 March 2023)	2023-24 (as at 31 March 2024)	2024-25 (as at 31 December 2024)
HKEC	Consultant	125	129	137
	Senior Medical Officer/Associate Consultant	194	193	184
	Medical Officer/Resident	333	361	415
	Total	651	683	735
HKWC	Consultant	148	148	157
	Senior Medical Officer/Associate Consultant	190	192	181
	Medical Officer/Resident	327	347	411
	Total	666	687	749
KCC	Consultant	276	299	309
	Senior Medical Officer/Associate Consultant	452	446	444
	Medical Officer/Resident	655	717	770
	Total	1 383	1 461	1 522
KEC	Consultant	141	148	154
	Senior Medical Officer/Associate Consultant	262	255	254
	Medical Officer/Resident	392	412	449
	Total	796	815	857
KWC	Consultant	191	208	219
	Senior Medical Officer/Associate Consultant	354	350	345
	Medical Officer/Resident	565	588	625
	Total	1 110	1 146	1 190
NTEC	Consultant	184	197	210
	Senior Medical Officer/Associate Consultant	305	302	301
	Medical Officer/Resident	556	573	627
	Total	1 045	1 072	1 139
NTWC	Consultant	154	172	177
	Senior Medical Officer/Associate Consultant	252	250	236
	Medical Officer/Resident	475	506	564
	Total	881	928	977
Cluster Total		6 532	6 793	7 169

The numbers of doctors in hospital clusters on a full-time equivalent basis by rank group from 2022-23 to 2024-25 (as at 31 December 2024) are set out in the table below:

Rank Group	2022-23 (as at 31 March 2023)	2023-24 (as at 31 March 2024)	2024-25 (as at 31 December 2024)
Consultant	1 219	1 300	1 363
Senior Medical Officer/Associate Consultant	2 010	1 989	1 945
Medical Officer/Resident	3 303	3 504	3 860
Cluster Total	6 532	6 793	7 169

Note:

- (1) The manpower figures above are calculated on a full-time equivalent basis including permanent, contract and temporary staff in the HA. They may not add up to the total due to rounding.
- (2) Doctors exclude Interns and Dental Officers.
- (3) Full-time equivalent for temporary part-time staff is calculated based on their actual working hours started from January 2024. Relevant figures prior to that month are for reference only and direct comparison with the data under the revised compilation method is not appropriate.

The numbers of Dental Officers in hospital clusters on a full-time equivalent basis by cluster from 2022-23 to 2024-25 (as at 31 December 2024) are set out in the table below:

Cluster	2022-23 (as at 31 March 2023)	2023-24 (as at 31 March 2024)	2024-25 (as at 31 December 2024)
HKEC	0	0	0
HKWC	0	0	0
KCC	2	2	2
KEC	11	10	10
KWC	1	1	1
NTEC	0	0	0
NTWC	0	0	0
Cluster Total	14	13	13

Note:

- (1) The manpower figures above are calculated on a full-time equivalent basis including permanent, contract and temporary staff in the HA. They may not add up to the total due to rounding.
- (2) Full-time equivalent for temporary part-time staff is calculated based on their actual working hours started from January 2024. Relevant figures prior to that month are for reference only and direct comparison with the data under the revised compilation method is not appropriate.

The numbers of Interns in hospital clusters on a full-time equivalent basis from 2022-23 to 2024-25 (as at 31 December 2024) are set out in the table below:

Rank Group	2022-23 (as at 31 March 2023)	2023-24 (as at 31 March 2024)	2024-25 (as at 31 December 2024)
Intern	499	530	528

Note:

- (1) The manpower figures above are calculated on a full-time equivalent basis including permanent, contract and temporary staff in the HA. They may not add up to the total due to rounding.
- (2) Full-time equivalent for temporary part-time staff is calculated based on their actual working hours started from January 2024. Relevant figures prior to that month are for reference only and direct comparison with the data under the revised compilation method is not appropriate.

Interns employed by the HA are medical trainees. During the training period, they have to undergo a total of 2 six-month rotations in internal medicine and surgery, each consisting of 2 three-month postings.

(c) and (d)

The numbers of nursing staff in hospital clusters on a full-time equivalent basis by cluster from 2022-23 to 2024-25 (as at 31 December 2024) are set out in the table below:

Cluster	2022-23 (as at 31 March 2023)	2023-24 (as at 31 March 2024)	2024-25 (as at 31 December 2024)
HKEC	3 018	3 031	3 067
HKWC	2 899	2 869	2 924
KCC	6 184	5 725	5 970
KEC	3 562	3 548	3 599
KWC	5 038	4 838	4 994
NTEC	4 865	4 744	4 808
NTWC	3 992	4 071	4 138
Cluster Total	29 558	28 825	29 499

Note:

- (1) The manpower figures above are calculated on a full-time equivalent basis including permanent, contract and temporary staff in the HA. They may not add up to the total due to rounding
- (2) The “nursing” group includes Senior Nursing Officers, Department Operations Managers, Nurse Consultants, Associate Nurse Consultants, Ward Managers, Nursing Officers, Advanced Practice Nurses, Registered Nurses, Enrolled Nurses and Nursing Trainees, etc.

- (3) Full-time equivalent for temporary part-time staff is calculated based on their actual working hours started from January 2024. Relevant figures prior to that month are for reference only and direct comparison with the data under the revised compilation method is not appropriate.

(e) and (f)

The numbers of allied health staff in hospital clusters on a full-time equivalent basis by cluster from 2022-23 to 2024-25 (as at 31 December 2024) are set out in the table below:

Cluster	2022-23 (as at 31 March 2023)	2023-24 (as at 31 March 2024)	2024-25 (as at 31 December 2024)
HKEC	928	971	1 022
HKWC	1 032	1 066	1 097
KCC	1 937	1 988	2 060
KEC	1 007	1 054	1 100
KWC	1 482	1 544	1 600
NTEC	1 479	1 549	1 629
NTWC	1 192	1 242	1 294
Cluster Total	9 056	9 415	9 803

Note:

- (1) The manpower figures above are calculated on a full-time equivalent basis including permanent, contract and temporary staff in the HA. They may not add up to the total due to rounding.
- (2) The “allied health” group includes Radiographers, Medical Technologists/Medical Laboratory Technicians, Occupational Therapists, Physiotherapists, Pharmacists and Medical Social Workers, etc.
- (3) Full-time equivalent for temporary part-time staff is calculated based on their actual working hours started from January 2024. Relevant figures prior to that month are for reference only and direct comparison with the data under the revised compilation method is not appropriate.

Abbreviations:

HKEC – Hong Kong East Cluster
 HKWC – Hong Kong West Cluster
 KCC – Kowloon Central Cluster
 KEC – Kowloon East Cluster
 KWC – Kowloon West Cluster
 NTEC – New Territories East Cluster
 NTWC – New Territories West Cluster

- End -

CONTROLLING OFFICER'S REPLY

HHB173

(Question Serial No. 2017)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

One of the aims of the Hospital Authority (HA) is to provide adequate, efficient and effective public hospital services of the highest standard recognised internationally within the resources available. At present, the Accident and Emergency (A&E) departments of the 18 public hospitals under the HA provide medical consultation and treatment for patients who need urgent medical attention. Patients are classified into 5 categories by triage nurses according to their medical conditions. In this connection, will the Government advise this Committee of the following information by the 5 categories (critical, emergency, urgent, semi-urgent and non-urgent) in table form:

- (a) the number of attendances at the A&E department of each public hospital in the past 3 years;
- (b) the number of patients granted fee waivers and the total amount of waived fees for A&E services in each public hospital in the past 3 years;
- (c) the average waiting time for A&E services in each public hospital in the past 3 years; and
- (d) the unit cost per attendance in each of the past 3 financial years?

Asked by: Hon TIEN Puk-sun, Michael (LegCo internal reference no.: 4)

Reply:

Hong Kong's public hospitals has been one of the world's most efficient healthcare systems. The Hospital Authority (HA) will continue promoting reforms to improve the service level of public hospitals. On 25 March this year, the Government announced the fees and charges reform for public healthcare which aims to guide the public to make optimal use of healthcare resources, reduce wastage and abuse, and enhance healthcare protection for "poor, acute, serious, critical" patients on all fronts, thereby enhancing the sustainability of the healthcare system.

The fees and charges reform for public healthcare covers the following 3 major areas:

1. Reforming the subsidisation structure: Reforming the subsidisation structure from a systemic perspective by setting the levels of government subsidisation and the proportion of co-payments by members of the public for various public healthcare

services to rationalise the relative demands for in-patient, A&E, as well as different tiers of out-patient services;

2. Reducing waste and abuse: Introducing a co-payment model for non-urgent diagnostic radiology and pathology services, etc., adjusting the charges for and quantities of standard drugs, making use of the fees and charges to drive changes to the public's behaviour in seeking medical treatment to guide the optimal use of resources; and
3. Enhancing healthcare protection: Strengthening protection for "poor, serious, critical" patients on all fronts by enhancing the fee waiver mechanism, introducing an annual cap on fees and charges at \$10,000, and increasing subsidies on drugs and medical devices for the critically ill, with a view to preventing "patients with serious conditions falling into poverty".

The HA will continue to promote reforms and strive to provide high quality and safe healthcare services to patients.

At present, there are 18 public hospitals under the HA providing Accident and Emergency (A&E) services for the critically ill or seriously injured people and victims of disasters. To ensure that citizens with urgent needs can receive timely services, A&E departments implement a patient triage system under which patients are classified into 5 categories, namely critical, emergency, urgent, semi-urgent and non-urgent based on their clinical conditions, and patients will receive treatment as prioritised by their urgency category. The HA's performance targets specify that all critical patients (i.e. 100%) will receive immediate treatment, and emergency and urgent patients will be prioritised for treatment upon arrival at A&E departments, with the targets being that most emergency patients (95%) and urgent patients (90%) will be treated within 15 or 30 minutes. A&E departments are not general out-patient clinics. If there are a large number of semi-urgent or non-urgent patients in A&E departments, it may affect the provision of treatment for emergency and urgent patients.

(a)

The tables below set out the attendances of A&E services under various triage categories in each HA hospital in 2022-23, 2023-24 and 2024-25 (up to 31 December 2024):

2022-23

Hospital cluster	Hospital	Number of A&E attendances				
		Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
HKEC	PYNEH	1 351	3 723	37 843	54 366	1 529
	RH	1 020	1 281	17 134	33 062	1 559
	SJH	45	115	1 995	4 898	105
HKWC	QMH	1 256	3 471	38 967	52 844	1 629
KCC	KWH	2 082	3 321	50 294	39 638	2 136
	QEH	3 884	3 895	82 243	56 116	3 369
KEC	TKOH	1 313	2 419	41 982	50 032	1 489
	UCH	3 279	4 518	63 275	53 174	4 958
KWC	CMC	1 084	2 991	38 873	49 110	1 975

Hospital cluster	Hospital	Number of A&E attendances				
		Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
	NLTH	383	913	15 620	51 272	1 568
	PMH	2 064	2 686	58 304	35 691	585
	YCH	1 558	2 199	35 014	53 930	854
NTEC	AHNH	630	1 511	18 840	58 004	1 897
	NDH	1 494	2 090	32 710	40 639	1 342
	PWH	2 473	5 782	40 334	90 862	1 191
NTWC	POH	630	3 015	25 375	45 709	5 031
	TMH	1 790	5 343	56 472	71 626	2 244
	TSWH	489	1 579	18 723	62 552	7 380
HA overall		26 825	50 852	673 998	903 525	40 841

2023-24

Hospital cluster	Hospital	Number of A&E attendances				
		Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
HKEC	PYNEH	1 296	4 545	44 069	63 027	1 492
	RH	1 516	1 132	21 652	38 975	3 551
	SJH	37	92	2 026	7 293	202
HKWC	QMH	1 320	3 717	45 704	60 653	3 203
KCC	KWH	2 260	3 608	63 669	55 147	2 301
	QEH	4 610	4 169	101 014	77 192	5 842
KEC	TKOH	1 213	2 832	50 659	67 027	3 710
	UCH	3 111	4 967	73 081	65 572	6 891
KWC	CMC	1 047	3 217	47 843	60 176	3 420
	NLTH	396	1 271	20 718	64 560	1 014
	PMH	1 858	3 199	69 492	41 268	621
	YCH	1 634	2 321	42 301	70 589	701
NTEC	AHNH	616	1 968	24 168	71 021	3 238
	NDH	1 501	2 392	40 495	50 099	1 795
	PWH	2 087	6 879	50 942	103 818	2 207
NTWC	POH	1 350	2 335	28 391	58 628	5 254
	TMH	1 626	5 946	70 492	89 057	2 096
	TSWH	660	1 976	23 637	82 105	11 427
HA overall		28 138	56 566	820 353	1 126 207	58 965

2024-25 (up to 31 December 2024)

Hospital cluster	Hospital	Number of A&E attendances				
		Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
HKEC	PYNEH	930	3 266	31 313	44 427	1 196
	RH	1 197	550	16 237	28 146	2 093
	SJH	49	81	1 526	4 686	140
HKWC	QMH	915	2 677	34 815	44 200	1 538
KCC	KWH	1 367	2 926	45 150	46 903	1 633
	QEH	3 259	2 826	70 054	58 383	4 644
KEC	TKOH	859	2 124	36 130	45 847	2 429
	UCH	2 090	3 463	52 802	47 553	3 916
KWC	CMC	779	2 155	34 252	36 115	1 546
	NLTH	268	800	14 615	43 511	842
	PMH	1 112	2 295	47 822	31 171	438
	YCH	1 348	1 667	33 656	49 578	170
NTEC	AHNH	445	1 568	20 511	46 262	1 621
	NDH	1 193	2 004	31 097	33 863	955
	PWH	1 319	5 250	36 030	73 604	1 002
NTWC	POH	610	2 294	21 532	39 389	3 920
	TMH	898	4 081	51 503	63 936	1 586
	TSWH	432	1 561	18 195	57 987	2 689
HA overall		19 070	41 588	597 240	795 561	32 358

The above attendances for A&E services under various triage categories in each HA hospital exclude (i) first-time visits without triage categories, and (ii) follow-up visits to the A&E departments.

(b)

The table below sets out the number of patients who were granted medical fee waivers and the amounts involved[#] at each A&E department in 2022-23, 2023-24 and 2024-25 (up to 31 December 2024).

		2022-23		2023-24		2024-25 (up to 31 December 2024)	
Hospital cluster	Hospital	No. of patients	Amount (\$m)	No. of patients	Amount (\$m)	No. of patients	Amount (\$m)
HKEC	PYNEH	13 376	4.3	15 225	5.5	12 180	4.0
	RTSKH	4 926	1.7	5 827	2.2	4 565	1.7
	SJH	692	0.3	886	0.4	672	0.3
HKWC	QMH	11 474	4.1	13 017	4.9	10 640	3.7
KCC	KWH	13 449	5.5	17 149	7.4	13 759	5.7
	QEH	24 432	9.1	28 583	11.8	22 099	8.5
KEC	TKOH	10 109	3.4	12 198	4.3	9 849	3.2
	UCH	25 278	8.3	28 771	9.8	22 498	7.1
KWC	CMC	17 411	7.0	19 889	8.5	14 954	5.8
	NLTH	5 979	1.8	5 321	2.3	4 106	1.6
	PMH	17 200	5.4	19 623	6.8	15 370	4.9
	YCH	14 265	4.4	16 574	5.7	13 208	4.3
NTEC	AHNH	9 181	3.2	10 697	4.0	8 645	3.0
	NDH	10 525	3.7	12 547	4.7	9 956	3.5
	PWH	18 186	5.7	21 214	7.2	16 805	5.2
NTWC	POH	10 068	4.8	11 023	5.7	8 891	4.3
	TMH	19 595	7.1	21 782	9.0	17 493	6.6
	TSWH	9 288	3.3	11 043	4.4	8 407	3.0
Total no. of patients*/amount		212 349	83.1	246 081	104.6	197 769	76.4

[#] The HA does not maintain relevant figures by triage category.

^{*} Since a patient may seek consultations at A&E departments of different public hospitals and receive medical fee waivers during the same financial year, the sum of the numbers of patients in each public hospital is not equal to the total number of patients who were granted medical fee waivers.

(c)

The tables below set out the average waiting time for A&E services in various triage categories at the A&E department of each HA hospital in 2022-23, 2023-24 and 2024-25 (up to 31 December 2024).

2022-23

Hospital cluster	Hospital	Average waiting time (in minutes) for A&E services				
		Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
HKEC	PYNEH	0	5	26	136	157
	RH	0	8	26	129	193
	SJH	0	9	16	27	36
HKWC	QMH	0	9	28	109	155
KCC	KWH	0	8	35	116	133
	QEH	0	7	16	86	125
KEC	TKOH	0	7	25	133	170
	UCH	0	11	32	206	241
KWC	CMC	0	4	27	119	113
	NLTH	0	8	24	85	103
	PMH	0	9	27	157	178
	YCH	0	3	37	161	194
NTEC	AHNH	0	8	27	83	90
	NDH	0	9	29	146	183
	PWH	0	11	29	101	130
NTWC	POH	0	6	19	118	156
	TMH	0	7	26	135	136
	TSWH	0	6	15	136	168
HA overall		0	8	26	124	158

2023-24

Hospital cluster	Hospital	Average waiting time (in minutes) for A&E services				
		Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
HKEC	PYNEH	0	5	32	204	215
	RH	0	8	27	151	219
	SJH	0	10	16	28	40
HKWC	QMH	0	10	38	168	205
KCC	KWH	0	8	50	251	256
	QEH	0	7	14	114	158
KEC	TKOH	0	8	27	152	191
	UCH	0	12	29	224	247
KWC	CMC	0	5	26	146	137
	NLTH	0	8	24	131	143
	PMH	0	9	37	257	226
	YCH	0	2	26	164	221

Hospital cluster	Hospital	Average waiting time (in minutes) for A&E services				
		Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
NTEC	AHNH	0	8	30	126	122
	NDH	0	9	30	230	307
	PWH	0	10	34	205	239
NTWC	POH	0	7	19	163	202
	TMH	0	7	25	246	294
	TSWH	0	5	15	180	212
HA overall		0	8	29	180	205

2024-25 (up to 31 December 2024)

Hospital cluster	Hospital	Average waiting time (in minutes) for A&E services				
		Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
HKEC	PYNEH	0	5	33	185	216
	RH	0	9	24	139	210
	SJH	0	9	15	26	32
HKWC	QMH	0	9	29	132	175
KCC	KWH	0	6	33	204	217
	QEH	0	7	11	91	133
KEC	TKOH	0	7	26	166	216
	UCH	0	12	24	199	228
KWC	CMC	0	4	25	175	164
	NLTH	0	7	20	98	113
	PMH	0	9	29	221	219
	YCH	0	4	25	140	176
NTEC	AHNH	0	9	28	142	135
	NDH	0	9	29	212	254
	PWH	0	11	34	200	212
NTWC	POH	0	7	20	155	193
	TMH	0	6	21	194	228
	TSWH	0	5	15	172	209
HA overall		0	8	25	164	190

(d)

The table below sets out the average cost per attendance of A&E services provided by the HA in 2022-23, 2023-24 and 2024-25.

Year	Average cost per attendance (\$)
2022-23	2,430
2023-24	2,070
2024-25 (revised estimate)	2,030

A&E service costs include direct staff costs (such as those on doctors and nurses) for providing services for patients, expenditure incurred for various clinical support services (such as pharmacy, diagnostic radiology and pathology tests) and other operating costs (such as utility expenses as well as repair and maintenance costs of medical equipment). The average cost per attendance represents an average computed with reference to the total A&E service costs and the corresponding activities (in terms of attendances) provided.

Notes:

1. In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA has adjusted its services to cope with the outbreak. This should be taken into consideration when comparing the service throughput of the HA in previous years. With the cessation of anti-epidemic measures in early 2023, the HA's public healthcare services has resumed normalcy gradually.
2. As the costing information for 2022-23 has reflected the impact of the COVID-19 epidemic outbreak on unit costs (if any), a direct comparison of the costing information for different years would be inappropriate.

Abbreviations:

Cluster

HKEC – Hong Kong East Cluster
HKWC – Hong Kong West Cluster
KCC – Kowloon Central Cluster
KEC – Kowloon East Cluster
KWC – Kowloon West Cluster
NTEC – New Territories East Cluster
NTWC – New Territories West Cluster

Hospital

PYNEH – Pamela Youde Nethersole Eastern Hospital
RH – Ruttonjee Hospital
RTSKH – Ruttonjee and Tang Shiu Kin Hospitals
SJH – St. John Hospital
QMH – Queen Mary Hospital
KWH – Kwong Wah Hospital
QEH – Queen Elizabeth Hospital
TKOH – Tseung Kwan O Hospital
UCH – United Christian Hospital
CMC – Caritas Medical Centre
NLTH – North Lantau Hospital
PMH – Princess Margaret Hospital
YCH – Yan Chai Hospital
AHNH – Alice Ho Miu Ling Nethersole Hospital
NDH – North District Hospital
PWH – Prince of Wales Hospital
POH – Pok Oi Hospital
TMH – Tuen Mun Hospital
TSWH – Tin Shui Wai Hospital

- End -

CONTROLLING OFFICER'S REPLY

HHB174

(Question Serial No. 2020)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Government announced in last year's Policy Address that it would implement hepatitis B screening based on a risk-based approach to prevent liver cancer. One of the Matters Requiring Special Attention of the Department of Health in 2025-26 is to formulate risk-based screening programmes for prevalent cancers. In this connection, will the Government advise this Committee as to the following:

- (a) In the 2025-26 financial year, will the Government consider providing citizens who have never received the hepatitis B vaccine with at least 1 free or partially subsidised hepatitis B screening service in phases according to age, in order to significantly improve the hepatitis B diagnosis rate, and providing hepatitis B carriers with corresponding follow-up and monitoring services? If yes, what are the work plan and estimated expenditure? If no, what are the reasons?
- (b) Will the Government consider including hepatitis B in the Chronic Disease Co-Care Pilot Scheme in the 2025-26 financial year and attracting more private doctors to participate in providing hepatitis B carriers with follow-up services, such as medication treatment and liver cancer monitoring services, under the established public-private partnership (PPP) model? If yes, what is the work plan? If no, what are the reasons?
- (c) In relation to providing patients diagnosed with hepatitis B with regular liver cancer monitoring services, will the Government consider allocating additional resources, including introducing the technology for detecting the biomarkers of abnormal coagulation (PIVKA-II), which is easier to administer in the community, to public and private healthcare institutions through various collaborative approaches, to alleviate the current lengthy waiting time and service pressure caused by the package of alpha-fetoprotein (AFP) biomarker testing and liver imaging ultrasound (US) examination, so as to provide patients with timely and appropriate treatment? If yes, what are the work plan and estimated expenditure? If no, what are the reasons?
- (d) In view of the risk of digestive system bleeding in patients with cirrhosis and liver cancer, regular check-ups should be conducted. Will the Government consider

increasing the number of oesophago-gastro-duodenoscopy (commonly known as gastroscopy) sessions, through various collaborative approaches such as the PPP model, to enhance the volume of endoscopy services, shorten the overall service waiting time and ensure that patients with cirrhosis and liver cancer receive timely gastroscopy? If yes, what is the work plan? If no, what are the reasons?

Asked by: Hon TIEN Puk-sun, Michael (LegCo internal reference no.: 7)

Reply:

(a)

With the provision of hepatitis B vaccination to all newborns in Hong Kong since 1988, the prevalence of hepatitis B among the younger generation has dropped significantly. According to the Population Health Survey 2020-22 conducted by the Department of Health, the age- and sex-adjusted prevalence of hepatitis B surface antigen was 5.6%, which means that about 410 000 people in Hong Kong were infected with hepatitis B virus (HBV), with those born before 1988 being affected the most (7.8% of the respondents aged between 35 and 84 were infected with HBV).

The matter was discussed at the 11th meeting of the Steering Committee on Prevention and Control of Viral Hepatitis held in early November 2024. The Steering Committee suggested expanding hepatitis B testing and follow-up care in Hong Kong under a four-pronged approach, including using rapid diagnostic tests, conducting screening at the primary care and community levels, strengthening the linkage to care, as well as expanding the scale of risk-based screening in a phased approach.

(b)

As announced in the 2024 Policy Address, the Government will roll out a new programme to subsidise hepatitis B screening to prevent liver cancer. The Primary Healthcare Commission (PHCC) will provide hepatitis B screening and continued management to groups with higher risk via District Health Centres and family doctors through strategic purchasing and co-payment model. The programme enables early detection of people infected with HBV in the community and early identification and treatment of chronic hepatitis B to reduce the risk of complications (such as cirrhosis and liver cancer). The PHCC will announce the programme details within 2025.

Meanwhile, the Government regularly reviews primary healthcare services and the service scope of the Chronic Disease Co-CarePilot Scheme based on scientific evidence and resource utilisation considerations, including the expansion of the Scheme coverage to hepatitis B and other chronic diseases.

(c)

Chronic hepatitis B patients of the Hospital Authority (HA) mostly receive treatment at the Medicine Specialist Out-patient Clinics or Family Medicine Specialty Clinics. They will receive regular clinical assessments and blood tests (such as liver function tests) during follow-up consultations. If the doctors believe that the patients have an increased risk of developing liver cancer, they will advise the patients to undergo alpha-fetoprotein testing and

liver ultrasound regularly for cancer surveillance, and to consider receiving antiviral treatment to reduce the risk of hepatocellular carcinoma. The doctors will arrange for appropriate management of the disease according to the clinical conditions of individual patients.

The HA provides laboratory testing services to support clinical diagnosis and monitoring of various diseases (including liver cancer) by various clinical specialties. The HA will introduce technology for detecting the biomarkers of abnormal coagulation (PIVKA-II) in 2025-26 to enhance the sensitivity of hepatocellular carcinoma testing.

(d)

The HA currently provides oesophago-gastro-duodenoscopy (commonly known as gastroscopy) and treatment as necessary and appropriate to cirrhosis or liver cancer patients with clinical needs. When exploring new public-private partnership (PPP) programmes, the HA will align with the Government's healthcare policies including the directions of primary healthcare development, and in accordance with the principle of strategic procurement of healthcare services, and consider a number of factors including evolving service needs, potential complexity of the programmes, capacity and readiness of the private sector, as well as the impact on public healthcare manpower and private healthcare charges. The HA will continue to communicate with the public and with patient groups, and work closely with stakeholders to review the effectiveness of existing programmes in a timely manner, and explore the demand for and feasibility of introducing other PPP programmes in order to meet the healthcare service needs of the general public.

- End -

CONTROLLING OFFICER'S REPLY

HHB175

(Question Serial No. 2025)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health, (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

One of the Matters Requiring Special Attention in 2025-26 for the Health Bureau is to support the work of the Task Group on New Medical School, while one of the objectives of the Hospital Authority is to manage and develop the public medical service system, and provide adequate, efficient and effective public hospital services of the highest standard recognised internationally within the resources available. In this connection, will the Government inform this Committee of:

- (a) the numbers of annual attendances and average daily attendances at each public hospital over the past 3 years;
- (b) the numbers of annual attendances and average daily attendances at each public hospital's Accident & Emergency Department over the past 3 years;
- (c) the respective numbers of annual admissions to each public hospital using emergency ambulance service and non-emergency ambulance transfer service over the past 3 years; and
- (d) the criteria for determining the location of a new public hospital?

Asked by: Hon TIEN Puk-sun, Michael (LegCo internal reference no.: 12)

Reply:

(a)

The table below sets out the number of general out-patient (GOP) attendances of the Hospital Authority (HA) by the hospital the clinics are under in 2022-23, 2023-24 and 2024-25 (up to 31 December 2024):

Hospital cluster	Hospital	Number of GOP attendances		
		2022-23	2023-24	2024-25 (up to 31 December 2024)
HKEC	PYNEH	307 419	372 603	275 931
	RTSKH	99 780	125 900	93 869
	SJH	32 549	37 161	28 596
	TWEH	26 874	26 512	21 214
HKWC	QMH	300 276	361 301	276 145
	TWH	25 289	32 079	24 668
KCC	HKBH	47 453	40 939	44 418
	KWH	169 526	172 681	136 153
	OLMH	302 492	383 296	293 888
	QEH	394 687	508 892	421 640
KEC	TKOH	258 361	307 019	248 409
	UCH	480 357	580 069	473 277
KWC	CMC	264 794	315 034	255 746
	NLTH	89 866	103 843	80 505
	PMH	314 307	378 685	295 905
	YCH	254 289	286 395	220 341
NTEC	AHNH	227 550	247 545	189 422
	NDH	233 220	273 898	215 522
	PWH	380 684	495 741	380 173
NTWC	TMH	785 575	958 490	727 062
HA overall		4 995 348	6 008 083	4 702 884

Note:

GOP attendances include the attendances for evening out-patient services and cover medical consultations, nurse and allied health services at GOP clinics.

The attendances of out-patient services at each clinic are counted under their respective hospitals.

Please refer to the remarks for the abbreviations.

The table below sets out the (approximate) number of average daily GOP medical consultations of the HA by the hospital the clinics are under on weekdays in 2022-23, 2023-24 and 2024-25 (up to 31 December 2024):

Hospital cluster	Hospital	(Approximate) Number of average daily GOP medical consultations on weekdays		
		2022-23	2023-24	2024-25 (up to 31 December 2024)
HKEC	PYNEH	850	1 160	1 110
	RTSKH	320	410	400
	SJH	120	140	130
	TWEH	100	100	100
HKWC	QMH	960	1 180	1 180
	TWH	80	110	110
KCC	HKBH	170	140	200
	KWH	610	620	640
	OLMH	940	1 270	1 280
	QEH	1 200	1 600	1 750
KEC	TKOH	830	1 030	1 090
	UCH	1 470	1 910	2 020
KWC	CMC	920	1 090	1 140
	NLTH	330	370	370
	PMH	970	1 280	1 300
	YCH	860	960	960
NTEC	AHNNH	750	830	830
	NDH	720	930	940
	PWH	1 140	1 710	1 690
NTWC	TMH	2 610	3 390	3 380
HA overall		15 890	20 220	20 640

Note:

The attendances of out-patient services at each clinic are counted under their respective hospitals.

Weekdays refer to Monday to Friday, excluding public holidays and days with service interruption due to extreme weather.

The figures are rounded to the nearest ten.

Individual figures may not add up to the total due to rounding.

The table below sets out the number of specialist out-patient (SOP) (clinical) attendances of the HA by the hospital the clinics are under in 2022-23, 2023-24 and 2024-25 (up to 31 December 2024):

Hospital cluster	Hospital	Number of SOP (clinical) attendances		
		2022-23	2023-24	2024-25 (up to 31 December 2024)
HKEC	PYNEH	592 914	598 344	468 293
	RTSKH	147 066	149 843	117 577
	TWEH	115 738	137 049	106 195
HKWC	DKCH	20 563	20 763	16 323
	FYKH	183	212	209
	GH	127 847	130 681	104 431
	MMRC	1 769	1 670	1 331
	QMH	662 206	675 080	530 107
	TWH	51 253	52 973	43 009
	TYH	18 065	18 491	10 687
KCC	HKBH	15 185	15 798	11 710
	HKCH	51 240	60 535	50 230
	HKEH	266 505	272 053	214 638
	KH	95 964	99 631	79 394
	KWH	335 235	346 430	275 740
	OLMH	63 747	64 693	49 595
	QEH	658 786	686 391	524 295
	WTSH	1 284	1 493	1 198
KEC	HHH	9 937	10 957	8 919
	TKOH	374 394	397 422	316 652
	UCH	538 009	559 802	438 452
KWC	CMC	421 728	449 493	350 873
	KCH	245 614	252 142	196 604
	NLTH	25 229	26 989	21 699
	PMH	464 618	475 231	360 248
	YCH	246 291	261 401	206 918
NTEC	AHNH	301 373	318 832	247 209
	BBH	95	89	46
	NDH	216 933	230 907	181 295
	PWH	834 655	861 582	667 167
	SH	248	259	233
	TPH	665	799	1 589
NTWC	CPH	152 344	153 159	120 998
	POH	185 826	199 726	158 804
	TMH	773 150	803 186	624 079
	TSWH	27 085	34 001	28 592
HA overall		8 043 744	8 368 107	6 535 339

Note:

The attendances of out-patient services at each clinic are counted under their respective hospitals.

The table below sets out the (approximate) number of average daily SOP (clinical) attendances on weekdays of the HA by the hospital the clinics are under in 2022-23, 2023-24 and 2024-25 (up to 31 December 2024):

Hospital cluster	Hospital	(Approximate) Number of average daily SOP (clinical) attendances on weekdays		
		2022-23	2023-24	2024-25 (up to 31 December 2024)
HKEC	PYNEH	2 440	2 470	2 560
	RTSKH	610	620	640
	TWEH	480	570	580
HKWC	DKCH	80	90	90
	FYKH	<5	<5	<5
	GH	530	540	570
	MMRC	10	10	10
	QMH	2 730	2 790	2 900
	TWH	210	220	240
	TYH	70	80	60
KCC	HKBH	60	70	60
	HKCH	210	250	270
	HKEH	1 100	1 120	1 170
	KH	390	410	430
	KWH	1 380	1 430	1 510
	OLMH	260	270	270
	QEH	2 710	2 840	2 870
	WTSH	10	10	10
KEC	HHH	40	50	50
	TKOH	1 540	1 640	1 730
	UCH	2 210	2 310	2 400
KWC	CMC	1 740	1 860	1 920
	KCH	1 010	1 040	1 070
	NLTH	100	110	120
	PMH	1 910	1 960	1 970
	YCH	1 010	1 080	1 130
NTEC	AHNH	1 240	1 320	1 350
	BBH	<5	<5	<5
	NDH	890	950	990
	PWH	3 430	3 560	3 650
	SH	<5	<5	<5
	TPH	<5	<5	10
NTWC	CPH	630	630	660
	POH	760	830	870
	TMH	3 180	3 320	3 410
	TSWH	110	140	160

Hospital cluster	Hospital	(Approximate) Number of average daily SOP (clinical) attendances on weekdays		
		2022-23	2023-24	2024-25 (up to 31 December 2024)
HA overall		33 100	34 580	35 710

Note:

The attendances of out-patient services at each clinic are counted under their respective hospitals.

Weekdays refer to Monday to Friday, excluding public holidays and days with service interruption due to extreme weather.

The figures are rounded to the nearest ten.

Individual figures may not add up to the total due to rounding.

(b)

The tables below set out the attendances of accident and emergency (A&E) services under various triage categories in various HA hospitals in 2022-23, 2023-24 and 2024-25 (up to 31 December 2024):

2022-23

Hospital cluster	Hospital	Number of A&E attendances				
		Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
HKEC	PYNEH	1 351	3 723	37 843	54 366	1 529
	RH	1 020	1 281	17 134	33 062	1 559
	SJH	45	115	1 995	4 898	105
HKWC	QMH	1 256	3 471	38 967	52 844	1 629
KCC	KWH	2 082	3 321	50 294	39 638	2 136
	QEH	3 884	3 895	82 243	56 116	3 369
KEC	TKOH	1 313	2 419	41 982	50 032	1 489
	UCH	3 279	4 518	63 275	53 174	4 958
KWC	CMC	1 084	2 991	38 873	49 110	1 975
	NLTH	383	913	15 620	51 272	1 568
	PMH	2 064	2 686	58 304	35 691	585
	YCH	1 558	2 199	35 014	53 930	854
NTEC	AHNH	630	1 511	18 840	58 004	1 897
	NDH	1 494	2 090	32 710	40 639	1 342
	PWH	2 473	5 782	40 334	90 862	1 191
NTWC	POH	630	3 015	25 375	45 709	5 031

Hospital cluster	Hospital	Number of A&E attendances				
		Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
	TMH	1 790	5 343	56 472	71 626	2 244
	TSWH	489	1 579	18 723	62 552	7 380
HA overall		26 825	50 852	673 998	903 525	40 841

2023-24

Hospital cluster	Hospital	Number of A&E attendances				
		Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
HKEC	PYNEH	1 296	4 545	44 069	63 027	1 492
	RH	1 516	1 132	21 652	38 975	3 551
	SJH	37	92	2 026	7 293	202
HKWC	QMH	1 320	3 717	45 704	60 653	3 203
KCC	KWH	2 260	3 608	63 669	55 147	2 301
	QEH	4 610	4 169	101 014	77 192	5 842
KEC	TKOH	1 213	2 832	50 659	67 027	3 710
	UCH	3 111	4 967	73 081	65 572	6 891
KWC	CMC	1 047	3 217	47 843	60 176	3 420
	NLTH	396	1 271	20 718	64 560	1 014
	PMH	1 858	3 199	69 492	41 268	621
	YCH	1 634	2 321	42 301	70 589	701
NTEC	AHNH	616	1 968	24 168	71 021	3 238
	NDH	1 501	2 392	40 495	50 099	1 795
	PWH	2 087	6 879	50 942	103 818	2 207
NTWC	POH	1 350	2 335	28 391	58 628	5 254
	TMH	1 626	5 946	70 492	89 057	2 096
	TSWH	660	1 976	23 637	82 105	11 427
HA overall		28 138	56 566	820 353	1 126 207	58 965

2024-25 (up to 31 December 2024)

Hospital cluster	Hospital	Number of A&E attendances				
		Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
HKEC	PYNEH	930	3 266	31 313	44 427	1 196
	RH	1 197	550	16 237	28 146	2 093
	SJH	49	81	1 526	4 686	140
HKWC	QMH	915	2 677	34 815	44 200	1 538
KCC	KWH	1 367	2 926	45 150	46 903	1 633
	QEH	3 259	2 826	70 054	58 383	4 644
KEC	TKOH	859	2 124	36 130	45 847	2 429
	UCH	2 090	3 463	52 802	47 553	3 916
KWC	CMC	779	2 155	34 252	36 115	1 546
	NLTH	268	800	14 615	43 511	842
	PMH	1 112	2 295	47 822	31 171	438
	YCH	1 348	1 667	33 656	49 578	170
NTEC	AHNH	445	1 568	20 511	46 262	1 621
	NDH	1 193	2 004	31 097	33 863	955
	PWH	1 319	5 250	36 030	73 604	1 002
NTWC	POH	610	2 294	21 532	39 389	3 920

Hospital cluster	Hospital	Number of A&E attendances				
		Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
	TMH	898	4 081	51 503	63 936	1 586
	TSWH	432	1 561	18 195	57 987	2 689
HA overall		19 070	41 588	597 240	795 561	32 358

Note:

The above attendances for A&E services under various triage categories in various HA hospitals exclude (i) first-time visits without triage categories, and (ii) follow-up visits to the A&E departments.

The tables below set out the (approximate) number of average daily A&E attendances under various triage categories in various HA hospitals in 2022-23, 2023-24 and 2024-25 (up to 31 December 2024):

2022-23

Hospital cluster	Hospital	(Approximate) Number of average daily A&E attendances				
		Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
HKEC	PYNEH	<5	10	100	150	<5
	RH	<5	<5	50	90	<5
	SJH	<5	<5	10	10	<5
HKWC	QMH	<5	10	110	140	<5
KCC	KWH	10	10	140	110	10
	QEH	10	10	230	150	10
KEC	TKOH	<5	10	120	140	<5
	UCH	10	10	170	150	10
KWC	CMC	<5	10	110	130	10
	NLTH	<5	<5	40	140	<5
	PMH	10	10	160	100	<5
	YCH	<5	10	100	150	<5
NTEC	AHNH	<5	<5	50	160	10
	NDH	<5	10	90	110	<5
	PWH	10	20	110	250	<5
NTWC	POH	<5	10	70	130	10
	TMH	<5	10	150	200	10
	TSWH	<5	<5	50	170	20
HA overall		70	140	1 850	2 480	110

2023-24

Hospital cluster	Hospital	(Approximate) Number of average daily A&E attendances				
		Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
HKEC	PYNEH	<5	10	120	170	<5
	RH	<5	<5	60	110	10
	SJH	<5	<5	10	20	<5
HKWC	QMH	<5	10	120	170	10
KCC	KWH	10	10	170	150	10
	QEH	10	10	280	210	20
KEC	TKOH	<5	10	140	180	10
	UCH	10	10	200	180	20
KWC	CMC	<5	10	130	160	10
	NLTH	<5	<5	60	180	<5
	PMH	10	10	190	110	<5
	YCH	<5	10	120	190	<5
NTEC	AHNH	<5	10	70	190	10
	NDH	<5	10	110	140	<5
	PWH	10	20	140	280	10
NTWC	POH	<5	10	80	160	10
	TMH	<5	20	190	240	10
	TSWH	<5	10	60	220	30
HA overall		80	150	2 240	3 080	160

2024-25 (up to 31 December 2024)

Hospital cluster	Hospital	(Approximate) Number of average daily A&E attendances				
		Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
HKEC	PYNEH	<5	10	110	160	<5
	RH	<5	<5	60	100	10
	SJH	<5	<5	10	20	<5
HKWC	QMH	<5	10	130	160	10
KCC	KWH	<5	10	160	170	10
	QEH	10	10	250	210	20
KEC	TKOH	<5	10	130	170	10
	UCH	10	10	190	170	10
KWC	CMC	<5	10	120	130	10
	NLTH	<5	<5	50	160	<5
	PMH	<5	10	170	110	<5
	YCH	<5	10	120	180	<5
NTEC	AHNH	<5	10	70	170	10
	NDH	<5	10	110	120	<5
	PWH	<5	20	130	270	<5

Hospital cluster	Hospital	(Approximate) Number of average daily A&E attendances				
		Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
NTWC	POH	<5	10	80	140	10
	TMH	<5	10	190	230	10
	TSWH	<5	10	70	210	10
HA overall		70	150	2 170	2 890	120

Note:

The above attendances for A&E services under various triage categories in various HA hospitals exclude (i) first-time visits without triage categories, and (ii) follow-up visits to the A&E departments.

The figures are rounded to the nearest ten.

Individual figures may not add up to the total due to rounding.

Note [(a) and (b)]:

In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA has adjusted its services to cope with the outbreak. This should be taken into consideration when comparing the service throughput of the HA in previous years. With the cessation of anti-epidemic measures in early 2023, the HA's services have returned to normalcy gradually.

(c)

In consultation with the Fire Services Department, the table below sets out the number of patient trips using emergency ambulance service for A&E admission in each HA hospital in 2022-23, 2023-24, 2024-25 (up to 31 December 2024):

Hospital cluster	Hospital	2022-23	2023-24	2024-25 (up to 31 December 2024)
HKEC	PYNEH	38 311	42 191	30 360
	RH	19 306	22 870	16 724
	SJH	1 598	1 800	1 303
HKWC	QMH	37 137	41 393	30 134
KCC	KWH	26 190	32 505	25 910
	QEH	72 903	82 446	56 654
KEC	TKOH	26 689	30 290	22 445
	UCH	61 229	69 100	49 605
KWC	CMC	36 444	42 580	29 878
	NLTH	12 675	12 736	9 656
	PMH	41 874	47 976	35 020
	YCH	27 742	31 338	23 022
NTEC	AHNNH	21 227	24 390	17 951
	NDH	26 933	33 183	25 981
	PWH	47 881	53 443	38 809
NTWC	POH	24 634	26 432	19 583
	TMH	41 632	49 179	36 670
	TSWH	14 953	18 885	14 110
HA overall		579 358	662 737	483 815

The non-emergency ambulance transfer service (NEATS) of the HA mainly provides point-to-point transfer service for patients' discharge, transfer, scheduled admission, and follow-up visits to SOP clinics/geriatric day hospitals. The service targets are primarily patients of public hospitals who are unable to use other means of transportation (e.g. bus, taxi, vehicle of residential care homes for the elderly, Rehabus, etc.) due to mobility disability or sensory impairment. The clinical conditions of the patients using this service should meet certain criteria such as being bed-ridden or requiring constant oxygen supply. In general, healthcare staff will check with eligible patients and their families/carers whether they need NEATS and make appropriate arrangement.

The table below sets out the number of patient trips using NEATS (including discharge, transfer, scheduled admission, etc.) in the past 3 years:

2022-23 (Note)	2023-24	2024-25 (projected figures up to 31 December 2024)
562 173	651 538	682 232

Note:

In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA has adjusted its services to cope with the outbreak. This should be taken into consideration when comparing the service throughput of the HA in previous years. With the cessation of anti-epidemic measures in early 2023, the HA's services have returned to normalcy gradually.

(d)

With the changes in the demographic structure, planning and development of Hong Kong, the Health Bureau and the HA will take into account multiple factors in planning new public hospitals, including the latest territory-wide and regional planning and development strategies, the Government's latest population policy, talent attraction measures, population statistics, district-based population distribution and demographic projections, healthcare service demand projection, the utilisation of healthcare services in various clusters, the need for and cost-effectiveness of building new hospitals instead of renovating, refurbishing, redeveloping or adding facilities to the existing ones and the accessibility of healthcare facilities. In selecting a site for the construction of a new hospital, it is also necessary to take into account the supply and condition of the land required, the accessibility of the site, the economies of scale and cost-effectiveness of construction, as well as the future development potential of the new hospital.

Remarks:

Abbreviations

Cluster

HKEC – Hong Kong East Cluster

HKWC – Hong Kong West Cluster

KCC – Kowloon Central Cluster

KEC – Kowloon East Cluster

KWC – Kowloon West Cluster

NTEC – New Territories East Cluster

NTWC – New Territories West Cluster

Hospital

PYNEH – Pamela Youde Nethersole Eastern Hospital

RH – Ruttonjee Hospital

RTSKH – Ruttonjee and Tang Shiu Kin Hospitals

SJH – St. John Hospital

TWEH – Tung Wah Eastern Hospital

DKCH – The Duchess of Kent Children's Hospital at Sandy Bay

FYKH – Tung Wah Group of Hospitals Fung Yiu King Hospital
GH – Grantham Hospital
MMRC – MacLehose Medical Rehabilitation Centre
QMH – Queen Mary Hospital
TWH – Tung Wah Hospital
TYH – Tsan Yuk Hospital
HKBH – Hong Kong Buddhist Hospital
HKCH – Hong Kong Children’s Hospital
HKEH – Hong Kong Eye Hospital
KH – Kowloon Hospital
KWH – Kwong Wah Hospital
OLMH – Our Lady of Maryknoll Hospital
QEH – Queen Elizabeth Hospital
WTSH – Tung Wah Group of Hospitals Wong Tai Sin Hospital
HHH – Haven of Hope Hospital
TKOH – Tseung Kwan O Hospital
UCH – United Christian Hospital
CMC – Caritas Medical Centre
KCH – Kwai Chung Hospital
NLTH – North Lantau Hospital
PMH – Princess Margaret Hospital
YCH – Yan Chai Hospital
AHNH – Alice Ho Miu Ling Nethersole Hospital
BBH – Bradbury Hospice
NDH – North District Hospital
PWH – Prince of Wales Hospital
SH – Shatin Hospital
TPH – Tai Po Hospital
CPH – Castle Peak Hospital
POH – Pok Oi Hospital
TMH – Tuen Mun Hospital
TSWH – Tin Shui Wai Hospital

- End -

CONTROLLING OFFICER'S REPLY

HHB176

(Question Serial No. 2026)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

One of the Matters Requiring Special Attention in 2025-26 for the Health Bureau is to continue overseeing the planning of projects under the Second Hospital Development Plan (HDP). Tin Shui Wai Hospital (TSWH) started services in phases from 2017, with a capacity of 300 beds. In view of the increase in the population of Tin Shui Wai and its vicinity, the Government announced in the 2018 Policy Address that it had invited the Hospital Authority to commence planning for the second 10-year HDP, including the expansion of TSWH to provide 800 additional beds. In this connection, will the Government advise this Committee on the following:

- (a) the expected commencement and completion timetables for the expansion works;
- (b) the estimated expenditures involved in the expansion works (including construction, manpower, etc.);
- (c) the estimated annual recurrent and non-recurrent expenditures for TSWH upon completion of the expansion works;
- (d) whether an assessment has been made to determine if sufficient healthcare staff are available to provide services upon completion of the expansion works; if so, the respective manpower requirements; if not, the reasons;
- (e) whether an assessment has been made to determine if the expansion works will affect nearby traffic upon completion; if yes, the details and the improvement measures; if not, the reasons.

Asked by: Hon TIEN Puk-sun, Michael (LegCo internal reference no.: 13)

Reply:

With the changes in the planning and development situation of Hong Kong, the Health Bureau and the Hospital Authority (HA) are currently reviewing the Second Hospital Development Plan (HDP). Amongst others, in view of the territory-wide and regional planning and development strategies as announced by the Planning Department, including the “Hong Kong 2030+: Towards a Planning Vision and Strategy Transcending 2030” and the “Northern Metropolis Development Strategy”, as well as the corresponding population projections of Hong Kong including the latest changes in overall population, its distribution and

demographics, the Health Bureau and the HA have to make reference to the latest future planning of the whole territory (including the development concepts of the Northern Metropolis), population statistics, projections of population distribution and demographics of various districts, and the population policy and talent attraction initiatives of the Government, etc, to adopt a planning horizon of up to 2040 and beyond for the Second HDP, and to project healthcare service demand and consider the supply and conditions of the land required, for optimising the Second HDP.

The Government also considers factors such as the needs for and cost-effectiveness of renovation, refurbishment, redevelopment or addition of facilities for individual hospitals, and the convenience of public access to healthcare services under various major transport infrastructure development plans for determining the distribution, scale and priority, etc. of various hospital development projects under the Second HDP. Upon completion of the review, the Government will announce the details of the Second HDP in due course. In the course of planning, the HA will forecast future service demand and corresponding healthcare manpower requirements, and make corresponding assessments and planning, with a view to flexibly deploying manpower and recruiting additional staff in a timely manner according to service plans during the commissioning of new hospital facilities and phased introduction of services to meet service demand.

- End -

CONTROLLING OFFICER'S REPLY

HHB177

(Question Serial No. 0012)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health, (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

With the gradual alignment of healthcare between the Mainland and Hong Kong, the Government of the Hong Kong Special Administrative Region (the Government) has rolled out various measures, including the Pilot Scheme for Supporting Patients of Hospital Authority in Guangdong-Hong Kong-Macao Greater Bay Area (GBA), the Elderly Health Care Voucher GBA Pilot Scheme, and the introduction of new functions in the five-year plan of eHealth+, etc. These efforts actively promote healthcare co-operation and resource sharing between the two regions, facilitating cross-border medical consultations for Hong Kong citizens. In this connection, please inform this Committee of:

1. whether the Government will conduct a comprehensive study and review on the trend of Hong Kong residents going north for medical treatment for formulation of related medical policies and subsidy schemes, healthcare manpower planning and construction of medical facilities in the future; if so, the expected time for completion; if not, the reasons for that.
2. To facilitate cross-boundary healthcare collaboration, the eHealth mobile application has piloted two new functions namely "Cross-boundary Health Record" and "Personal Folder" since the middle of last year. Under the principle of "bring your own health records", the new functions enable Hong Kong citizens to use electronic health records at designated medical institutions outside Hong Kong. What is the implementation progress of the pilot functions?

Asked by: Hon TSE Wai-chuen, Tony (LegCo internal reference no.: 73)

Reply:

The Government of the Hong Kong Special Administrative Region (HKSAR) has been following the principles of complementarity and mutual benefits to enhance the healthcare collaboration with various Mainland cities of the Guangdong-Hong Kong-Macao Greater Bay Area (GBA), on the premise that the development of the healthcare systems of Hong Kong and the Mainland can be benefitted, so as to promote the overall enhancement of the medical professional standards within the GBA and provide more options of healthcare services for

Hong Kong residents who choose to develop and reside in the Mainland. As a member of the GBA, the HKSAR Government, when formulating cross-boundary healthcare measures, will not only focus on meeting the needs of Hong Kong citizens, but will also consider the potential impacts of the policies on the social resources and livelihood of the citizens in the Mainland. The healthcare resources and needs, relevant laws and regulations, as well as regulatory regimes for healthcare professionals are different in Hong Kong and the Mainland. The HKSAR Government plays a crucial role in safeguarding the health of Hong Kong citizens and will continue to provide quality healthcare services to them.

The Government launched the Elderly Health Care Voucher Greater Bay Area Pilot Scheme (Pilot Scheme) in 2024 to extend the coverage of the Elderly Health Care Vouchers (EHCVs) to suitable medical institutions in the GBA. As at September 2024, together with the 2 existing service points operated by the University of Hong Kong-Shenzhen Hospital (HKU-SZH), the coverage of EHCVs has been extended to 7 integrated medical/dental institutions in the GBA (a total of 9 service points), located at Guangzhou, Zhongshan, Dongguan and Shenzhen, offering more convenience and flexibility for eligible Hong Kong elderly persons by providing more service points for them to better use their EHCVs on primary healthcare services. The Chief Executive's 2024 Policy Address announced the extension of the Pilot Scheme to cover the 9 Mainland cities in the GBA. The initial plan is to gradually commence the relevant arrangements under the Pilot Scheme by the 4th quarter of 2025.

Moreover, the Government also launched the Pilot Scheme for Supporting Patients of the Hospital Authority (HA) in the GBA (Pilot Scheme for Supporting HA Patients in GBA) in May 2023 by making reference to the experience of the Special Support Scheme launched during the COVID-19 epidemic, so that patients with scheduled follow-up appointments at designated clinics of the HA can receive corresponding specialist out-patient subsidised consultations at the HKU-SZH. The Government has announced the extension of the Pilot Scheme for Supporting HA Patients in GBA till 31 March next year. As of end-February this year, over 5 100 patients have participated in the Scheme, amounting to over 18 000 attendances. Building on the Scheme and targeting at specific HA services, the Government is exploring the introduction of more healthcare choices of receiving services in the GBA for patients with follow-up appointments in the HA. The Government and the HA will decide if the Pilot Scheme for Supporting HA Patients in GBA will be further extended or the scope of services be adjusted in a timely manner, based on the actual results of the Scheme.

In respect of health records, in accordance with the overarching principles of ensuring due compliance of laws and regulations of both places, and safeguarding data security and patients' privacy, the Government has all along been facilitating citizens to self-carry their electronic health records (eHRs) for cross-boundary uses via eHealth to enhance the continuity of care across the boundary. Among other things, the Government launched the "Cross-boundary Health Record" (CBHR) and "Personal Folder" functions of the eHealth mobile application at the HKU-SZH and 7 medical institutions under the Pilot Scheme in 2024. The feedback on relevant cross-boundary functions has been positive. As of end-February 2025, citizens have submitted over 4 500 CBHR applications and deposited over 6 400 eHRs through the "Personal Folder" function, most of which are investigation reports such as laboratory and radiology reports, and about 25% of them are from the specified medical institutions in the GBA. We will continue to streamline the workflow and improve the user experience, and progressively extend the cross-boundary functions to more medical institutions under cross-boundary healthcare collaboration programmes. We will also

enhance the role of eHealth as the core system for cross-boundary health data sharing, so as to support citizens' cross-boundary healthcare needs more effectively.

We also note that requiring citizens carrying their own eHRs for cross-boundary use each time is not the most convenient, secure, and effective way for both citizens and healthcare providers (HCPs). For example, given the more stringent technical requirements, it is difficult for citizens to self-upload high-resolution radiology images to their eHealth accounts. In accordance with the current legislation, HCPs outside Hong Kong are unable to register with eHealth. The Government introduced the Electronic Health Record Sharing System (Amendment) Bill 2025 into the Legislative Council this year to provide a legal framework to assist citizens in building a more comprehensive eHR profile. Among other things, the Government has proposed to empower the Commissioner for the Electronic Health Record to recognise individual HCPs and public health record systems outside Hong Kong, subject to sufficient protection of data privacy and system security as well as due compliance with specified requirements and conditions. This will enable citizens to use their eHRs across the boundary in a more convenient and secure manner. If an individual citizen uses services at a recognised HCP outside Hong Kong, he/she can choose to authorise the HCP to securely access his/her eHRs and deposit the health records of the services received into his/her personal eHealth account, with a view to enhancing the quality and safety of cross-boundary healthcare services. HCPs outside Hong Kong can only access and deposit citizens' eHRs when a registered citizen provides explicit consent while using its services. Under no other circumstances will eHealth records be transmitted across the boundary.

The Government will continue to closely monitor the progress of various cross-boundary healthcare collaboration initiatives, with a view to supporting the medical needs of Hong Kong citizens more effectively. Meanwhile, we will continue to take forward measures that are conducive to building up and improving the standards of the overall healthcare manpower pool in the GBA. For example, through talent exchange programmes, healthcare professionals in the GBA are offered good opportunities to learn from each other and raise clinical work standards, so that healthcare manpower resources of the 3 places can be jointly developed for the benefit of the people, and, to a certain extent, alleviating the pressure of manpower shortage in local public hospitals.

- End -

CONTROLLING OFFICER'S REPLY

HHB178

(Question Serial No. 0056)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

In December 2022, the Government launched the Primary Healthcare Blueprint (Blueprint) as a major effort to direct resources towards primary healthcare services, with a view to strengthening chronic disease management and reinforcing the different levels of prevention. In this connection, will the Government inform this Committee of:

1. the annual estimates of promoting sports in the community and healthy eating, and how to ensure effective allocation of resources to the high-risk population groups such as the elderly and low-income families;
2. how to enhance synergies with the Chinese medicine in primary healthcare services with a focus on chronic disease prevention and health management; and
3. the cost of upgrading the District Health Centre Expresses in Central and Western District, Eastern District and Yau Tsim Mong District into District Health Centres (DHCs), how to assess the utilisation rate and effectiveness of the existing services at the DHCs, and whether a review mechanism will be put in place to improve or discontinue suboptimal services.

Asked by: Hon TSE Wai-chuen, Tony (LegCo internal reference no.: 76)

Reply:

(1)

As the Government's public health adviser and regulatory authority responsible for territory-wide health promotion, the Department of Health (DH) has taken forward a series of health promotion programmes targeting various age groups with a life-course approach, and promotes a healthy lifestyle, including physical activity and a balanced diet, in settings such as schools, workplaces and the community, as well as at different health service points, including Maternal and Child Health Centres, Student Health Service Centres and Elderly Health Centres, etc. The Primary Healthcare Commission (PHCC) focuses on health empowerment and promotion at the individual level, and promotes the "Life Course Preventive Care Plan" (LCPC Plan) through District Health Centres (DHCs). Based on the

core principles of preventive-oriented and whole-person care, and with reference to the latest evidence, the LCPC Plan formulates personalised health plans for people at different life stages, including advice on healthy diet and exercise, to enhance self-care awareness and improve personal health.

Taking into account the demographic structure of Hong Kong and the health needs of different social groups, the DH will formulate a life-course approach health promotion strategy and draw up health management plans for members of the public according to different age groups and health statuses. The estimated expenditure on promoting physical activity and a healthy diet cannot be separately quantified as it is absorbed by DH's overall provision under its Programmes of Disease Prevention and Health Promotion.

(2)

The Government will continue to develop primary healthcare services, including Chinese medicine (CM) services, in accordance with the Primary Healthcare Blueprint (the Blueprint) to utilise the resources of both public and private CM sectors. The Government will enhance the CM services in DHCs, and encourage CM practitioners (CMPs) to join the DHC network to provide subsidised services such as acupuncture and acupressure treatment for DHC members with stroke, knee arthritis and back pain, as well as provide disease prevention, health maintenance and health education. DHCs also plan to work with the Chinese Medicine Clinics cum Training and Research Centres to promote or provide Tianjiu service at DHCs under a collaborative model. The Government will further explore the strengthening of the role of CM in primary healthcare, for example, by exploring the enhancement of the role of CMPs in providing services for chronic disease management and diseases in which CM has an advantage through strategic purchasing.

(3)

Based on the recommendations of the Blueprint, the Government established the Primary Healthcare Commission (PHCC) in July 2024 to oversee primary healthcare service delivery, standard setting, quality assurance and the training of primary healthcare professionals under one roof, as well as to plan primary healthcare services and allocate resources through strategic purchasing with the support of the Strategic Purchasing Office. The Government will explore the possibility of introducing other quality assurance measures, such as review and evaluation of clinical practices, and setting performance indicators for primary healthcare services (including DHCs).

The Government will also enhance the terms of DHC service contracts. The service contracts of DHCs have provided specific descriptions of various facilities and service requirements, including the qualifications and relevant experience of key staff, the districts and numbers of satellite centres to be established, and the staffing establishment of DHCs. The PHCC has gradually adjusted the terms of service contracts, including adjusting the categorisation of service targets to tie in with the enhancement of DHC services, such as the pairing of family doctors with citizens and provision of nurse clinic services, etc. The PHCC has also begun to introduce performance assessment indicators in new service contracts, including an indicator for new members' participation in the Chronic Disease Co-Care Pilot Scheme. The service contracts of DHCs also stated that the Government shall have the right to terminate the contract if

an operator fails to comply with the contract requirements. In addition, the PHCC is progressively enhancing the performance monitoring mechanism of DHCs by regularly reviewing a number of quantitative and qualitatively related aspects, including service volume, operational effectiveness, health-related outcomes, etc., to assess the performance of DHCs and to make timely recommendations to the operators for improvement. The relevant assessment results will also be taken into consideration when renewing the service contracts (if applicable).

The Government will continue to review the services of DHCs, with a view to strengthening their role as the co-ordinators of community primary healthcare services and case managers, so as to provide comprehensive primary healthcare services to the public in the community.

In 2024, the Health Bureau launched a tender exercise for the operation of the Central and Western, Eastern and Yau Tsim Mong DHCs. The Central and Western DHC is expected to commence operation in the third quarter of this year, and the service contracts for the Eastern and Yau Tsim Mong DHCs are expected to be awarded this year. The operational expenses (including renovation costs) borne by the operators have been included in the total price of the service contracts.

Upon the upgrading of the 3 District Health Centre Expresses (DHCEs) to DHCs this year, the 11 existing DHCEs will gradually reduce to 8, while the number of DHCs will increase to 10. The estimated expenditure for DHCs and DHCEs (including provisions for service contracts, site maintenance and rental cost) for 2025-26 are \$1.083 billion and \$213 million respectively.

- End -

CONTROLLING OFFICER'S REPLY

HHB179

(Question Serial No. 3253)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

There was a media report that while a frontline staff member of a public hospital tried to recover hospital charges from a discharged patient over the phone, the patient in question declined to settle the charges and stated that he/she would not do so. In this connection, please advise this Committee of:

(1) the number of unsuccessful cases of recovering medical fees (with a breakdown by local and non-local residents) in the past 5 financial years, the annual defaulted amounts, the total defaulted amount, the annual numbers of successful cases of recovering medical fees and the annual amounts so recovered, and their year-on-year changes;

(2) the expenditure incurred in recovering defaulted payments and the total defaulted amount in written-off cases in the past 5 financial years; and

(3) the measures to be put in place by the Government in the new financial year to proactively recover defaulted payments, and the provision and manpower earmarked for such recovery work.

Asked by: Hon TSE Wai-chun, Paul (LegCo internal reference no.: 38)

Reply:

(1)

The details of unsuccessful and successful cases of recovering medical fees in public hospitals involving (a) Eligible Persons (EP) and (b) Non-eligible Persons (NEP) in each of the past 5 financial years are tabulated as follows:

		Cumulative successful cases of recovering medical fees as at 7 March 2025		Cumulative unsuccessful cases of recovering medical fees as at 7 March 2025	
Financial year		Number of cases	Amount (\$ million)^{Note 1}	Number of cases	Amount (\$ million)^{Note 2}
2020-21 (As at 31 March 2021)	(a)	34 002	31	6 275	6
	(b)	1 894	54	1 810	25
Total		35 896	85	8 085	31
2021-22 (As at 31 March 2022)	(a)	34 419	28	7 411	8
	(b)	2 347	62	1 745	24
Total		36 766	90	9 156	32
(Change over last year)		870	5	1 071	1
2022-23 (As at 31 March 2023)	(a)	36 055	30	8 125	8
	(b)	1 963	39	4 344	31
Total		38 018	69	12 469	39
(Change over last year)		1 252	(-21)	3 313	7
2023-24 (As at 31 March 2024)	(a)	39 858	36	10 611	9
	(b)	1 746	34	2 477	40
Total		41 604	70	13 088	49
(Change over last year)		3 586	1	619	10
2024-25 (As at 31 December 2024) Note 3	(a)	32 069	24	16 869	16
	(b)	1 265	17	2 668	48
Total		33 334	41	19 537	64

Note 1: During debt recovery process, some of the patients may apply for fee waiver due to financial difficulties. The Hospital Authority (HA) will handle these cases according to the established mechanism. If fee waiver applications are subsequently approved, debt recovery procedures will terminate. The above figures include the amounts settled and the amounts waived up to 7 March 2025.

Note 2: The amount of accounts receivable in each year includes the unsettled medical fees for the current year and those carried forward from the previous year(s).

Note 3: The change over the preceding year is not applicable since 2024-25 is not a full financial year.

(2)

The write-off amount accounts for about 1.9% - 2.3% of the total medical fees in the past 5 years. The (i) total debt recovery costs and (ii) total write-off amount of the HA in each of the past 5 financial years are listed below:

Financial year	2020-21	2021-22	2022-23	2023-24	2024-25
(i) Total debt recovery costs (\$ million)	4.1	4.4	4.7	4.8	Information not yet available
(ii) Total write-off amount (\$ million)	46	41	39	47	39

(3)

The HA has an established mechanism to minimise the outstanding medical fees, including:

(a) The HA will issue interim bills every 3 days to NEP during their hospital stay (every 7 days for EP) and remind them or their families to settle the bills. Besides, NEP are required to pay a specified amount of deposit upon admission.

(b) The HA will issue final bills to patients upon discharge or mail the bills to patients' registered local or overseas addresses. If the bills remain outstanding at the patients' discharge, the patients or their family members will be reminded through telephone calls to settle the bills with monthly statements mailed to their registered local or overseas addresses. Administrative charges will be imposed if patients fail to settle the bills within a specified time period.

(c) If the bills remain outstanding after the above actions have been taken, the HA will undertake legal actions where appropriate, including filing claims to the Small Claims Tribunal or issuing demand letters through lawyers for debt recovery.

(d) For those NEP who do not require hospitalisation after treatment but need assistance with the discharge arrangement, the HA will liaise with the Social Welfare Department or contact the relevant Consulates or Mainland authorities through the Immigration Department to arrange discharge accordingly. If their bills have not been settled, apart from taking legal actions as far as practicable, the HA will also notify the Consulates to assist on debt recovery.

(e) The HA will from time to time review the prevailing debt recovery mechanism and keep in view the payment modes commonly used in the market. The HA has been actively implementing electronic payment services in recent years. Patients can settle medical fees anytime through the HA's mobile application "HA Go" and one-stop multi-function electronic kiosks. In future, the HA will continue to enhance the functions of the existing electronic payment services and explore the feasibility of various payment methods, with a view to facilitating payment through various means by patients so as to reduce outstanding fees.

- End -

CONTROLLING OFFICER'S REPLY

HHB180

(Question Serial No. 1188)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health, (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Hospital Authority, through talent exchange programmes, invites healthcare professionals from the Greater Bay Area (GBA) for professional and clinical exchange with local healthcare personnel and plans to establish a regional healthcare talent pool in the long run. In this connection, will the Government inform this Committee of:

- (1) the expenditure of the Greater Bay Area Healthcare Talents Visiting Programmes;
- (2) the number of participants, exchange events and achievements under each phase of the Greater Bay Area Healthcare Talents Visiting Programmes;
- (3) the measures put in place to facilitate mutual recognition of healthcare talent in the GBA;
- (4) the number of Hong Kong residents with the national doctor qualification who are based here, and whether a census will be conducted for their inclusion in the regional healthcare talent pool; and
- (5) whether the Government will offer bridging courses to Hong Kong people studying medicine in the Mainland, capitalising on the opportunity offered by establishing a third medical school.

Asked by: Hon WONG Kwok, Kingsley (LegCo internal reference no.: 8)

Reply:

1. and 2.

The Hospital Authority (HA) has all along been actively promoting the exchange of healthcare talents. The mutual Talents Visiting Programmes, which were launched with the Mainland, cover healthcare personnel of various disciplines, including doctors, nurses, allied health professionals and Chinese medicine (CM) practitioners, among others. With support from the Health Commission of Guangdong Province (GDHC) and the Health Bureau of the HKSAR Government, the HA has implemented the Greater Bay Area (GBA) Healthcare

Talents Visiting Programmes since the fourth quarter of 2022, covering healthcare personnel of various disciplines, including doctors, nurses, allied health professionals and CM practitioners, among others.

For doctors, the “GBA Visiting Doctors Programme” enables doctors working in the public healthcare system in the Guangdong Province and Hong Kong to undergo exchanges in public hospitals of the other side. The first batch was completed in 2024, with 12 GBA doctors completing exchanges ranging from 6 months to 1 year. The second phase of the exchange programme has expanded to cover 9 GBA cities, with a total of 47 GBA visiting doctors who came to Hong Kong in batches between the fourth quarter of 2024 and the first quarter of 2025 to commence a year of clinical exchange.

For nurses, the HA has recruited a total of 300 experienced nurses in 3 cohorts from the Guangdong Province to join the “GBA Specialty Nursing Knowledge-Exchange Programme” since 2023, providing them with online learning followed by 45-week on-site clinical practicum at selected service areas of HA hospitals. The first cohort of 70 nurses completed clinical practicum in Geriatric Nursing in February 2024. Another 99 exchange nurses of the second cohort completed clinical practicum in Geriatric Nursing, Peri-operative Nursing, Critical Care, Cardiac Critical Care, Ophthalmology and Endoscopy in January 2025. The HA also sent a 26-strong delegation to visit Tier III Class A hospitals in Guangdong Province in January 2024 for a 3-day study tour. The HA and the GDHC have agreed that the programme will further expand to cover Emergency Care, Nephrology and Stroke Care, and will assist the third cohort of about 130 Guangdong nurses in their applications for limited registration, enabling them to engage deeply in clinical work during their stay.

For radiographers, the “GBA Visiting Radiographer (Diagnostic) Programme” was completed in August 2023. Subjects of exchange in the first phase include: Radiology (different categories of radiological imaging) and Medical Physics. 5 diagnostic radiographers from Tier III Class A hospitals were nominated by the GDHC for a 2-week technical exchange. Subsequently, in January 2024, the HA sent 14 radiographers and 5 medical physicists to Tier III Class A hospitals in the Guangdong Province for a two-way exchange. The HA and the GDHC have discussed and further expanded the second phase of the two-way exchange programme to include radiation therapists and enhanced it as the Guangdong-Hong Kong Allied Healthcare Talents Visiting Programme (「粵港專職醫療人才交流計劃」). The GDHC sent a total of 35 allied health professionals for a 1-week exchange in Hong Kong in second half of 2024.

For CM practitioners, the HA launched the “GBA CM Visiting Scholars Programme” in November 2022. This “mentoring and shadowing model” CM in-patient training programme, being the first of its kind in Hong Kong, invites CM experts from Tier III Class A CM hospitals in the GBA and under limited registration granted by the Chinese Medicine Council of Hong Kong to direct and provide in-patient clinical training in public hospitals for CMPs from the CM Clinics cum Training and Research Centres (CMCTRs) across 18 districts. Since the launch of the programme, around 20 experienced CM experts have joined the CM expert pool and come to Hong Kong in phases with around 130 local CMPs having received training so far.

Looking ahead to 2025, the HA will actively explore with more stakeholders to establish two-way exchange mechanisms, including short-term observation exchange, medium-term

clinical practice exchange and sending healthcare professionals from Hong Kong to the Mainland for mutual learning and exchange in the latter's public hospitals, with a view to expanding the talent pool of Hong Kong's public healthcare system. The management of healthcare staff under the HA, including the recruitment, training (inclusive of talent exchange) and retaining of staff, is part of the overall duties of the HA. The manpower and resources involved are subsumed under the overall expenditure of the HA and cannot be separately provided.

3. and 4.

Under the framework of the Mainland and Hong Kong Closer Economic Partnership Arrangement (CEPA), 12 categories of statutory healthcare professionals registered in Hong Kong (namely medical practitioners, CMPs, dentists, pharmacists, nurses, midwives, medical laboratory technicians, occupational therapists, optometrists, radiographers, physiotherapists and chiropractors) are allowed to provide short-term services in the Mainland for a maximum duration of 3 years under a licence, which is renewable on expiry. Hong Kong Permanent Residents who may legally practise medicine in Hong Kong are not required to sit the Mainland's National Qualification Examination for Doctors for the purpose of short-term practice in the Mainland.

To facilitate non-locally trained healthcare professionals (including those from the Mainland) to practice in Hong Kong in order to address the manpower shortage in the public healthcare system, the Government amended the relevant legislation to create new entry pathways for admission of qualified non-locally trained doctors, nurses and dentists to serve in Hong Kong's public healthcare institutions. As at 31 December 2024, a total of 106 doctors were approved for practising in Hong Kong under special registration or limited registration, 10 of whom obtained their medical qualifications in the Mainland. Additionally, 3 nurses and 2 dentists with professional qualifications obtained in the Mainland were approved for special registration/enrolment or limited registration/enrolment. Apart from the aforementioned healthcare professions, the Government has recently introduced the Supplementary Medical Professions (Amendment) Bill into the Legislative Council, proposing a new pathway to admit qualified non-locally trained allied health professionals to serve in public healthcare institutions.

Furthermore, the Hong Kong Academy of Medicine joined hands with the Health Commission of Shenzhen Municipality to establish the "Shenzhen-Hong Kong Medical Specialist Training Centre" to leverage Hong Kong's strength in nurturing international medical talent, with a view to setting up in the Mainland a system in structured training of medical specialists for enhancing the competency of Mainland medical professionals and quality of healthcare services. As of the end of February 2025, the Centre has organised 73 sessions of specialist training for hospitals across Shenzhen, with a cumulative total of 2 095 training participants.

Healthcare talent exchange in the Guangdong-Hong Kong-Macao GBA continues to make steady progress. The Government will continue to support facilitative measures that promote exchange and inter-connectivity in the GBA healthcare domain, and maintain close communication with the Mainland authorities to keep abreast of the latest development of healthcare talents.

5.

In October 2024, the Task Group on New Medical School (the Task Group) was established to devise the direction and parameters for a new medical school as well as selecting a suitable university for setting up the new medical school. The purpose of establishing a new medical school is to nurture more talented medical practitioners in support of the local healthcare system to provide quality service, while at the same time driving Hong Kong's development into an international medical training, research and innovation hub. The new medical school will develop complementarily with the two existing ones by adopting innovative strategic position in medical curriculum and sources of students to promote diversified and internationalised development in medical education, in line with Hong Kong's development as an international hub for medical training, research and innovation. The Task Group received a total of 3 proposals for the establishment of the third medical school before the submission deadline. These proposals were submitted by Hong Kong Baptist University, the Hong Kong Polytechnic University and the Hong Kong University of Science and Technology. The Task Group has agreed to adopt a holistic and comprehensive approach to evaluating the proposals submitted by universities from various perspectives, in accordance with the 10 key parameters set by the Task Group in November 2024 (including curriculum structure and assessment methodologies, and student admission arrangements). The curriculum design of the third medical school will depend on the recommendations of the Task Group and the implementation timeline of the recommended proposal.

- End -

CONTROLLING OFFICER'S REPLY

HHB181

(Question Serial No. 1190)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in the Programme that the Health Bureau will continue to take forward cross-boundary health co-operation, including overseeing the Pilot Scheme for Direct Cross-boundary Ambulance Transfer in the Greater Bay Area (Pilot Scheme), and consider extending the Scheme subject to operation experience. In this connection, will the Government inform this Committee of the following:

- (1) The number of patient transferred, the charge per case, and the number of rejected cases since the launch of the Pilot Scheme;
- (2) It is noted that the charges under the Pilot Scheme are determined according to the patients' medical conditions or needs. Will the University of Hong Kong-Shenzhen Hospital or other future participating medical institutions of the scheme be encouraged to provide charging scenarios or basic charging criteria so that potential users can better understand the charging levels? and
- (3) Will a flat rate charge be introduced or subsidies be provided to patients using cross-boundary ambulance services based on the cost per local ambulance call?

Asked by: Hon WONG Kwok, Kingsley (LegCo internal reference no.: 10)

Reply:

(1) - (3)

The study on the provision of land-based cross-boundary transfer for non-emergency and non-critically ill patients and the exploration of rolling out a pilot co-operation scheme for cross-boundary referral of patients between designated public hospitals were put forward in the Outline Development Plan for the Guangdong-Hong Kong-Macao Greater Bay Area (GBA). The Chief Executive of the Hong Kong Special Administration Region (SAR) also put forward in the 2023 Policy Address the initiative to explore cross-boundary ambulance transfer arrangements between hospitals in the GBA. With the staunch support and guidance of various national ministries, the Hong Kong SAR Government, in collaboration with the Guangdong Provincial Government, the Shenzhen Municipal Government and the Macao SAR Government, officially launched the one-year Pilot Scheme for Direct Cross-boundary Ambulance Transfer in the GBA (the Pilot Scheme) on 30 November 2024.

The first phase of the Pilot Scheme starts by arranging direct cross-boundary ambulance transfer of patients from designated sending hospitals in Shenzhen and Macao (i.e. the University of Hong Kong - Shenzhen Hospital (HKU-SZH) and the Conde S. Januario Hospital (CHCSJ) of Macao) to designated public hospitals in Hong Kong.

Under the Pilot Scheme, upon assessment and agreement by the teams of designated cross-boundary collaborating hospitals, arrangements can be made for patients with specific clinical needs and suitable clinical conditions to be transferred directly to Hong Kong between designated hospitals in a point-to-point mode without the handover of patients between ambulances at boundary control points, thus minimising risks posed to patients during transfer.

The direct cross-boundary ambulance transfer arrangement is not an ambulance call service, but a cross-boundary inter-hospital transfer arrangement made by the relevant medical teams according to the medical conditions of individual patients. Hence, the Pilot Scheme has a mechanism in place to avoid abuse while ensuring the safety of cross-boundary transfer. Since medical conditions and needs vary among patients, doctors at the sending hospital will assess, on a case-by-case basis, the need for the patient to have cross-boundary inter-hospital transfer for continuous treatment or recovery services, taking the patient's clinical diagnosis and actual conditions into consideration. The doctors at the sending hospital will communicate with the Major Incident Control Centre of the Hospital Authority (HA) for joint assessment, information exchange and co-ordination with the receiving hospital to decide whether the transfer mechanism should be activated. The sending and receiving hospitals will also ensure that the patient's relatives and/or the patient have given consent to the relevant arrangements and are informed of the risks involved in the transfer.

As at early April 2025, the HA received a total of 10 cases of cross-boundary ambulance transfer, of which 7 were referred by the HKU-SZH and 3 were referred by the CHCSJ of Macao. According to professional medical assessment, the conditions of the patients in the above cases are relatively stable, but are unable to return to Hong Kong on their own and are unsuitable for transfer to Hong Kong ambulances via the existing boundary control points. A patient as referred by HKU-SZH was considered not meeting the criteria for transfer after the joint assessment of the case by the medical teams of the two places, and hence, the mechanism of transfer arrangement was not activated.

At present, ambulances, drivers, medical staff, medical equipment and medicines involved in cross-boundary ambulance transfer are provided by the HKU-SZH and the CHCSJ of Macao. The charges for cross-boundary ambulance transfer are determined by the above hospitals. Among them, the charges of the HKU-SZH are determined in accordance with the guidelines issued by the relevant Mainland authorities and have been reported to the relevant Mainland authorities. The current standard flat rate charge is RMB 4,990. The Hong Kong SAR Government will continue to keep in view the implementation of the scheme and maintain the transparency of the fees and charges with the collaborating sending hospitals, such that patients and their families will be clear about the relevant charges.

The public hospitals in Hong Kong, as the receiving hospitals for transferring patients, do not charge for the cross-boundary transfer arrangement and have no plan to provide subsidy to patients participating in the Pilot Scheme. Depending on whether a patient participating in the Pilot Scheme is an "Eligible Person" or a "Non-eligible Person", the HA will charge the

patient in accordance with the scale of fees and charges as set out in the Gazette of the Hong Kong SAR Government for the continuation of the medical services provided to the patient in the public hospitals in Hong Kong.

The government departments of Guangdong, Hong Kong and Macao will review the effectiveness and operational experience of the Pilot Scheme in a timely manner to consider whether and how to expand the scheme, for example, by including more pilot hospitals and/or extending the scheme to a two-way arrangement.

- End -

CONTROLLING OFFICER'S REPLY

HHB182

(Question Serial No. 1191)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned under this Programme that the Hospital Authority (HA) will strengthen centralised procurement of drugs and medical devices in 2025-26. In this connection, will the Government inform this Committee:

- (1) of respective expenditures on drugs and medical devices of the HA in the past 3 years;
- (2) of the reduction in the cost of drugs and medical devices after centralised procurement by the HA;
- (3) whether private healthcare facilities such as the CUHK Medical Centre will be allowed to participate in the centralised procurement by the HA, and whether agreements will be made to lower the charges for drugs and medical devices so as to alleviate the burden on patients; if yes, of the details; if not, the reasons for that; and
- (4) whether the HA will seek to participate in the centralised procurement arrangement of the country to further reduce the cost of procuring drugs and medical devices; if yes, of the details; if not, the reasons for that?

Asked by: Hon WONG Kwok, Kingsley (LegCo internal reference no.: 11)

Reply:

(1)

In line with the Government's public healthcare policy to ensure that citizens are not denied adequate medical care due to lack of means, the Hospital Authority (HA) provides healthcare services and drugs or medical items, which are heavily subsidised by the Government, to patients based on their clinical needs and in accordance with the HA's treatment guidelines. Currently, the HA Drug Formulary (HADF) includes about 1 500 types of drugs, encompassing approximately 2 700 items, to meet treatment needs. The table below sets out the HA's expenditure on the procurement of drugs (including the expenditure on drugs charged at standard fees and drugs purchased by patients at their own expenses) in the past 3 years:

	2022-23	2023-24	2024-25 (Projection)
Drug expenditure* (\$ billion)	12.451	13.127	12.951

* Excluding other expenditures (such as storage and repackaging).

On medical equipment items, minor items costing \$200,000 or less each are generally procured by individual hospital clusters, and the HA does not maintain statistics on the procurement of such minor items. The procurement of large and major medical equipment items costing over \$200,000 each, which are upgraded and acquired with the Government's designated funding, is co-ordinated by the HA Head Office to enhance bargaining power and efficiency of procurement. The total expenditure of the HA on the procurement of large and major medical equipment items in the past 3 years is set out in the table below:

	2022-23	2023-24	2024-25 (Projection)
Expenditure on large and major medical equipment items (\$ billion)	1.2	1.2	1.2

(2) to (4)

The HA is a statutory body responsible for the provision of public hospital and related healthcare services in Hong Kong. It is also a procuring entity under the Agreement on Government Procurement (GPA) of the World Trade Organization (WTO). Its procurements, including those for pharmaceutical products and medical equipment items, must therefore comply with the relevant requirements to ensure compliance with the requirements of the GPA of the WTO.

The HA has put in place a robust procurement mechanism, utilising multiple channels to introduce more cost-effective drugs and medical equipment items while ensuring that the quality and safety standards are met. Meanwhile, the HA enhances market competition through central co-ordination and continuous optimisation of procurement strategies to achieve better procurement efficiency and economies of scale, thereby further reducing operational cost. Among the drugs currently used in public hospitals, except for a few drugs with special purposes or used in small quantities, most drugs are centrally procured. Given the relatively large quantity of drugs purchased, the HA has a certain degree of bargaining power in negotiating drug prices with pharmaceutical manufacturers, which is expected to improve cost-effectiveness. The HA established a "Cost Assessment Panel" in 2024 to conduct price negotiation with pharmaceutical companies with a view to reducing the costs and prices of introducing new drugs as far as possible. For example, not only has the procurement cost of 2 new drugs for treating metastatic colorectal cancer been reduced by nearly 30% after successful price negotiation, but they have also been listed in the "Special Drug" category of the HADF. Patients are only required to pay the standard fee, i.e. currently \$15 per item, if they are prescribed these 2 drugs under specified clinical indications, greatly alleviating their financial burden. It is expected that nearly 300 cancer patients will benefit each year. For another new drug for treating paroxysmal nocturnal haemoglobinuria, price negotiation has not only reduced the procurement cost by 30%, but also triggered a voluntary price reduction of 37% for a similar drug.

On procurement of medical equipment items, the HA has optimised its strategies, which include drawing up standardised product specifications for central procurement and proactively identifying new sources of supply so as to develop new markets and introduce competition, as well as strengthening central co-ordination of procurement to tie in with the HA's strategic directions, thereby enhancing procurement efficiency and cost-effectiveness while addressing the needs of clinical operations.

As for procurement collaboration, the local regulatory systems of different regions and the customs territory system under the WTO must be strictly adhered to in the procurement processes for drugs and medical equipment items. At present, Hong Kong's healthcare system, regulatory regimes for drugs and medical equipment items as well as import and export mechanism are different from those of the Mainland, and as a result, the procurement procedures for drugs and medical devices of the two places are not entirely compatible. It is crucial to ensure that the inherent strengths of Hong Kong's drug and medical device regulatory regime are not compromised when considering the HA's drug and medical device procurement strategies.

The HA will continue to implement various measures and enhance its centralised procurement model to introduce more cost-effective drugs and medical equipment items, thereby optimising the use of limited public resources. The HA also conducts mutual visits and exchanges with Mainland experts on issues of common concern from time to time so as to facilitate mutual learning of experience, and promote the co-operation and development of the two places. Moreover, the HA will continue to closely monitor market developments and maintain communication with different stakeholders to promote diversification of supply of drugs and medical equipment so as to provide patients with safe, efficacious and cost-effective drugs and medical equipment items.

- End -

CONTROLLING OFFICER'S REPLY

HHB183

(Question Serial No. 1192)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health, (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Health Bureau states that it will “rationalise fees and charges of public healthcare services to enhance resource efficiency and reduce wastage.” In this connection, will the Government inform this Committee of the following:

- (1) Please set out the total amount of patient service fees unrecovered by the Hospital Authority (HA) in the past 3 years, with a breakdown of the total amount of unrecovered non-local patient service fees.
- (2) It is reported that some psychiatric patients who have been approved for discharge overstay in the ward because their family members refuse to pick them up. This hinders bed turnover and causes long-term arrears. What measures are there to reduce patient overstay and the arrears?
- (3) At present, the chargeable unit for each prescription drug is up to 16 weeks and the unit charge is HK\$15. Many chronic patients criticise that the chargeable unit does not align with their follow-up consultation schedule. For example, they pay for 2 units of each of multiple drugs only to receive medication for 24 weeks. Will the Bureau consider enhancement measures regarding the chargeable unit and charging arrangements?

Asked by: Hon WONG Kwok, Kingsley (LegCo internal reference no.: 12)

Reply:

(1)

The total amount of patient service fees written off by the Hospital Authority (HA) and the total amount of unrecovered fees that were written off for non-eligible persons (NEPs) in the past 3 years are tabulated as follows:

	2022-23	2023-24	2024-25*
Total amount of patient service fees written off (Fees that were written off for NEPs) (\$ million)	39 (33)	47 (39)	39 (31)

* Figures as at 31 December 2024

(2)

The HA, through its multi-disciplinary healthcare teams (including healthcare professionals and medical social workers), makes professional judgement on whether a patient is suitable for discharge. It also makes plans for discharge arrangements and provides appropriate support for individual patients having regard to their conditions.

The Government's fees and charges reform for public healthcare will adjust the levels of government subsidisation and the proportion of co-payments by members of the public for various public healthcare services to rationalise the relativity for in-patient, as well as different tiers of out-patient services, allocate resources in a more targeted manner and reduce wastage and abuse. Implementation of the fees and charges reform will help the HA to address the problem of prolonged hospitalisation of patients due to non-medical reasons.

Meanwhile, the HA has established mechanism to minimise the outstanding medical fees. The related measures include:

- (a) The HA will issue interim bills every 3 days to NEPs during their hospital stay (every 7 days for eligible persons) and remind patients or their families to settle them. Besides, NEPs are required to pay a specified amount of deposit upon admission.
- (b) The HA will issue final bills to patients upon discharge or mail the bills to patients' registered local or overseas addresses. If the bills remain outstanding at the patients' discharge, the patients or their families will be reminded through telephone calls to settle the bills with monthly statements mailed to their registered local or overseas addresses. Administrative charges will be imposed if patients fail to settle the bills within a specified timeframe.
- (c) If the bills remain outstanding after the above actions have been taken, the HA will take legal actions where appropriate, including filing claims to the Small Claims Tribunal or issuing demand letters through lawyers for debt recovery.
- (d) For those NEPs not requiring hospitalisation after treatment but in need of assistance with discharge arrangement, the HA will contact the Social Welfare Department or the relevant consulates or Mainland authorities through the Immigration Department to arrange discharge accordingly. If their bills have not been settled, apart from taking legal actions as far as practicable, the HA will also notify the relevant consulate to assist in debt recovery.
- (e) The HA will review the mechanism for recovering medical fees from time to time and keep in view the popular charging models in the market. In recent years, the HA has been actively implementing e-payment services whereby patients can pay medical fees

anytime through the HA's mobile application "HA Go" and the multi-functional one-stop e-service kiosks. In the future, the HA will continue to enhance the functions of the existing e-payment service and explore the feasibility of adopting different payment modes, with a view to facilitate patients to pay their fees through various channels, thereby reducing the incidence of default payment.

(3)

The Government and the HA announced on 25 March this year the fees and charges reform for public healthcare services. Starting from 1 January 2026, specialist out-patient drugs will be charged at \$20 per drug item, while family medicine out-patient drugs will be charged at \$5 per drug item, both on the basis of a four-week period. Healthcare professionals will prescribe the quantity of drugs according to the actual needs of the patients to avoid wastage due to over-dispensing of drugs.

- End -

CONTROLLING OFFICER'S REPLY**HHB184****(Question Serial No. 1193)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (3) Subvention: Hospital AuthorityControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

The financial provision for the Hospital Authority (HA) in 2025-26 is above \$100 billion, a 5% increase on 2024-25 Original. In this connection, please advise this Committee of:

(1) the total expenditure on annual remuneration of full-time-equivalent HA staff and its changes over each of the past 3 years;

(2) whether the HA has examined the wider application of telemedicine technology to reduce face-to-face consultations for reduction of costs; If yes, what are the details? If no, what are the reasons?

(3) whether the HA has used artificial intelligence to optimise the delivery of work such as diagnostics, treatment and clerical duties for reduction of costs; If yes, what are the details? If no, what are the reasons?

(4) whether the HA has introduced 3D printed medical devices to replace traditional high-cost products for reduction of costs; If yes, what are the details? If no, what are the reasons?

Asked by: Hon WONG Kwok, Kingsley (LegCo internal reference no.: 13)

Reply:

(1)

In 2025-26, the Government provides a recurrent subvention of \$99 billion to the Hospital Authority (HA), a 3.7% increase compared to the 2024-25 revised estimate of \$95.4 billion.

The number and total expenditure on remuneration of HA staff calculated on full-time equivalent basis in the past 3 years are set out in the table below:

Year	No. of staff calculated on full-time equivalent basis⁽¹⁾	Total expenditure on remuneration (\$million)
2022-23	90 040	59,419
2023-24	90 785	62,414
2024-25 (as at 31 December 2024) ⁽²⁾	93 698	Note ⁽³⁾

Note:

1. The manpower figures above are calculated on a full-time equivalent basis including permanent, contract and temporary staff in the HA.
2. From January 2024 onwards, the number of full-time-equivalent part-time temporary staff is calculated according to their actual working hours. The figures prior to this month are for reference only and cannot be directly compared with the data under the current revised calculation method.
3. The actual expenditure for 2024-25 can only be ascertained after completion of audit inspection by an independent auditor.

(2)

The HA has been striving to optimise the use of technology to enhance service quality and patient experience, and telehealth is one of the key development directions. The HA is actively promoting telehealth to provide an additional option for suitable patients seeking medical consultation, such that they may receive healthcare services from the HA without making in-person visits to hospitals or clinics. Telehealth services have been introduced in different out-patient, day inpatient, inpatient and outreach services. The HA will regularly review the effectiveness relating to the use of telehealth, including exploring the progressive application of information technology on appropriate healthcare services with a view to benefitting more patients in need. Nonetheless, telehealth has its limitations and may not be suitable for all patients or circumstances. For example, patients who need to undergo clinical examinations by doctors are required to visit hospitals in person to complete the whole examination procedure.

(3)

In recent years, the HA has actively promoted the application of artificial intelligence (AI) to enhance the efficiency and quality of daily operations as well as medical decision-making, improve patient experience and achieve sustainable development in the long run.

On diagnosis and treatment, the HA has already implemented several AI projects. For example, the HA has applied the chest X-ray model in its 18 Accident & Emergency Departments (A&E) and 73 Specialist Out-patient Clinics and General Out-patient Clinics to assist doctors in identifying abnormal chest X-rays so as to expedite the handling of high-risk cases. AI technology has also been introduced in A&E departments to help doctors analyse brain computed tomography scans for promptly detecting urgent conditions such as brain injuries and intracranial haemorrhages. In a bid to address the rising prevalence of falls and hip fractures among the aging population, the HA has also employed AI technology to assist doctors in identifying cases of hip fractures in order to provide early treatment for patients. Moreover, the HA has developed an AI system on medication safety to automatically flag up cases of Hepatitis B virus positivity. The Hospital Command Centre also makes use of AI to make predictions on resource demands so as to facilitate the allocation of beds and non-emergency ambulance transfer service, etc.

Furthermore, the HA is actively exploring the application of generative AI technology to enhance work efficiency, thereby improving the overall cost-effectiveness of the organisation in the long run. Among other initiatives, a trial run of a system that assists doctors in writing medical reports has been launched in 6 public hospitals since March this year. Additionally,

the HA is actively exploring the application of generative AI technology in other aspects, including the digitalisation of paper-based medical reports and a language model platform for internal use to assist staff in editing articles, writing emails and searching records, etc.

(4)

To dovetail with its strategic directions and service development needs, the HA procures and replaces different types of medical equipment from time to time. All clusters under the HA are equipped with medical 3D-printing devices to cater for patient services and operational needs.

- End -

CONTROLLING OFFICER'S REPLY**HHB185****(Question Serial No. 1194)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (2) HealthControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

It is mentioned in this Programme that the Health Bureau will continue to pursue the recommendations of the strategic review on healthcare manpower planning and professional development. In this connection, please advise this Committee of the following:

- (1) What are the actual and estimated numbers of midwives and psychiatric nurses in the total nursing staff of the Hospital Authority (HA), which increased from 28 865 in 2023-24 to 30 620 in 2025-26; What are the actual and estimated emolument expenditures involved;
- (2) According to the Healthcare Manpower Projection 2023, there is a severe manpower shortage in some healthcare professions, such as general nurses, but a significant surplus of midwives, exceeding the demand by 1 070 by 2030. Will the Government promptly reduce the quota for midwifery courses to avoid a wastage of training resources due to saturated demand; and
- (3) Psychiatric nurses will also be in great surplus, exceeding demand by 1 220 by 2040. However, with increasing social attention to mental health, will the HA make use of the surplus manpower effectively to enhance related mental health services?

Asked by: Hon WONG Kwok, Kingsley (LegCo internal reference no.: 14)Reply:

(1)

The table below sets out the numbers of nurses working in the stream of obstetrics & gynaecology (O&G) or psychiatry in the Hospital Authority (HA) in 2023-24 and 2024-25 (as of 31 December 2024).

Year	O&G nurses ^{(1),(2),(3),(5)}	Psychiatric nurses ^{(1),(2),(4),(5)} (including community psychiatric nurses)
2023-24 (as of 31 March 2024)	1 111	3 064
2024-25 (as of 31 December 2024)	1 097	3 147

Regarding the nursing group in the HA, in 2023-24 and 2024-25 (as of 31 December 2024), the overall numbers of nurses are 28 865 and 29 538^{(1),(2),(5)} respectively, and the total emolument expenditures⁽⁶⁾ are \$23.832 billion (2023-24) and \$24.892 billion (a full-year projection for 2024-25) respectively. The O&G and psychiatric nurses covered in the above table are included in the nursing group in the HA.

Note:

- (1) The manpower figures are calculated on a full-time equivalent basis including permanent, contract and temporary staff in the HA.
- (2) The strength of nurses includes senior nursing officers, department operation managers, nurse consultants, associate nurse consultants, ward managers, nursing officers, advanced practice nurses, registered nurses, enrolled nurses and nursing trainees, etc.
- (3) O&G nurses include all midwives and general nurses working in the O&G stream.
- (4) Psychiatric nurses include all nurses working in psychiatric hospitals (i.e. Kwai Chung Hospital, Castle Peak Hospital and Siu Lam Hospital), nurses working in psychiatric departments of other non-psychiatric hospitals, as well as all nurses in the psychiatric stream.
- (5) Starting from January 2024, the full-time equivalent for temporary part-time staff has been calculated based on their actual working hours. The figures prior to that are for reference only and are not directly comparable with those derived from the modified calculation currently adopted.
- (6) The total emolument expenditures include basic salaries, allowances, gratuities and other on-costs such as provision of housing benefits and death & disability benefits. The figure for 2024-25 represents a full-year projection. As nurses holding valid practising certificates in midwifery or psychiatric nursing may work outside the stream of O&G or psychiatry, and the manpower figures of nurses working in O&G and psychiatry streams also include general nurses, the total emolument expenditure of the nursing group is therefore provided for reference.

(2)

The HA's school of midwifery is currently the only provider of midwifery training in Hong Kong. In determining the midwifery course quotas, factors in various aspects are taken into consideration, including service demands, wastage rates of midwives, training needs of the HA and non-HA institutions (such as maternal and child health centres under the Department of Health and private hospitals), etc. The HA will continue to review and adjust the midwifery course quotas on a regular basis.

(3)

The Government conducts a healthcare manpower projection for the healthcare professions (including psychiatric nurses) on a regular basis. By taking into account all factors such as the known and planned services as well as the development directions, the projection provides systematic insights into the future healthcare manpower requirement to meet the relevant service needs. As indicated by the latest round of healthcare manpower projection in 2023, there will be manpower shortage of psychiatric nurses in the short term. With a continued

steady supply of graduates, it is expected that the manpower gap of psychiatric nurses will be narrowed gradually.

Currently, by fully utilising the manpower of psychiatric nurses under a multi-disciplinary team approach, the HA's mental health services provide a comprehensive range of medical services to patients with mental health needs. For example, the HA's Case Management Programme provides appropriate community support to persons in mental recovery in the community. As the case managers of the programme, professional personnel (including psychiatric nurses) conduct assessment on the needs, risks and clinical conditions of the patients, and maintain close liaison with community partners to take appropriate follow-up actions. The HA further recruited additional case managers in 2024-25 to strengthen community psychiatric services in a further optimised ratio of no higher than 1:40. Moreover, the HA has put in place nurse clinic services to provide nursing care support, such as mental health education and medication management, for patients at psychiatric specialist outpatient clinics. The HA plans to enhance the multi-disciplinary element in the service delivery model by strengthening manpower (including psychiatric nurses), so that doctors can devote more time to managing new cases.

To better utilise the manpower of different professional sectors (including psychiatric nurses), and step up cross-sectoral co-ordination to improve mental health services, the Chief Executive's 2024 Policy Address put forward the initiative of formulating a stepped-care model, where a multi-disciplinary framework with tiers will be adopted to deal with cases ranging from general emotional problems in the frontline to cases requiring follow-up and more serious mental illnesses cases. The framework will set out the roles of different sectors such as teaching staff, social workers, healthcare workers, as well as other auxiliary personnel and service providers at each tier, and their division of work in the provision of mental health services for cases in each tier, enabling them to smoothly work together and perform their respective roles smoothly, and assist in handling different types of cases with mental health needs systematically.

The Government will continue to observe the long-term demand and supply situation in the manpower of psychiatric nurses, and timely adjust the training strategy in line with policy measures for mental health services.

- End -

CONTROLLING OFFICER'S REPLY

HHB186

(Question Serial No. 1195)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in the Programme that the Health Bureau will continue to take forward and implement the five-year plan of eHealth+. In this connection, please inform this Committee of the following:

- (1) What is the overview of eHealth+ in supporting cross-boundary healthcare, such as the number of electronic health records accessed by Mainland healthcare providers?
- (2) In 2023, over 99% of the electronic health records shared on eHealth were from the Department of Health and the Hospital Authority, with very low participation from the private healthcare sector. Has there been any improvement in the past year? Will the Government expedite the imposing of mandatory requirements?
- (3) In the approved commitment for eHealth+, approximately \$189 million is allocated for “rollout, engagement and implementation” over five years. Please provide details of the related expenditure and its effectiveness in 2024-25.
- (4) What is the progress of the “eMedical Certificate” in supporting fit for drive, sick leave, advance medical directives, etc?
- (5) Regarding the support for electronic medication management and electronic dispensing, can it be completed before 2028-29?

Asked by: Hon WONG Kwok, Kingsley (LegCo internal reference no.: 15)

Reply:

eHealth is a territory-wide electronic health record sharing system launched by the Government in 2016 that enables citizens to authorise healthcare providers (HCPs) in the public and private sectors to view and share their electronic health records (eHRs) for healthcare purposes. Building on the strengths of the existing infrastructure of eHealth, the Government announced in the 2023 Policy Address the initiative to roll out a five-year development plan of eHealth+ to transform eHealth into a comprehensive healthcare information infrastructure that integrates multiple functions of data sharing, service delivery and care journey management. eHealth+ aims to facilitate care coordination, cross-sector collaboration, as well as active health management and surveillance, thereby better serving our citizens in obtaining optimal healthcare services, and supporting the healthcare reform and various healthcare policies more effectively, such as primary healthcare and cross-

boundary healthcare services. The Government is taking forward the eHealth+ development in phases in accordance with the patient-centric principle and four strategic directions, namely, “One Health Record”, “One Care Journey”, “One Digital Front Door to Empowering Tool” and “One Health Data Repository”.

The reply to the questions raised by the Hon WONG Kwok, Kingsley is as follows:

(1) With the ever-tighter economic and social integration between Hong Kong and the Mainland, Hong Kong citizens making use of medical services in the Mainland, especially in the Guangdong-Hong Kong-Macao Greater Bay Area (GBA), is becoming more common. In accordance with the overarching principles of ensuring due compliance of laws and regulations of both places, and safeguarding data security and patients’ privacy, the Government has all along been facilitating citizens to self-carry their electronic health records (eHRs) for cross-boundary uses via eHealth to enhance the continuity of care across the boundary. Among other things, the Government in 2024 launched the “Cross-boundary Health Record” (CBHR) and “Personal Folder” functions of the eHealth mobile application (eHealth App) at the University of Hong Kong-Shenzhen Hospital and 7 medical institutions under the Elderly Health Care Voucher (EHCv) Greater Bay Area Pilot Scheme to enable Hong Kong citizens to self-carry their eHRs for cross-boundary uses, thereby obtaining more coherent healthcare services. The CBHR function enables eligible Hong Kong elderly persons using EHCv at specified medical institutions in the GBA to apply for a copy of their eHRs in eHealth over the past three years through the eHealth App in advance. Healthcare professionals of the specified healthcare institutions can then access and browse the relevant eHRs by scanning the QR codes presented by the elderly persons at the time of consultation to assist in diagnoses and treatment. The “Personal Folder” function enables citizens to provide eHRs obtained during consultations within and outside Hong Kong to their personal eHealth accounts to facilitate storage and use of eHRs, including access by Hong Kong HCPs authorised by citizens through the eHealth system during follow-up care. The feedback on relevant cross-boundary functions has been positive.

As of end-February 2025, citizens have submitted over 4 500 CBHR applications and deposited over 6 400 eHRs through the “Personal Folder” function, most of which are investigation reports such as laboratory and radiology reports, and about 25% of them are from the specified medical institutions in the GBA. We will continue to streamline the workflow and improve the user experience, and progressively extend the cross-boundary functions to more medical institutions under cross-boundary healthcare collaboration programmes. We will also enhance the role of eHealth as the core system for cross-boundary health data sharing, so as to support citizens’ cross-boundary healthcare needs more effectively.

We also noted that requiring citizens carrying their own eHRs for cross-boundary use each time is not the most convenient, secure, and effective way for both citizens and HCPs. For example, given the more stringent technical requirements, it is difficult for citizens to self-upload high-resolution radiology images to their eHealth accounts. In accordance with the current legislation, HCPs outside Hong Kong are unable to register with eHealth. The Government introduced the Electronic Health Record Sharing System (Amendment) Bill 2025 (the Amendment Bill) into the Legislative Council this year to provide a legal framework to assist citizens in building a more comprehensive eHR profile. Among other

things, the Government proposed to empower the Commissioner for the Electronic Health Record to recognise individual HCPs and public health record systems outside Hong Kong, subject to sufficient protection of data privacy and system security as well as due compliance with specified requirements and conditions. This will enable citizens to use their eHRs across the boundary in a more convenient and secure manner. If an individual citizen uses services at a recognised HCP outside Hong Kong, he/she can choose to authorise the HCP to securely access his/her eHRs and deposit the health records of the services received into his/her personal eHealth account, with a view to enhancing the quality and safety of cross-boundary healthcare services. HCPs outside Hong Kong can only access and deposit citizens' eHRs when a registered citizen provides explicit consent while using its services. Under no other circumstances will eHealth records be transmitted across the boundary.

(2) Under the strategic development direction of “One Health Record”, we seek to consolidate the longitudinal eHRs of citizens spread across a multitude of healthcare processes into their personal eHealth accounts. A comprehensive and complete eHR profile enables the HCPs authorised by citizens to respond to their health needs more effectively, thus enhancing clinical outcomes and saving costs of the care process. Nevertheless, while private HCPs have been actively using eHealth in supporting clinical processes as evidenced by the fact that nearly 60% of eHR access by HCPs as of end-February 2025 were by private HCPs, more than 99% of some 4.5 billion eHRs shared on eHealth are from public HCPs.

The Government has been taking a multi-pronged approach to incentivise and facilitate the provision of citizens' eHRs into eHealth by private HCPs, thereby assisting citizens in accessing, managing and using their own eHRs during the healthcare process more conveniently. Last year, the Government launched a platform enabling self-service data compliance testing to simplify the technical testing procedures, and provided dedicated technical support to healthcare institutions. When taking forward various public-private partnership programmes, the Government would require HCPs to deposit the related medical records of the participating citizens into eHealth. The Government also rolled out the eHealth Adoption Sponsorship Pilot Scheme (the Pilot Scheme) by partnering with electronic medical record (eMR) solutions vendors and medical groups to co-fund system enhancements in achieving seamless eHR sharing between eHealth and eMR systems in the market. From July 2023 to February 2025, about 80 private HCPs (involving around 480 private doctors and 200 service locations) connected to eHealth and provided more than 1.12 million eHRs under the Pilot Scheme.

With the Government's endeavours, the eHRs provided by private HCPs in a year increased from 2.19 million in 2023 to 3.67 million in 2024. The Government will continue to collaborate with the private healthcare sector to enhance the connectivity between eHealth and their eMR solutions. In particular, given the positive impacts of the Pilot Scheme, we have progressively expanded the scheme to include more eMR solution vendors, medical groups and other sectors, including Chinese medicine. We will also launch the eHealth+ accreditation scheme in 2025 to enable citizens to easily identify if an HCP has the capability to deposit health records into their personal eHealth accounts and the extent of data involved. Citizens can make reference to such information in choosing a suitable HCP, to ensure that their medical records will be deposited in their personal eHealth accounts.

Besides, the Amendment Bill will streamline the consent mechanism such that once citizens agree to join eHealth, their HCPs will be able to deposit health data into their personal eHealth

accounts. Meanwhile, citizens will continue to retain full control over their personal data and can grant individual HCPs access to their eHealth records at their own will. The Amendment Bill will also empower the Secretary for Health to require specified HCPs to provide specified important health data into the personal eHealth accounts of citizens registered with eHealth and with their consents, in order to facilitate citizens' easy access and control of their key health information.

The Government will continue to provide support and collaborate with the private healthcare sector to enable the majority of private HCPs to seamlessly connect with eHealth; and will consider providing additional assistance to healthcare institutions and professionals that are less prepared for digitalisation.

(3) In July 2024, the Finance Committee of the Legislative Council approved a commitment of \$1,395.8 million for the eHealth+ development. The Hospital Authority (HA) is the technical agency supporting the development of eHealth. Among other things, the HA will procure suitable information technology operation services (e.g. software development, cybersecurity and quality assurance) from the market to support and complement the work of the HA's development team, in order to strengthen collaboration with private service providers, create synergies and enhance cost-effectiveness. About \$189.7 million of the approved funding is budgeted for communication and service implementation with relevant stakeholders to support project development. This includes providing technical support and collaborating with private HCPs and eMR solution vendors to co-fund system enhancements, so as to promote private sector participation and ensure the smooth implementation of the eHealth+ projects. The estimate for the related works in 2024-25 is \$36.2 million, which primarily covers enhancement of system connectivity between private HCPs and eHealth (e.g. the aforementioned Pilot Scheme), as well as provision of technical support to specified medical institutions in the GBA and other related preparatory works for the implementation of the CBHR and "Personal Folder" functions.

(4) Electronic medical documents can reduce the risk of losing paper documents and facilitate convenient access and use of the documents by citizens. Under the eHealth+ development, we plan to introduce the "eMedical Certificate" function for the public to manage their personal medical documents (such as medical certificates, prescriptions, healthcare referrals and advance medical directives (AMDs)) in a centralised manner through the one-stop eHealth App. We expect to roll out the first phase of the "eMedical Certificate" function in 2025-26, covering medical certificates issued by the HA and the Department of Health. A verification function will be incorporated to enable users to verify electronic medical documents by scanning the QR codes to prevent forgery and alteration of documents, and enable users to confirm the authenticity and validity of documents at anytime and anywhere. We will also consider expanding the "eMedical Certificate" function to cover more private HCPs and other types of medical documents, such as the development of an "electronic AMD" function (including the electronic storage of paper AMDs and the electronic making of AMDs directly through eHealth). To tie in with these developments, the Amendment Bill will provide a clear legal framework for governing electronic medical documents issued or authenticated through eHealth, and to enable the Government to designate eHealth as the only platform for issuing certain medical documents under appropriate circumstances, in order to facilitate the centralised management and support of the usage of these documents.

(5) Medication management is a critical part of the therapeutic process for patients. As one of the core functions under eHealth+, “eMedication” will integrate medication records and related healthcare services of different HCPs, thereby enhancing patient safety and healthcare efficiency. In 2024, the Government and the HA collaborated with the Logistics and Supply Chain MultiTech R&D Centre to launch the eMedication (RCH) project to support residential care homes (RCHs) and their electronic medication management system providers in connecting with eHealth. By enabling RCHs to gain access to residents’ prescription information via eHealth, “eMedication” not only reduces the reliance on manual copying of medication information and streamlines the flow of medication dispensing and management, but also enhances the dispensing efficiency and medication monitoring within the RCHs, thereby reducing the risk of medication incidents.

We will continue to launch more features under “eMedication”. Among other things, the Chief Executive’s 2024 Policy Address announced the Government’s plan to develop a community drug formulary and launch a community pharmacy programme to help the public obtain affordable drugs through central purchasing and the community network. As the core platform supporting primary healthcare services, eHealth+ will serve as a crucial bridge connecting the HA, community pharmacies and relevant HCPs. To tie in with the future synergistic development of community pharmacies and primary healthcare services, we will work to connect and integrate the medication records of the HA and various HCPs to support the medication management processes, including prescribing and dispensing medications.

- End -

CONTROLLING OFFICER'S REPLY

HHB187

(Question Serial No. 1196)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in the Speech that the Government will enhance collaboration, including medical co-operation, with cities in the Greater Bay Area (GBA). In this connection, will the Government inform this Committee:

- (1) with the enhancement of cross-boundary medical co-operation and the establishment of the GBA Clinical Trial Collaboration Platform, whether the Health and Medical Research Fund has adjusted its thematic priorities in approving funding applications, with greater consideration given to the factors of the GBA and the needs to develop new quality productive forces; if yes, of the details; if not, the reasons for that;
- (2) given that the current balance of the approved commitment for the Health and Medical Research Fund is about \$1.8 billion, when it is expected to seek approval for new funding commitment; and whether it has taken into account the increase in demand for funding support on Chinese medicine research with the upcoming commencement of operation of the Chinese Medicine Hospital of Hong Kong; and
- (3) given that the Greater Bay Area International Clinical Trial Institute plans to move into a wet laboratory-enabled building to be completed in due course, of the estimated expenditure for such move; and whether the storage systems, freezers, blood and cell samples, etc. of the biobank need to be relocated by that time?

Asked by: Hon WONG Kwok, Kingsley (LegCo internal reference no.: 16)

Reply:

The Health and Medical Research Fund (HMRF), which is administered by the Health Bureau (HHB), aims to build research capacity in Hong Kong, to encourage, facilitate and support local health and medical research, and to support evidence-based health promotion projects in Hong Kong. The HMRF is open only to applications by principal applicants who are researchers employed by local institutions such as tertiary education universities. The HMRF encourages and allows principal applicants of funded projects to collaborate with other institutions, both local and non-local.

The funding scope of the HMRF has all along covered the following areas: i) infectious diseases research with public health implications, including those are prevalent in or pose threat to Hong Kong and neighbouring areas, including the Greater Bay Area (GBA); ii) advanced medical research which applies advanced technologies to facilitate the translation of knowledge gained into clinical practice and to inform health policy; and iii) clinical research which is based on Chinese medicine theory.

The Research Council, the governing body of the HMRF, will also set thematic priorities for each annual Open Call for investigator-initiated projects. Higher priority for funding will be given to proposals addressing these thematic priorities. To tie in with the Government's commitment to advancing medical innovation, including the policy direction of encouraging more local clinical research, the HMRF has identified digital health, advanced technology and clinical trials, among others, as thematic priorities in the latest 2024 Open Call applications.

The approved commitment for the HMRF is \$4,223 million. The balance as of 31 March 2025 is \$1,807 million. The HHB is reviewing the funding requirement of the HMRF, including funding priorities, in the coming years, and will consider and seek additional funding in a timely manner under established mechanism.

As the first dedicated fund set up to support Chinese Medicine (CM) development on all fronts, the Chinese Medicine Development Fund has introduced the Chinese Medicine Applied Studies and Research Funding Scheme. The Scheme supports eligible institutions to conduct more high-level CM research and applied studies with local and international impact (including projects that align with the development needs of the Chinese Medicine Hospital of Hong Kong) with a view to driving academic and clinical research, and the professional and industry development of CM in Hong Kong.

The Chief Executive announced in the 2023 Policy Address that the Government would establish the GBA International Clinical Trial Institute (GBAICTI) to provide a one-stop clinical trial support platform for medical research institutions. The GBAICTI would coordinate clinical trial resources in the public and private healthcare sectors in Hong Kong to promote the coordinated development of the Hong Kong and Shenzhen Parks. The HHB has set aside a total time-limited provision of \$140 million from 2024-25 to 2028-29 for meeting manpower and other operational expenses of the GBAICTI. Besides, the HHB will earmark an additional provision of around \$38 million to support the implementation of specific strategic initiatives by the GBAICTI in 2025-26, including the expenditure for the initial phase of moving into the wet laboratory-enabled building in the Hong Kong Park that will be completed later.

The biobank of the GBAICTI, managed by the Hospital Authority and the Chinese University of Hong Kong, is an important infrastructure supporting multi-centre cross-boundary clinical trials. Leveraging their expertise in international certification and biobank management, the GBAICTI aims to establish a high-level research facility that provides strong support for clinical trials. The GBAICTI and the biobank will move into the wet laboratory-enabled building in the Hong Kong Park upon its completion, providing more comprehensive facilities and services to support clinical trial development. Regarding the relocation of the biobank, the GBAICTI has formulated strict protocols for sample handling and transfer to ensure the integrity and stability of samples during the relocation process. Specific relocation

arrangements will follow established operational procedures with equipment for monitoring temperature to ensure the quality of samples.

- End -

CONTROLLING OFFICER'S REPLY

HHB188

(Question Serial No. 1326)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in paragraph 207 of the Budget Speech that taking into account the latest demographic structure, planning and development situation in Hong Kong, the Government will review the distribution, scale and priority of projects under the Second Hospital Development Plan (HDP), and will make the announcement in due course. In this connection, will the Government inform this Committee whether it will study the establishment of an acute hospital, in the form of a cluster of hospital buildings, in the context of the expansion of the Tung Wah Group of Hospitals Wong Tai Sin Hospital on the vacant land made available after the relocation of the Diamond Hill Service Reservoirs and even in conjunction with the development of Our Lady of Maryknoll Hospital under the Second Ten-year HDP to meet the demand for accident and emergency services by residents of Wong Tai Sin district?

Asked by: Hon YANG Wing-kit (LegCo internal reference no.: 4)

Reply:

The Hospital Authority (HA) plans and develops various public healthcare services on a cluster basis, taking into account a number of factors, including the increase in service demand as a result of population growth and demographic changes, rising prevalence of chronic diseases, technology advancement, manpower availability as well as service arrangement of the clusters.

At present, Wong Tai Sin is within the catchment area of the Kowloon Central Cluster (KCC). There are 9 hospitals/healthcare institutions in the KCC providing healthcare services to the residents of the district, including Queen Elizabeth Hospital (QEH) and Kwong Wah Hospital (KWH) which are both equipped with Accident and Emergency (A&E) departments. In future, A&E services for the district will be provided by the New Acute Hospital at Kai Tak Development Area (NAH) and KWH. A service network with other extended care hospitals in the cluster will be formed to provide comprehensive healthcare services continuously in the KCC, including the residents of Wong Tai Sin.

In view of the healthcare services demand of Kowloon, the HA is implementing various hospital development projects in the three Kowloon clusters under the First Hospital Development Plan (HDP). Among the projects, the new Phase 1 Building of the redevelopment project of KWH was completed in late 2022, providing a construction floor area of about 145 000 square metres. As compared to the old KWH, 4 operating theatres, 1 cardiac catheterisation room, 4 endoscopy rooms, 1 magnetic resonance imaging room and a one-stop ambulatory care centre are provided additionally. For the new A&E Department, which is approximately three times the size of the old one, it has an additional Emergency Medicine Ward with 40 beds, isolation areas for infection control and other supporting facilities. With the commissioning of the new A&E department, the average waiting time for patients who, after treatment at the A&E department of KWH, need to wait before being admitted to the hospital has dropped by 24 per cent in the third and fourth quarters of 2024 as compared with the same period in 2023. In addition, upon completion, NAH will provide 2 400 beds and 37 operating theatres, which are more than the existing about 1 940 beds (Note) and 24 operating theatres in QEH. The gross floor area of the A&E department of NAH (including the Emergency Medicine ward) is about thrice the current area of that of QEH.

When planning A&E services, the HA will ensure that the A&E department is located within a reasonable distance from its catchment areas. In further planning the Second HDP, the Health Bureau (HHB) and the HA will continue to review the healthcare services development of the clusters in the Kowloon Region. Various factors, including the territory-wide and regional planning and development strategies as announced by the Planning Department, the Government's latest population statistics, population distribution and demographics projections of various districts, projected service demand, the clusters' healthcare service utilisation, accessibility of medical facilities and the supply and conditions of the land required, will be considered during the process with a view to providing the most appropriate healthcare service model and facilities for meeting the public needs in the long run. Both the redevelopment or expansion of the existing hospitals in Kowloon and the construction of new hospitals subject to the availability of suitable sites, including the feasibility of identifying a suitable site for the construction of a new acute hospital in Wong Tai Sin, are options that would be considered by the HHB and the HA to meet the demand.

After the completion of the review of the Second HDP, the Government will announce details of the hospital development projects, including those in the Kowloon Region, in due course.

Note: Acute and extended care beds.

- End -

CONTROLLING OFFICER'S REPLY**HHB189****(Question Serial No. 1328)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (2) HealthControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

Bile duct cancer is a relatively rare but highly fatal cancer. As its symptoms are not obvious in the early stage, bile duct cancer is usually diagnosed at the advanced stage, leaving patients with limited treatment options. Regarding the treatment of bile duct cancer, will the Government inform this Committee of the following:

1. the number of cases diagnosed with bile duct cancer and deaths due to bile duct cancer in each of the past 5 years, as well as the five-year survival rate for patients; and
2. in view of the wide acceptance of combining Durvalumab with chemotherapy as a first-line treatment for bile duct cancer by the overseas medical community, will the Government consider including the above treatment in the drug formulary and safety net to benefit patients with bile duct cancer? If yes, what are the work plan, timetable, and estimated expenditure; if not, what are the reasons?

Asked by: Hon YANG Wing-kit (LegCo internal reference no.: 6)Reply:

1.

According to the statistics of the Hong Kong Cancer Registry, the number of cases diagnosed with bile duct cancer ^{Note} each year from 2018 to 2022 is set out below. The numbers of new cases for 2023 and 2024 are not yet available.

Year	Number of new cases
2018	395
2019	462
2020	443
2021	470
2022	456

The numbers of deaths from bile duct cancer from 2019 to 2023 are set out below. The number of deaths is determined based on the "Number of Deaths by Leading Causes of Death,

2001-2023” released by the Centre for Health Protection of the Department of Health. The number of deaths for 2024 is not yet available.

Year	Number of deaths
2019	387
2020	375
2021	421
2022	395
2023	416

The HA does not maintain statistics on the five-year survival rate of patients.

Note: Including intrahepatic and extrahepatic bile duct cancer

2.

As the major provider of publicly funded public healthcare services, the Hospital Authority (HA) attaches great importance to the provision of optimal care for all patients (including cancer patients) while ensuring patients have equitable access to cost-effective drugs of proven safety and efficacy under the highly subsidised public healthcare system.

On drug management, the HA has mechanisms in place to regularly appraise new drugs and review the HA Drug Formulary (HADF) and the coverage of the safety net (including the Samaritan Fund and the Community Care Fund Medical Assistance Programmes). In evaluating applications for inclusion of new drugs in the HADF and the coverage of the safety net, the HA follows an evidence-based approach, having regard to the principles of safety, efficacy and cost-effectiveness and other relevant factors including international recommendations and practices as well as views from professionals and patient groups.

Besides, the Government and the HA will press ahead with the implementation of the fees and charges reform for public healthcare announced recently, which aims to guide the public to make optimal use of healthcare resources through 3 aspects, namely reforming the subsidisation structure, reducing wastage and abuse, and enhancing healthcare protection. It also seeks to strengthen the healthcare protection on all fronts for patients who are “poor, acute, serious or critical”. Such measures include enhancing the protection in terms of drugs and medical devices for critically ill patients (including cancer patients) through accelerating the introduction of more effective innovative drugs and devices to the HADF and the coverage of the safety net, with a view to ensuring that the limited healthcare resources can be directed in a more targeted manner to assist those patients most in need. This will thereby enhance the sustainability of the healthcare system so as to cope with the challenges posed by an ageing population, inflation of healthcare cost, etc., and serve as a safety net for all.

The HA will keep in view to the latest scientific and clinical evidence on different drugs for treatment of various types of cancer (including bile duct cancer), with a view to ensuring that patients are provided with cost-effective drugs of proven safety and efficacy as well as optimal care on a continuous basis.

- End -

CONTROLLING OFFICER'S REPLY

HHB190

(Question Serial No. 1332)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority, (4) Subvention: Prince Philip Dental Hospital

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

On recruiting non-locally trained dentists to practise in Hong Kong under limited registration and special registration, please advise this Committee of:

1. the number of job applications submitted by non-locally trained dentists under limited registration and special registration to the Department of Health (DH) and the Hospital Authority (HA), the number of applications for the 2 types of registration submitted to the Dental Council of Hong Kong (DCHK), the number of applications approved by the DCHK, and the number of appointment letters issued by the DH and the HA;
2. the number of applicants under limited registration and special registration, their employing institutions, the countries/places where they have obtained their dentistry qualifications, and the number of applicants with qualifications in specialties of dentistry;
3. the posts of non-locally trained dentists employed by the DH and the HA under limited registration and special registration; and
4. the publicity for the registration pathway for non-locally trained dentists undertaken by and the recruitment exercises conducted by the DH and the HA in places outside Hong Kong, as well as the details of the expenditure so involved.

Asked by: Hon YANG Wing-kit (LegCo internal reference no.: 10)

Reply:

1. to 4.

The Dentists Registration (Amendment) Bill 2024, which was passed by the Legislative Council in July 2024, took effect on 1 January 2025. The amendment aims to introduce new pathways to admit qualified non-locally trained dentists, including limited registration (LR) which is open to all dentists and special registration (SR) targeting specialist dentists. Non-locally trained dentists who are selected for full-time employment in specified institutions,

including the Department of Health (DH), the Hospital Authority (HA), the University of Hong Kong (HKU) and the Prince Philip Dental Hospital (PPDH), may apply to the Dental Council of Hong Kong (DCHK) for LR or SR and, upon approval, directly practise in the aforementioned specified institutions. In addition to the aforementioned 4 specified institutions, in February 2025, 34 non-governmental organisations participating in designated publicly-funded dental programmes and 1 training institution for dental care professionals have been further included under the Dentists Registration Ordinance (DRO).

The DH launched a recruitment exercise for full-time Contract Dentist (General Dentistry) from July to September 2024 and accepted applications from both locally trained and non-locally trained dentists. In addition to disseminating information on its website for access from around the world, the DH conducted promotion in different regions through offices outside Hong Kong. At the same time, the relevant information was disseminated to dental training institutions and dentists organisations outside Hong Kong. Online briefing sessions were held to introduce the job opportunities offered by the DH to interested parties in the Mainland and overseas. Over 90 applications in total from non-locally trained dentists were received during the period. As at 28 February 2025, the DH issued conditional offers to 11 non-locally trained dentist applicants who have been assessed to be suitable for appointment. They will join the DH upon completion of their applications to the DCHK and issuance of LR or SR. Among these 11 appointed non-locally trained dentists, 3 of them have applied to the DCHK for LR and their applications have been approved. They assumed duty on 10 March 2025. The countries/places where the 3 applicants obtained their dentistry qualifications are China (including the Mainland, the Macao Special Administrative Region and Taiwan region) (2 applicants) and the United Kingdom (1 applicant).

Separately, as at 28 February 2025, the DCHK also received 1 application for LR relating to employment with HKU. The application is being processed.

The HA will make appropriate arrangements in the light of service needs and vacancies. At present, HA is not conducting any promotion or publicity regarding the registration pathway for non-locally trained dentists, nor carrying out any recruitment exercise.

- End -

CONTROLLING OFFICER'S REPLY

HHB191

(Question Serial No. 1333)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

On recruiting non-locally trained doctors to practise in Hong Kong under limited registration and special registration, will the Government inform this Committee of the following:

1. the number of job applications submitted by non-locally trained doctors under limited registration and special registration to the Hospital Authority (HA), the number of applications for limited registration and special registration submitted by the HA to the Medical Council of Hong Kong (MCHK), the number of applications for limited registration and special registration approved by the MCHK, the number of appointment letters issued by the HA, the number of non-locally trained doctors accepting the HA's appointment offers, and the number of non-locally trained doctors resigning from the HA in each of the past 3 years;
2. the number of applications for limited registration and special registration received (including applications from doctors with recognised medical qualifications and from those with limited registration bridging to the special registration regime), the institutions where those doctors serve, the countries/places where those doctors obtained their medical qualifications, and the number of those who have acquired specialist qualifications;
3. the years of service in the HA of doctors with limited registration and special registration employed by the HA, their specialties and posts in each of the past 3 years in table form;
4. the number of non-locally trained doctors receiving specialist training offered by the constituent specialty colleges of the Hong Kong Academy of Medicine (HKAM), with a breakdown by specialty college; and
5. the number of publicity events promoting the special registration pathway to non-locally trained doctors and recruitment exercises conducted by the HA in places outside Hong Kong and the expenditure involved last year.

Asked by: Hon YANG Wing-kit (LegCo internal reference no.: 11)

Reply:

The Government has adopted a multi-pronged strategy to tackle the severe shortage of doctors in the public healthcare system. On the admission of qualified non-locally trained doctors, the Government created a new pathway (i.e. special registration (SR)) under the existing Medical Registration Ordinance (MRO) (Cap. 161) in 2021 to allow more qualified non-locally trained doctors to practise in our public healthcare sector so as to increase the supply of doctors in Hong Kong.

1.

Relevant information on recruiting non-locally trained doctors for long-term service in Hong Kong under limited registration (LR) and SR by the HA from 2022-23 to 2024-25 (up to 31 December 2024) is set out in the following table:

	2022-23		2023-24		2024-25 (up to 31 December 2024)	
	LR	SR	LR	SR	LR	SR
Number of job applications from non-locally trained doctors received by the HA ⁽¹⁾⁽²⁾	145	99	984		699	
Number of non-locally trained doctors who accepted job offers from the HA ⁽³⁾	19	19	102	52	50	31
Number of applications for respective registration from the HA to the MCHK ⁽⁴⁾	16	10	65	51	46	32
Number of applications approved by the MCHK ⁽⁵⁾	16	7	56	51	47	32
Number of non-locally trained doctors who departed from the HA	2	0	8	1	10	1

Note:

(1) The HA has refined the criteria and procedures for recruiting non-locally trained doctors since 2023-24. Applicants are not required to select registration pathways when submitting their applications.

(2) The figure reflects the total number of job applications received by the HA in the relevant financial year from non-locally trained doctors, including those submitted via various channels and those received by the HA in overseas recruitment exercises since 2023-24.

(3) The above number includes non-locally trained doctors who have accepted job offers from the HA with applications for registration being processed.

(4) The figure reflects the total number of applications for LR/SR submitted by the HA to the MCHK in the relevant financial year, including those submitted upon acceptance of job offers in the previous financial year, those submitted but pending approval and those for migrating from LR to SR, while excluding renewal applications.

(5) The figure includes applications submitted by the HA in the previous financial year which were subsequently approved by the MCHK in the relevant financial year.

2.

The table below sets out the figures of SR and LR in relation to the number of applications, employing institutions, countries/places where doctors under LR or SR obtained medical qualifications and the number of applicants who have acquired specialist qualifications as at 31 December 2024, according to the information provided by the MCHK:

	SR			LR
	Holding recognised medical qualifications	Bridging from LR	Total	
Number of applications				
- Number of applicants ^{Note (1)}	108	13	121	436
- Number of approved applicants ^{Note (1)}	106	13	119 ^{Note (2)}	436
- Number of applicants with registration in effect	93 ^{Note (8)}	13	106	315 ^{Note (4)}
Employing Institutions				
- The University of Hong Kong	4	5	9	27
- The Chinese University of Hong Kong	2	7	9	51
- HA	79	1	80	200
- Department of Health	8	0	8	16
- Clinics exempted from the provisions of section 7 of the Medical Clinics Ordinance	Not applicable			7
- Public or private hospitals/medical institutions which are registered with the health administrative department of the local people’s government in the Mainland/the Health Bureau of Macao Special Administrative Region	Not applicable			14 ^{Note (5)}

	SR			LR
	Holding recognised medical qualifications	Bridging from LR	Total	
(SAR)				
Total	93	13	106	315
Countries/places where the medical qualifications were obtained				
- China (Except Hong Kong) ^{Note (6)}	9	1	10	128
- United Kingdom	63	6	69	72
- Australia	15	0	15	15
- New Zealand	0	0	0	2
- Canada	2	2	4	5
- United States	2	2	4	8
- Singapore	0	0	0	2
- South Africa	2	1	3	3
- India	0	0	0	7
- Others	Not applicable	1 ^{Note (7)}	1	73 ^{Note (8)}
Total	93	13	106	315
Specialist qualifications acquired ^{Note (9)}				
- Anaesthesiology	4	0	4	1
- Clinical Oncology	1	0	1	0
- Emergency Medicine	0	1	1	0
- Family Medicine	1	0	1	0
- Gastroenterology & Hepatology	1	2	3	0
- General Surgery	0	0	0	1
- Geriatric Medicine	0	1	1	0
- Intensive Care	0	0	0	1
- Medical Oncology	0	1	1	0
- Neurosurgery	1	0	1	0
- Obstetrics & Gynaecology	0	0	0	1
- Ophthalmology	0	1	1	2
- Otorhinolaryngology	0	1	1	0
- Paediatrics	0	1	1	2
- Pathology	0	0	0	1
- Public Health Medicine	0	2	2	0
- Radiology	1	3	4	1
- Rheumatology	0	0	0	1
- Urology	1	0	1	0
Total	10	13	23	11

Note:

- (1) The numbers of applicants and approved applicants include the numbers from 1 January 2022 to 31 December 2024, excluding renewal applications.
- (2) Among the 121 SR applications, 1 application was not approved and 1 application was approved in January 2025.
- (3) Among the 106 approved SR doctors holding recognised medical qualifications, the SR of 9 applicants came into effect only after 31 December 2024, 3 applicants had their SR terminated before 31 December 2024 and 1 applicant passed the MCHK's licensing examination and became a doctor with full registration in February 2024. The number of applicants with SR in effect includes renewed applications.
- (4) Among the 436 doctors approved for LR, 20 had their LR came into effect only after 31 December 2024; 101 had their LR terminated on or before 31 December 2024 due to expiry of registration or resignation. The number of doctors with LR in effect includes renewed applications.
- (5) It refers to doctors attending to the medical needs of patients(s) during the direct point-to-point cross-boundary ambulance transfer service between Hong Kong SAR and the Mainland/Macao SAR and attending to the medical needs of the patient(s) under transfer according to Promulgation No. 13 on LR under the MRO (Cap. 161).
- (6) Including the Mainland China, the Macao SAR and the Taiwan region.
- (7) The doctor with SR obtained his medical qualification in the Czech Republic.
- (8) Regarding the 73 doctors with LR, the countries/regions involved are: the Czech Republic (2), the Philippines (13), Sri Lanka (2), Ireland (13), France (1), Italy (1), the Netherlands (2), Argentina (1), Malaysia (15), Thailand (3), Saudi Arabia (2), Russia (3), Japan (1), Turkey (3), Poland (2), Germany (2), Myanmar (1), Indonesia (2), Pakistan (1), Colombia (1), Hungary (1) and Nigeria (1).
- (9) It refers to the number of specialists whose names are included in the Specialist Register of the MCHK as at 31 December 2024 and their relevant specialties.

3.

The years of service of non-locally trained doctors who provided services in the HA through the LR pathway, including those who came to Hong Kong for exchanges, with breakdown by specialty and rank, from 2022-23 to 2024-25 (as at 31 December 2024) are set out in the following table:

Specialty	Number of doctors ^{Note(1)}									Total
	Consultant			Associate Consultant			Resident			
	<1 Year	1 - <6 Years	6 - <11 Years	<1 Year	1 - <6 Years	6 - <11 Years	<1 Year	1 - <6 Years	6 - <11 Years	
2022-23										
Anaesthesia	0	0	0	0	3	0	0	2	0	5
Cardiothoracic Surgery	0	0	0	1	3	0	0	0	0	4
Ear, Nose & Throat	0	0	0	1	0	0	0	0	0	1
Emergency Medicine	0	0	0	0	0	0	0	2	1	3

Specialty	Number of doctors ^{Note(1)}									Total
	Consultant			Associate Consultant			Resident			
	<1 Year	1 - <6 Years	6 - <11 Years	<1 Year	1 - <6 Years	6 - <11 Years	<1 Year	1 - <6 Years	6 - <11 Years	
Family Medicine	0	0	0	0	0	0	1	6	1	8
Internal Medicine	0	0	0	0	0	0	5	1	1	7
Neurosurgery	0	0	0	0	2	0	0	1	0	3
Obstetrics & Gynaecology	0	0	0	0	1	0	0	0	0	1
Ophthalmology	0	0	0	1	1	0	1	0	0	3
Paediatrics	0	0	0	0	0	0	2	4	0	6
Pathology	0	0	0	0	0	0	1	0	0	1
Psychiatry	0	0	0	0	0	0	1	0	0	1
Radiology	0	0	0	2	3	0	0	0	0	5
Surgery	0	0	0	0	1	0	0	1	0	2
Total	0	0	0	5	14	0	11	17	3	50
2023-24										
Anaesthesia	0	0	0	1	1	0	4	1	0	7
Cardiothoracic Surgery	0	0	0	0	3	0	1	0	0	4
Clinical Oncology	0	0	0	0	0	0	1	0	0	1
Ear, Nose & Throat	0	0	0	0	1	0	1	0	0	2
Emergency Medicine	0	0	0	0	0	0	5	2	1	8
Family Medicine	0	0	0	0	0	0	3	6	1	10
Intensive Care Unit	0	0	0	0	0	0	1	0	0	1
Internal Medicine	0	0	0	8	0	0	11	4	1	24
Neurosurgery	0	0	0	0	1	0	2	1	0	4
Obstetrics & Gynaecology	0	0	0	0	0	0	2	0	0	2
Ophthalmology	0	0	0	2	2	0	2	1	0	7
Orthopaedics & Traumatology	0	0	0	0	0	0	3	0	0	3
Paediatrics	0	0	0	0	0	0	5	5	0	10
Pathology	0	0	0	0	0	0	1	1	0	2
Psychiatry	0	0	0	0	0	0	2	1	0	3

Specialty	Number of doctors ^{Note(1)}									Total
	Consultant			Associate Consultant			Resident			
	<1 Year	1 - <6 Years	6 - <11 Years	<1 Year	1 - <6 Years	6 - <11 Years	<1 Year	1 - <6 Years	6 - <11 Years	
Radiology	0	0	0	2	5	0	7	0	0	14
Surgery	0	0	0	0	1	0	2	1	0	4
Total	0	0	0	13	14	0	53	23	3	106
2024-25 (as at 31 December 2024)										
Anaesthesia	0	0	0	0	1	0	16	3	0	20
Cardiothoracic Surgery	0	0	0	0	2	1	2	1	0	6
Clinical Oncology	0	0	0	0	0	0	1	0	0	1
Ear, Nose & Throat	0	0	0	1	1	0	0	1	0	3
Emergency Medicine	0	0	0	1	0	0	3	6	1	11
Family Medicine	0	0	0	0	0	0	4	9	1	14
Intensive Care Unit	0	0	0	0	0	0	3	1	0	4
Internal Medicine	0	0	0	2	0	0	28	6	1	37
Neurosurgery	0	0	0	0	1	0	1	3	0	5
Obstetrics & Gynaecology	0	0	0	0	0	0	1	1	0	2
Ophthalmology	0	0	0	1	1	0	7	2	0	11
Orthopaedics & Traumatology	0	0	0	0	0	0	3	3	0	6
Paediatrics	0	0	0	0	1	0	7	4	0	12
Pathology	0	0	0	0	0	0	5	1	0	6
Psychiatry	0	0	0	0	0	0	3	2	0	5
Radiology	0	0	0	0	5	0	6	6	0	17
Surgery	0	0	0	1	1	0	17	2	0	21
Total	0	0	0	6	13	1	107	51	3	181

Note:

- (1) Including 2 non-locally trained doctors who migrated from LR to full registration in December 2024.

The years of service of non-locally trained doctors who provided services in the HA through the SR pathway, including those who came to Hong Kong for exchanges, with breakdown by specialty and rank, from 2022-23 to 2024-25 (as at 31 December 2024) are set out in the following table:

Specialty	Number of doctors									Total
	Consultant			Associate Consultant			Resident			
	<1 Year	1 - <6 Years	6 - <11 Years	<1 Year	1 - <6 Years	6 - <11 Years	<1 Year	1 - <6 Years	6 - <11 Years	
2022-23										
Anaesthesia	0	0	0	0	1	0	0	0	0	1
Internal Medicine	0	0	0	0	0	0	0	1	0	1
Radiology	0	0	0	0	1	0	0	0	0	1
Surgery	0	0	0	0	0	0	1	1	0	2
Total	0	0	0	0	2	0	1	2	0	5
2023-24										
Anaesthesia	0	0	0	1	2	1	10	0	0	14
Cardiothoracic Surgery	0	0	0	0	0	0	1	0	0	1
Clinical Oncology	0	0	0	0	0	0	1	0	0	1
Ear, Nose & Throat	0	0	0	0	0	0	2	0	0	2
Family Medicine	0	0	0	0	0	0	1	0	0	1
Internal Medicine	0	0	0	0	0	0	9	1	0	10
Neurosurgery	0	0	0	1	0	0	1	0	0	2
Obstetrics & Gynaecology	0	0	0	0	0	0	3	0	0	3
Ophthalmology	0	0	0	0	0	0	2	0	0	2
Orthopaedics & Traumatology	0	0	0	0	0	0	2	0	0	2
Paediatrics	0	0	0	0	0	0	1	0	0	1
Psychiatry	0	0	0	0	0	0	1	0	0	1
Radiology	0	1	0	0	0	0	2	0	0	3
Surgery	0	0	0	0	0	0	5	1	0	6
Total	0	1	0	2	2	1	41	2	0	49
2024-25 (as at 31 December 2024)										
Anaesthesia	0	1	0	2	1	1	8	6	0	19
Cardiothoracic Surgery	0	0	0	0	0	0	1	0	0	1
Clinical Oncology	0	0	0	0	0	0	2	0	0	2
Ear, Nose & Throat	0	0	0	0	0	0	1	1	0	2

Emergency Medicine	0	0	0	0	0	1	0	0	0	1
Family Medicine	0	0	0	0	0	0	1	1	0	2
Intensive Care Unit	0	0	0	0	0	0	1	0	0	1
Internal Medicine	0	0	0	0	0	0	3	8	0	11
Neurosurgery	0	0	0	1	0	0	0	1	0	2
Obstetrics & Gynaecology	0	0	0	0	0	0	2	2	0	4
Ophthalmology	0	0	0	0	0	0	4	0	0	4
Orthopaedics & Traumatology	0	0	0	0	0	0	3	0	0	3
Paediatrics	0	0	0	0	0	0	1	1	0	2
Psychiatry	0	0	0	0	0	0	0	1	0	1
Radiology	0	1	0	0	1	0	7	1	0	10
Surgery	0	0	0	0	0	0	10	5	0	15
Total	0	2	0	3	2	2	44	27	0	80

4.

The number of non-locally trained doctors receiving specialist training offered by the constituent specialty colleges of the Hong Kong Academy of Medicine is 395. A breakdown is set out below:

Colleges	Number of non-local trainees
Anaesthesiologists	44
Community Medicine	11
Dental Surgeons	10
Emergency Medicine	31
Family Physicians	32
Obstetricians & Gynaecologists	11
Ophthalmologists	13
Orthopaedic Surgeons	17
Otorhinolaryngologists	2
Paediatricians	20
Pathologists	9
Physicians	85
Psychiatrists	14
Radiologists	29

Surgeons	67
Total	395

5.

The HA established the Hospital Authority Global Healthcare Professional Recruitment Centre in December 2023 to co-ordinate the recruitment and exchange programmes of non-locally trained healthcare professionals from around the world. Publicity and recruitment drives for non-locally trained doctors include:

No.	Time	Format
1.	April 2023	HA representatives participated in a recruitment exercise organised by the Government of the Hong Kong Special Administrative Region (HKSARG) in London, United Kingdom.
2.	June 2023	HA representatives participated in a recruitment exercise organised by the HKSARG in Sydney, Australia.
3.	July 2023	The HA participated in a web conference organised by the Hong Kong Medical Society of Australia.
4.	September 2023	The HA delegation held meetings with the Beijing Municipal Health Commission and visited several hospitals, taking the opportunity to exchange views with renowned healthcare institutes. While in Beijing, the delegation also participated in the activities of the China International Fair for Trade in Services (CIFTIS), including its Thematic Exhibition on Health Services.
5.	September 2023	The HA delegation visited Malaysia and had exchanges with representatives of local medical schools and universities.
6.	October 2023	The HA delegation visited Portugal and had exchanges with representatives of local hospitals.
7.	December 2023	The HA delegation held a web conference with representatives of hospitals in Germany.
8.	April 2024	HA representatives participated in a recruitment exercise organised by the HKSARG in London and Manchester, United Kingdom.
9.	May 2024	HA participated in the Global Talent Summit · Hong Kong - CareerConnect Expo organised by the Hong Kong Talent Engage to introduce job or exchange opportunities to participants.
10.	June 2024	The HA delegation visited Wuhan and had exchanges with representatives of local universities and healthcare institutions.
11.	July 2024	The HA delegation visited Singapore and had exchanges with representatives of local healthcare institutions.
12.	August 2024	The HA participated in a web conference organised by the Hong Kong Medical Society of Australia.

No.	Time	Format
13.	September 2024	The HA delegation held meetings with the Beijing Municipal Health Commission and visited several universities and hospitals. While in Beijing, the delegation also participated in the CIFTIS and had exchanges with medical and health experts from different places.
14.	November 2024	The HA delegation held meetings with representatives from the Shanghai Municipal Health Commission, the Health Commission of Zhejiang Province and the Health Commission of Ningbo, and had exchanges with representatives of various hospitals and universities.

The manpower and expenditure involved in the publicity and recruitment drives for non-locally trained doctors are absorbed by the existing provisions of the HA.

- End -

CONTROLLING OFFICER'S REPLY

HHB192

(Question Serial No. 1334)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the Greater Bay Area (GBA) Visiting Doctors Programme, the GBA Chinese Medicine Visiting Scholars Programme, the GBA Specialty Nursing Knowledge-exchange Programme and the GBA Visiting Radiographer (Diagnostic) Programme, will the Government inform this Committee of the following:

1. Since the launch of the above programmes, what are (i) the numbers of Western medicine practitioners, Chinese medicine practitioners, nurses and radiographers who have come to work in Hong Kong; and (ii) the qualifications and specialties of the healthcare professionals?
2. The HA is exploring the extension of the GBA Healthcare Talent Exchange Programme to cover more specialties. What are the details of the plan? and
3. The HA is gradually planning and actively exploring to establish two-way talent exchange with Beijing and Shanghai. What is the progress of the plan?

Asked by: Hon YANG Wing-kit (LegCo internal reference no.: 12)

Reply:

1. & 2.:

The Hospital Authority (HA) has all along been actively promoting the exchange of healthcare talents and, with support from the Health Commission of Guangdong Province (GDHC) and the Health Bureau of the HKSAR Government, has implemented the Greater Bay Area (GBA) Healthcare Talents Visiting Programmes since the fourth quarter of 2022. The programmes cover healthcare personnel of various disciplines, including doctors, nurses, allied health professionals and CM practitioners, and were well received by participating healthcare professionals of both places. Having worked in concerted efforts, the healthcare professionals conducted exchanges with their counterparts to achieve the anticipated outcomes. Details of the Programmes are set out below:

GBA Visiting Doctors Programme

This programme aims to establish a mechanism for doctors working in the public healthcare system in the Guangdong Province and Hong Kong to undergo exchanges in public hospitals of the other place. A participating GBA doctor must be a holder of a Bachelor of Medicine degree in clinical western medicine or equivalent academic qualifications serving in a Tier III Class A hospital in the Mainland at the rank of Attending Physician or above, and having met the clinical experience requirements of the relevant speciality.

Under the first batch launched in April 2023, 10 GBA doctors nominated by the GDHC successfully completed a year of exchange in April 2024. Their specialties include Respiratory Medicine, Infectious Disease, Nephrology, Cardiology, Anaesthesiology and Radiology. In view of the desirable outcomes of exchange from the first batch, the HA conducted a trial of an ophthalmology pilot exchange programme with Zhongshan Ophthalmic Center of Sun Yat-Sen University in March 2024. 2 participating ophthalmologists completed a half-year exchange in Hong Kong in August 2024, during which they performed in a number of ophthalmology operations and procedures, providing optimal treatment to patients whilst having fostered the development of ophthalmology services in Hong Kong.

Building on the success from the above exchange programmes, the HA has progressively explored the expansion of the visiting doctors programme with stakeholders in the GBA since 2024. Under the co-ordination of the GDHC, the second phase of the exchange programme has expanded to cover 9 GBA cities, with 34 selected doctors from 8 clinical specialties participating in the exchange. Their specialties include Ophthalmology, Cardiology, Anaesthesiology, Integrated Medicine, Emergency Medicine, Hepatobiliary Surgery, Endoscopy, and Radiology.

In addition, according to the co-operation agreement signed between the HA and the First Affiliated Hospital of Sun Yat-sen University (FAHSYU) in the first quarter of 2024, the hospital has also nominated the first batch of 13 doctors from various specialties for exchange in Hong Kong. Their specialties include Cardiology, Anaesthesiology, Integrated Medicine, Emergency Medicine, Hepatobiliary Surgery, Endoscopy, Radiology, Intensive Care Medicine, Clinical Oncology, and Cardiothoracic Surgery. After obtaining the required licences of registration and relevant visas, the above 47 GBA visiting doctors (including 34 doctors under the second phase of the exchange programme and 13 doctors from FAHSYU) came to Hong Kong in batches between the fourth quarter of 2024 and the first quarter of 2025 to commence a year of clinical exchange.

These visiting doctors work with local healthcare teams to provide optimal clinical services or perform proper medical procedures for patients. Some of the more experienced visiting doctors share their professional skills with local doctors to strengthen the clinical capabilities of local teams. On the other hand, these visiting doctors gain insight into the management model and health information technology of Hong Kong's public healthcare system. The programme showcases the enhanced professional exchange between the two places and fully realises the spirit of mutual learning and enrichment with a patient-centred and professional-minded approach.

GBA Specialty Nursing Knowledge-Exchange Programme

The HA have recruited a total of 300 experienced nurses in 3 cohorts from the Guangdong Province to join the exchange programme within the two years starting from 2023, providing them with online learning followed by 45-week on-site clinical practicum at selected service areas of HA hospitals. All exchange visitors must hold a Bachelor Degree in Nursing and possess at least 3 years of post-registration nursing experience in related specialty area. Priority is given to those currently working in Tier III Class A hospitals in the Mainland.

The HA will organise online briefings by specialty tutors on nursing care in the relevant specialty areas for exchange nurses before their departure. After their arrival, practicum hospitals will offer induction training to familiarise them with the organisation structure and daily operation of the hospitals. On adaptation to life in Hong Kong and clinical practicum, cluster coordinators and clinical tutors will provide exchange nurses with appropriate support.

The first cohort of 70 nurses completed clinical practicum in Geriatric Nursing in February 2024. Another 99 exchange nurses of the second cohort completed clinical practicum in Geriatric Nursing, Peri-operative Nursing, Critical Care, Cardiac Critical Care, Ophthalmology and Endoscopy in January 2025. During the exchange period, the Guangdong and HA nurses worked closely. Their clinical expertise and application of skills were elevated through mutual interactions.

With the implementation of the amended Nurses Registration Ordinance, the HA and the GDHC have reached the consensus to further expand the programme beyond the above specialties to cover Emergency Care, Nephrology and Stroke Care. The HA will also assist the entire third cohort of about 130 Guangdong nurses in their applications for limited registration, thereby enabling them to engage intensively in clinical work for a more comprehensive experience during their stay. To further raise the nursing standards in the GBA and foster professional development, the HA is exploring with the GDHC on the possibility of regularising and further expanding the programme, while also planning to initiate exchange and collaborative programmes with other potential partners.

Furthermore, the HA sent a 26-strong delegation to visit 4 Tier III Class A hospitals in Guangdong Province in January 2024 for a 3-day study tour so as to deepen its nursing leaders' understanding of the modus operandi of Mainland hospitals. Later in December 2024, 17 nurses specialising in Neonatal Care or Obstetrics and Gynaecology also visited the Guangzhou Women and Children's Medical Center and Guangzhou's breast milk bank for clinical observation. The HA will keep engaging various stakeholders to explore the development of two-way exchange programmes, envisioning a multi-win situation with ongoing interflow of nursing talents between Hong Kong and other GBA cities.

GBA Visiting Radiographer (Diagnostic) Programme

The GBA Visiting Radiographer (Diagnostic) Programme was successfully completed in August 2023. Subjects of exchange in the first phase include: Radiology (different categories of radiological imaging) and Medical Physics. 5 diagnostic radiographers from Tier III Class A hospitals were nominated by the GDHC for a 2-week technical exchange. Subsequently, in January 2024, the HA sent 14 radiographers and 5 medical physicists to several Tier III Class A hospitals in the Guangdong Province for a two-way exchange.

Building on the successful experience of the first phase of the two-way exchange programme, which has laid a solid foundation for future exchange in the radiography and oncology professions between the two places, the HA and the GDHC have discussed and further expanded the second phase of the two-way exchange programme to include radiotherapists and enhanced it as the Guangdong-Hong Kong Allied Healthcare Talents Visiting Programme (「粵港專職醫療人才交流計劃」), so as to foster exchange in the radiography and oncology professions between the two places in a more comprehensive manner. Subjects of exchange in the second phase include: Radiology (different categories of radiological imaging), Clinical Oncology (different categories of radiation therapy techniques), and Medical Physics. The GDHC sent a total of 35 allied health professionals for a one-week exchange in Hong Kong, including 5 radiation therapists, 5 physiotherapists and 25 radiographers in August, September and November 2024 respectively. Separately, the HA also arranged to send 17 radiographers, 11 medical physicists and 13 radiotherapists for a one-week in-depth exchange at Tier III Class A hospitals in the Guangdong Province in January 2025, so as to enhance their understanding about the practice and service models in the Mainland.

In view of the successful experience and positive response of the Guangdong-Hong Kong Allied Healthcare Talents Visiting Programme, the HA is actively preparing for the implementation of the next phase with the GDHC, including inviting the third batch of allied health personnel from the Guangdong Province for exchange in Hong Kong. The HA is also exploring the feasibility of in-depth exchange and placement for the third batch of its allied healthcare teams at Tier III Class A hospitals in the Guangdong Province.

GBA CM Visiting Scholars Programme

To expedite the development of local core CM clinical talents, the HA launched the GBA CM Visiting Scholars Programme in November 2022. This “mentoring and shadowing model” CM in-patient training programme, being the first of its kind in Hong Kong, enhances the professional competency of our CM practitioners (CMPs) and fosters the development of our Integrated Chinese-Western Medicine (ICWM) services by inviting CM experts from Tier III Class A CM hospitals in the GBA and under limited registration granted by the Chinese Medicine Council of Hong Kong to coach and provide in-patient clinical training in our public hospitals for CMPs from the CM Clinics cum Training and Research Centres (CMCTRs) across 18 districts.

Since the launch of the programme, around 20 experienced CM experts have joined the CM expert pool and come to Hong Kong in phases with around 130 local CMPs having received training so far.

Nominated by the GDHC, visiting scholars have to be at the rank of Associate Chief Physician or above, and with solid clinical experience in renowned hospitals or institutions. Their specialties include Respiratory Medicine, Neurology, Oncology, Orthopaedics & Traumatology, and Acupuncture, etc. With a view to nurturing more CM clinical talents, the HA will continue to maintain close liaison and collaboration with the current CM hospitals in the GBA, and explore the feasibility of exchange and cooperation with provinces and cities beyond GBA for training of talents and extension to more types of diseases subject to the development of ICWM services.

CM Enhanced In-patient Training Programme with the GBA

In April 2024, the HA launched the CM Enhanced In-patient Training Programme with the GBA, a first-of-its-kind training programme that makes a breakthrough in arranging CMPs selected from the 18 CMCTRs to obtain Mainland practising qualifications, enabling them to participate in the clinical teams of CM hospitals in the GBA for clinical work and receive advanced in-patient clinical training. The Guangdong Provincial Hospital of Traditional Chinese Medicine is the collaborating training partner for the first phase of the Programme. At present, a total of 16 local CMPs have joined the Programme, and the training covers neurology, acupuncture and oncology.

The HA will maintain close liaison and collaboration with CM hospitals in the GBA to dovetail with the development of ICWM for training of talents and extension to various types diseases.

3.

HK-Shanghai and HK-Beijing Two-Way Exchange Programmes

The HA has all along dovetailed the policy directions of the HKSAR Government, and strived to press ahead with the two-way training and exchange of healthcare talents between Hong Kong and the Mainland. Since the announcement of the relevant directions in the Chief Executive's Policy Address 2023, the HA has actively discussed with different Mainland cities, including Beijing and Shanghai, on establishing a two-way talent exchange mechanism, with a view to enhancing exchanges with healthcare talents in terms of depth and breadth.

In respect of Shanghai, the arrangements for exchanges with healthcare talents were formalised after a consensus had been reached between the HA and the Shanghai Municipal Health Commission on the launch of the two-way healthcare talents training and exchange programme between the two places in the first quarter of 2024. Since March 2024 (as at 31 December 2024), 6 doctors have either completed or been participating in the exchange in Hong Kong, and their specialties covering Endoscopy, Cardiology, Organ Transplantation and Anaesthesiology; while the HA has also arranged for 3 doctors in Cardiology and Organ Transplantation to participate in clinical exchange in Shanghai, with 2 of them for practice exchange and 1 for clinical observation. With regard to nurses, the HA sent 4 nurses to Shanghai to engage in clinical observation from June to September 2024, with 2 Advanced Practice Nurses (Perfusionist) and 2 Advanced Practice Nurses (Perfusionist Trainee) having completed their exchange in 1 week and 4 weeks respectively.

As for Beijing, the details of two-way exchange between Beijing and Hong Kong have been implemented progressively over the past year, with specialties covering Orthopaedics & Traumatology, Neurosurgery, and Rare Diseases. In August 2024, the Beijing Municipal Health Commission sent 5 orthopaedic doctors to Hong Kong to engage in clinical observation, while the HA also plans to send more than 10 doctors to Beijing for exchange within the said specialty. As at 31 December 2024, 5 HA doctors have either started or completed their exchange in Beijing, with more doctors about to start in 2025 progressively. In addition, the HA signed a collaborative agreement with the Peking Union Medical College Hospital (PUMCH) in January 2024 on strengthening exchanges and co-operation between

the two parties in the development and management of public hospitals. Currently, the arrangements for the two-way exchanges with healthcare talents between the HA and the PUMCH are being implemented in an orderly manner. It is expected that, in 2025, the first batch of PUMCH doctors will visit Hong Kong for clinical exchange, at the same time the HA will continue to identify suitable doctors in their respective specialties and send them for exchange in Beijing.

Looking ahead to 2025, the HA is actively exploring with more stakeholders to establish two-way exchange, including short-term observation exchange, medium-term clinical practice exchange and sending healthcare professionals from Hong Kong to the Mainland for mutual learning and exchange in the latter's public hospitals, with a view to expanding the talent pool of Hong Kong's public healthcare system.

- End -

CONTROLLING OFFICER'S REPLY

HHB193

(Question Serial No. 1335)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the staffing arrangements of healthcare staff in the Hospital Authority, will the Government please set out:

1. by hospital clusters, the establishment, existing strength, intake number, attrition number and retirement number of specialists and specialty nurses of each specialty and allied health professionals of all major grades in each of the past 3 years;
2. by years of service and rank group, the attrition number of specialists and specialty nurses of each specialty in each of the past 3 years;
3. by years of service, the number of doctors promoted to the ranks of Consultant and Senior Medical Officer/Associate Consultant in each of the past 3 years;
4. by years of service, the number of nurses promoted to the rank of Advanced Practice Nurse in each of the past 3 years; and
5. whether any new measures will be introduced to attract and retain talents, and the estimated expenditure involved; if yes, the details; if not, the reasons for that?

Asked by: Hon YANG Wing-kit (LegCo internal reference no.: 13)

Reply:

1.

The Hospital Authority (HA) delivers healthcare services through a multi-disciplinary team approach involving doctors, nurses, allied health professionals and care-related support staff. The HA assesses its manpower situation from time to time and flexibly deploys its staff to meet service and operational needs.

The tables below set out the manpower strength, intake number and full-time attrition (wastage) number of doctors by major specialty in each hospital cluster of the HA from 2022-23 to 2024-25 (April – December 2024):

2022-23

Cluster	Major Specialty	Manpower Strength (As at 31.3.2023) (Include FT and PT)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
HKEC	Accident & Emergency	56	9	1	10
	Anaesthesia	39	3	0	2
	Family Medicine	56	4	1	4
	Intensive Care Unit	17	5	0	0
	Medicine	163	15	4	19
	Neurosurgery	14	1	0	1
	Obstetrics & Gynaecology	21	1	0	1
	Ophthalmology	24	5	0	1
	Orthopaedics & Traumatology	38	4	0	0
	Paediatrics	29	2	0	3
	Pathology	23	2	0	0
	Psychiatry	43	5	0	3
	Radiology	45	3	0	2
	Surgery	54	10	0	2
	Others	31	5	0	4
	Total	651	74	6	52
HKWC	Accident & Emergency	26	2	1	4
	Anaesthesia	67	5	0	5
	Cardiothoracic Surgery	13	2	1	0
	Family Medicine	45	4	0	2
	Intensive Care Unit	14	2	0	3
	Medicine	165	16	1	8
	Neurosurgery	13	2	0	0
	Obstetrics & Gynaecology	26	3	1	3
	Ophthalmology	15	1	0	1
	Orthopaedics & Traumatology	39	2	0	1
	Paediatrics	36	4	2	1
	Pathology	35	6	0	3
	Psychiatry	25	2	0	4
	Radiology	30	3	2	4
	Surgery	84	5	0	3
	Others	32	4	0	4
	Total	666	63	8	46
KCC	Accident & Emergency	85	5	2	5
	Anaesthesia	111	6	3	4

Cluster	Major Specialty	Manpower Strength (As at 31.3.2023) (Include FT and PT)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Cardiothoracic Surgery	20	2	0	2
	Family Medicine	113	6	1	6
	Intensive Care Unit	23	2	0	0
	Medicine	293	21	3	12
	Neurosurgery	36	3	1	1
	Obstetrics & Gynaecology	55	4	0	2
	Ophthalmology	37	4	1	3
	Orthopaedics & Traumatology	66	2	0	2
	Paediatrics	178	17	1	6
	Pathology	60	6	0	3
	Psychiatry	42	2	1	4
	Radiology	86	9	1	2
	Surgery	123	17	2	10
	Others	56	5	0	3
	Total	1 383	111	16	65
KEC	Accident & Emergency	72	3	2	5
	Anaesthesia	53	1	0	2
	Family Medicine	96	14	2	8
	Intensive Care Unit	14	0	0	0
	Medicine	196	20	1	11
	Obstetrics & Gynaecology	33	3	0	1
	Ophthalmology	22	2	0	1
	Orthopaedics & Traumatology	58	4	0	1
	Paediatrics	44	0	0	1
	Pathology	31	2	1	1
	Psychiatry	44	0	0	3
	Radiology	36	5	0	2
	Surgery	64	6	0	4
	Others	33	4	0	5
	Total	796	64	6	45
KWC	Accident & Emergency	124	12	3	6
	Anaesthesia	67	4	1	9
	Family Medicine	118	8	1	7
	Intensive Care Unit	32	3	0	1
	Medicine	245	27	4	6
	Neurosurgery	15	1	0	0

Cluster	Major Specialty	Manpower Strength (As at 31.3.2023) (Include FT and PT)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Obstetrics & Gynaecology	23	2	0	7
	Ophthalmology	25	7	0	3
	Orthopaedics & Traumatology	75	5	0	1
	Paediatrics	59	3	1	1
	Pathology	51	7	0	6
	Psychiatry	75	10	1	1
	Radiology	46	4	2	1
	Surgery	105	9	0	5
	Others	49	6	1	5
	Total	1 110	108	14	59
NTEC	Accident & Emergency	82	3	1	4
	Anaesthesia	64	9	0	4
	Cardiothoracic Surgery	13	2	0	2
	Family Medicine	106	9	1	8
	Intensive Care Unit	30	2	0	3
	Medicine	238	18	3	10
	Neurosurgery	13	2	0	1
	Obstetrics & Gynaecology	34	2	0	1
	Ophthalmology	27	1	0	2
	Orthopaedics & Traumatology	70	4	0	2
	Paediatrics	58	1	0	3
	Pathology	45	7	3	0
	Psychiatry	71	6	0	3
	Radiology	47	3	0	3
	Surgery	89	14	0	5
	Others	58	4	0	1
	Total	1 045	87	8	52
NTWC	Accident & Emergency	95	4	0	5
	Anaesthesia	58	2	0	3
	Cardiothoracic Surgery	2	0	0	0
	Family Medicine	90	6	1	4
	Intensive Care Unit	24	2	0	2
	Medicine	185	17	0	6
	Neurosurgery	13	2	1	0
	Obstetrics & Gynaecology	33	4	0	4
	Ophthalmology	27	2	1	0
	Orthopaedics & Traumatology	53	2	0	5

Cluster	Major Specialty	Manpower Strength (As at 31.3.2023) (Include FT and PT)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Paediatrics	41	5	2	3
	Pathology	26	3	0	2
	Psychiatry	81	11	2	1
	Radiology	41	2	1	3
	Surgery	75	7	2	5
	Others	38	3	0	4
	Total	881	72	10	47

2023-24

Cluster	Major Specialty	Manpower Strength (As at 31.3.2024) (Include FT and PT)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
HKEC	Accident & Emergency	62	8	0	3
	Anaesthesia	40	4	0	3
	Family Medicine	55	4	0	6
	Intensive Care Unit	21	6	0	0
	Medicine	176	28	1	9
	Neurosurgery	13	2	0	1
	Obstetrics & Gynaecology	23	3	0	1
	Ophthalmology	24	3	0	2
	Orthopaedics & Traumatology	38	1	0	1
	Paediatrics	31	3	0	0
	Pathology	23	1	0	0
	Psychiatry	44	9	0	5
	Radiology	48	5	0	2
	Surgery	53	6	0	2
	Others	32	3	0	0
	Total	683	86	1	35
HKWC	Accident & Emergency	33	8	0	0
	Anaesthesia	59	3	0	12
	Cardiothoracic Surgery	14	6	0	5
	Family Medicine	45	1	0	1
	Intensive Care Unit	16	2	0	1
	Medicine	168	14	1	6
	Neurosurgery	13	2	0	0

Cluster	Major Specialty	Manpower Strength (As at 31.3.2024) (Include FT and PT)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Obstetrics & Gynaecology	30	5	0	1
	Ophthalmology	17	2	0	2
	Orthopaedics & Traumatology	35	1	0	1
	Paediatrics	38	5	0	2
	Pathology	34	0	0	1
	Psychiatry	27	3	0	1
	Radiology	38	6	0	0
	Surgery	86	9	0	9
	Others	33	5	0	2
	Total	687	72	1	44
KCC	Accident & Emergency	91	8	1	3
	Anaesthesia	113	10	0	7
	Cardiothoracic Surgery	19	1	0	0
	Family Medicine	121	11	0	8
	Intensive Care Unit	25	2	0	1
	Medicine	305	30	0	10
	Neurosurgery	37	6	0	1
	Obstetrics & Gynaecology	57	5	0	2
	Ophthalmology	41	5	0	5
	Orthopaedics & Traumatology	70	4	0	4
	Paediatrics	180	11	0	9
	Pathology	62	7	0	1
	Psychiatry	46	8	0	1
	Radiology	95	9	1	1
	Surgery	140	22	1	3
	Others	61	9	0	4
	Total	1 461	148	3	60
KEC	Accident & Emergency	73	6	0	6
	Anaesthesia	56	4	0	6
	Family Medicine	100	11	2	8
	Intensive Care Unit	14	0	0	0
	Medicine	202	22	0	11
	Obstetrics & Gynaecology	32	3	0	3
	Ophthalmology	22	2	0	1
	Orthopaedics & Traumatology	57	3	0	2
	Paediatrics	41	2	0	4
	Pathology	32	2	0	1

Cluster	Major Specialty	Manpower Strength (As at 31.3.2024) (Include FT and PT)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Psychiatry	45	4	0	4
	Radiology	37	1	0	2
	Surgery	69	8	0	1
	Others	32	2	0	4
	Total	815	70	2	53
KWC	Accident & Emergency	131	13	0	10
	Anaesthesia	71	5	0	4
	Family Medicine	124	9	0	7
	Intensive Care Unit	33	2	0	0
	Medicine	251	17	1	6
	Neurosurgery	18	4	0	0
	Obstetrics & Gynaecology	29	5	0	0
	Ophthalmology	27	2	0	1
	Orthopaedics & Traumatology	76	3	1	0
	Paediatrics	56	1	0	2
	Pathology	54	3	1	0
	Psychiatry	79	6	0	2
	Radiology	50	3	0	0
	Surgery	98	9	0	7
	Others	50	5	1	0
	Total	1 146	87	4	39
NTEC	Accident & Emergency	90	7	0	2
	Anaesthesia	66	11	0	6
	Cardiothoracic Surgery	14	1	0	0
	Family Medicine	104	7	0	8
	Intensive Care Unit	27	4	0	3
	Medicine	242	18	2	11
	Neurosurgery	13	1	0	0
	Obstetrics & Gynaecology	34	3	0	2
	Ophthalmology	29	4	0	0
	Orthopaedics & Traumatology	70	5	0	3
	Paediatrics	55	3	0	3
	Pathology	43	2	0	4
	Psychiatry	69	5	0	2
	Radiology	54	7	0	2
	Surgery	101	16	0	2
	Others	60	4	0	2

Cluster	Major Specialty	Manpower Strength (As at 31.3.2024) (Include FT and PT)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Total	1 072	98	2	50
NTWC	Accident & Emergency	88	7	1	9
	Anaesthesia	65	5	0	2
	Cardiothoracic Surgery	3	1	0	0
	Family Medicine	96	10	0	3
	Intensive Care Unit	25	1	0	0
	Medicine	191	25	0	11
	Neurosurgery	14	2	0	0
	Obstetrics & Gynaecology	34	2	0	1
	Ophthalmology	28	3	2	0
	Orthopaedics & Traumatology	55	4	0	1
	Paediatrics	39	4	0	4
	Pathology	29	3	0	2
	Psychiatry	88	9	0	2
	Radiology	47	5	0	0
	Surgery	80	13	1	6
	Others	45	5	0	1
	Total	928	99	4	42

2024-25

Cluster	Major Specialty	Manpower Strength (As at 31.12.2024) (Include FT and PT)	Intake No. (April – December 2024) (Include FT and PT)	Full-time Attrition (Wastage) No. (April – December 2024)	
				Retirement	Non-retirement
HKEC	Accident & Emergency	71	7	0	3
	Anaesthesia	44	2	0	0
	Clinical Oncology	23	2	0	0
	Ear, Nose & Throat/Otorhinolaryngology	12	1	0	0
	Family Medicine	59	8	1	1
	Intensive Care Unit	19	1	0	0
	Medicine	195	29	0	7
	Neurosurgery	16	4	0	0
	Obstetrics & Gynaecology	22	1	0	2
	Ophthalmology	25	1	0	2
	Orthopaedics & Traumatology	39	2	1	1

Cluster	Major Specialty	Manpower Strength (As at 31.12.2024) (Include FT and PT)	Intake No. (April – December 2024) (Include FT and PT)	Full-time Attrition (Wastage) No. (April – December 2024)	
				Retirement	Non-retirement
	Paediatrics	28	1	0	2
	Pathology	24	2	0	1
	Psychiatry	49	5	0	1
	Radiology	52	5	0	2
	Surgery	58	9	0	2
	Others	1	0	0	0
	Total	735	80	2	24
HKWC	Accident & Emergency	34	1	0	1
	Anaesthesia	70	14	0	4
	Cardiothoracic Surgery	17	2	0	0
	Clinical Oncology	21	2	0	0
	Ear, Nose & Throat/Otorhinolaryngology	16	2	0	0
	Family Medicine	46	1	0	0
	Intensive Care Unit	16	1	1	0
	Medicine	183	22	0	5
	Neurosurgery	14	2	0	0
	Obstetrics & Gynaecology	28	2	0	4
	Ophthalmology	19	3	0	0
	Orthopaedics & Traumatology	37	4	1	0
	Paediatrics	38	4	1	1
	Pathology	37	2	1	1
	Psychiatry	29	4	0	2
	Radiology	41	4	0	1
	Surgery	102	17	0	2
	Total	749	87	4	21
KCC	Accident & Emergency	94	3	0	0
	Anaesthesia	117	12	0	5
	Cardiothoracic Surgery	21	1	0	0
	Clinical Oncology	34	3	0	0
	Ear, Nose & Throat/Otorhinolaryngology	19	0	0	0
	Family Medicine	122	7	0	6
	Intensive Care Unit	26	3	0	1
	Medicine	323	24	1	7
	Neurosurgery	42	7	0	0
	Obstetrics & Gynaecology	60	5	0	1

Cluster	Major Specialty	Manpower Strength (As at 31.12.2024) (Include FT and PT)	Intake No. (April – December 2024) (Include FT and PT)	Full-time Attrition (Wastage) No. (April – December 2024)	
				Retirement	Non-retirement
	Ophthalmology	46	5	0	2
	Orthopaedics & Traumatology	74	5	0	2
	Paediatrics	182	15	0	11
	Pathology	64	3	0	3
	Psychiatry	46	2	0	1
	Radiology	95	8	0	6
	Surgery	145	12	0	4
	Others	12	0	0	0
	Total	1 522	115	1	49
KEC	Accident & Emergency	78	6	0	1
	Anaesthesia	56	7	1	2
	Clinical Oncology	15	2	0	0
	Ear, Nose & Throat/Otorhinolaryngology	13	0	0	3
	Family Medicine	102	12	0	6
	Intensive Care Unit	26	0	0	0
	Medicine	212	30	0	3
	Obstetrics & Gynaecology	32	2	0	2
	Ophthalmology	24	4	0	2
	Orthopaedics & Traumatology	56	1	0	2
	Paediatrics	43	2	0	1
	Pathology	33	1	0	2
	Psychiatry	46	1	0	1
	Radiology	40	4	0	1
	Surgery	76	9	0	3
	Others	5	0	0	0
	Total	857	81	1	29
KWC	Accident & Emergency	132	15	2	7
	Anaesthesia	75	4	1	3
	Clinical Oncology	29	1	0	0
	Ear, Nose & Throat/Otorhinolaryngology	19	1	0	0
	Family Medicine	131	9	0	2
	Intensive Care Unit	36	3	0	1
	Medicine	265	19	0	7
	Neurosurgery	19	1	0	0
	Obstetrics & Gynaecology	29	1	0	1

Cluster	Major Specialty	Manpower Strength (As at 31.12.2024) (Include FT and PT)	Intake No. (April – December 2024) (Include FT and PT)	Full-time Attrition (Wastage) No. (April – December 2024)	
				Retirement	Non-retirement
	Ophthalmology	26	0	0	0
	Orthopaedics & Traumatology	77	2	0	1
	Paediatrics	57	2	0	2
	Pathology	53	2	0	3
	Psychiatry	79	4	0	1
	Radiology	49	2	1	1
	Surgery	112	15	1	1
	Others	1	0	0	0
	Total	1 190	81	5	30
NTEC	Accident & Emergency	94	7	2	2
	Anaesthesia	77	8	0	0
	Cardiothoracic Surgery	14	0	0	0
	Clinical Oncology	41	4	0	0
	Ear, Nose & Throat/Otorhinolaryngology	19	0	0	0
	Family Medicine	112	11	0	2
	Intensive Care Unit	31	5	0	1
	Medicine	253	29	0	12
	Neurosurgery	15	0	0	0
	Obstetrics & Gynaecology	34	4	0	3
	Ophthalmology	31	6	0	1
	Orthopaedics & Traumatology	76	9	1	1
	Paediatrics	58	7	0	2
	Pathology	46	6	0	3
	Psychiatry	74	6	0	2
	Radiology	56	5	0	1
	Surgery	102	13	0	3
	Others	5	3	0	1
	Total	1 139	123	3	34
NTWC	Accident & Emergency	92	11	0	2
	Anaesthesia	69	8	0	3
	Cardiothoracic Surgery	3	1	0	0
	Clinical Oncology	29	2	0	1
	Ear, Nose & Throat/Otorhinolaryngology	16	0	0	0
	Family Medicine	102	9	0	4
	Intensive Care Unit	24	3	0	0

Cluster	Major Specialty	Manpower Strength (As at 31.12.2024) (Include FT and PT)	Intake No. (April – December 2024) (Include FT and PT)	Full-time Attrition (Wastage) No. (April – December 2024)	
				Retirement	Non-retirement
	Medicine	205	26	0	9
	Neurosurgery	16	2	0	0
	Obstetrics & Gynaecology	34	2	1	1
	Ophthalmology	27	1	0	3
	Orthopaedics & Traumatology	57	4	0	2
	Paediatrics	40	4	0	3
	Pathology	29	3	0	2
	Psychiatry	92	4	0	1
	Radiology	47	4	0	5
	Surgery	92	15	0	3
	Others	1	0	0	0
	Total	977	99	1	39

Note:

- (1) The manpower figures above are calculated on full-time equivalent basis including permanent, contract and temporary staff in the HA. Individual figures may not add up to the total due to rounding.
- (2) Starting from January 2024, full-time equivalent for temporary part-time staff is calculated based on their actual working hours. The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.
- (3) Intake refers to the total number of permanent and contract staff joining the HA on headcount basis during the period. Transfer, promotion and staff movement within the HA are not regarded as Intake.
- (4) From January 2024 onwards, the HA excludes those staff under the Extending Employment Beyond Retirement (EER) arrangement when compiling the statistics of Intake. The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.
- (5) The Intake of Doctors includes the number of Interns appointed as Residents.
- (6) Attrition (Wastage) includes all types of cessation of service (including retirement) from the HA for permanent and contract staff on headcount basis.
- (7) From January 2024 onwards, the HA excludes those staff under the EER arrangement when compiling the statistics of Attrition (Wastage). The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.
- (8) Doctors exclude Interns and Dental Officers.
- (9) Starting from 2024-25, Ear, Nose & Throat/Otorhinolaryngology and Clinical Oncology will no longer be classified in the category of “Others”. The related figures of this category before 2024-25 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.

The tables below set out the manpower strength, intake number and full-time attrition (wastage) number of nurses by major specialty in each hospital cluster of the HA from 2022-23 to 2024-25 (April – December 2024):

2022-23

Cluster	Major Specialty	Manpower Strength (As at 31.3.2023) (Include FT and PT)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
HKEC	Accident & Emergency	141	16	1	24
	Intensive Care Unit	139	13	1	19
	Medicine	1 008	101	11	89
	Obstetrics & Gynaecology	119	4	2	5
	Orthopaedics & Traumatology	133	4	1	7
	Paediatrics	115	10	2	10
	Psychiatry	283	25	6	13
	Surgery	241	25	4	21
	Others	840	70	14	64
	Total	3 018	268	42	252
HKWC	Accident & Emergency	58	7	2	6
	Intensive Care Unit	87	2	1	11
	Medicine	783	73	23	70
	Obstetrics & Gynaecology	142	6	4	16
	Orthopaedics & Traumatology	71	3	3	8
	Paediatrics	150	2	1	19
	Psychiatry	136	10	3	8
	Surgery	456	24	9	53
	Others	1 017	125	22	75
	Total	2 899	252	68	266
KCC	Accident & Emergency	199	10	0	20
	Intensive Care Unit	158	3	2	15
	Medicine	1 449	96	26	144
	Obstetrics & Gynaecology	284	7	13	21
	Orthopaedics & Traumatology	187	9	0	10
	Paediatrics	538	72	10	59
	Psychiatry	281	32	15	8
	Surgery	491	35	11	42
	Others	2 596	282	39	212
	Total	6 184	546	116	531
KEC	Accident & Emergency	172	12	1	15
	Intensive Care Unit	183	6	4	26

Cluster	Major Specialty	Manpower Strength (As at 31.3.2023) (Include FT and PT)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Medicine	1 260	101	10	68
	Obstetrics & Gynaecology	121	10	0	20
	Orthopaedics & Traumatology	214	21	0	13
	Paediatrics	158	8	0	14
	Psychiatry	210	18	3	9
	Surgery	238	23	0	20
	Others	1 008	72	9	65
	Total	3 562	271	27	250
KWC	Accident & Emergency	293	16	9	31
	Intensive Care Unit	188	3	6	17
	Medicine	1 273	75	14	106
	Obstetrics & Gynaecology	119	5	7	12
	Orthopaedics & Traumatology	246	4	2	9
	Paediatrics	192	8	2	15
	Psychiatry	744	93	28	43
	Surgery	387	18	10	26
	Others	1 595	220	20	149
	Total	5 038	442	98	408
NTEC	Accident & Emergency	229	15	1	22
	Intensive Care Unit	220	17	1	20
	Medicine	1 611	155	18	135
	Obstetrics & Gynaecology	210	18	5	23
	Orthopaedics & Traumatology	263	23	5	25
	Paediatrics	230	23	4	32
	Psychiatry	396	34	10	18
	Surgery	489	32	3	39
	Others	1 217	70	34	90
	Total	4 865	387	81	404
NTWC	Accident & Emergency	230	23	2	30
	Intensive Care Unit	158	19	1	17
	Medicine	912	95	4	101
	Obstetrics & Gynaecology	138	11	6	18
	Orthopaedics & Traumatology	155	6	2	12
	Paediatrics	169	4	2	19
	Psychiatry	737	45	24	34
	Surgery	193	13	2	22
	Others	1 301	123	7	89

Cluster	Major Specialty	Manpower Strength (As at 31.3.2023) (Include FT and PT)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Total	3 992	339	50	342

2023-24

Cluster	Major Specialty	Manpower Strength (As at 31.3.2024) (Include FT and PT)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
HKEC	Accident & Emergency	146	17	0	14
	Intensive Care Unit	138	16	0	12
	Medicine	1 029	108	7	67
	Obstetrics & Gynaecology	110	1	1	10
	Orthopaedics & Traumatology	140	13	1	12
	Paediatrics	107	5	1	9
	Psychiatry	291	21	3	8
	Surgery	255	30	1	20
	Others	814	49	11	65
	Total	3 031	260	25	217
HKWC	Accident & Emergency	55	5	0	9
	Intensive Care Unit	80	5	3	10
	Medicine	784	69	10	65
	Obstetrics & Gynaecology	136	6	1	17
	Orthopaedics & Traumatology	73	5	0	7
	Paediatrics	155	16	1	10
	Psychiatry	142	7	0	5
	Surgery	458	66	6	42
	Others	986	95	9	62
	Total	2 869	274	30	227
KCC	Accident & Emergency	201	15	2	22
	Intensive Care Unit	149	1	2	11
	Medicine	1 508	127	15	123
	Obstetrics & Gynaecology	279	7	2	22
	Orthopaedics & Traumatology	183	11	3	10
	Paediatrics	520	36	7	60
	Psychiatry	286	20	3	14
	Surgery	480	36	4	43
	Others	2 119	270	32	169

Cluster	Major Specialty	Manpower Strength (As at 31.3.2024) (Include FT and PT)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Total	5 725	523	70	474
KEC	Accident & Emergency	167	7	2	5
	Intensive Care Unit	190	8	1	12
	Medicine	1 220	110	3	62
	Obstetrics & Gynaecology	117	6	3	5
	Orthopaedics & Traumatology	208	21	1	8
	Paediatrics	163	18	0	7
	Psychiatry	222	14	1	5
	Surgery	234	27	0	10
	Others	1 029	65	6	51
	Total	3 548	276	17	165
KWC	Accident & Emergency	301	33	3	27
	Intensive Care Unit	191	13	2	10
	Medicine	1 258	142	8	78
	Obstetrics & Gynaecology	124	8	1	4
	Orthopaedics & Traumatology	232	15	0	17
	Paediatrics	188	19	2	11
	Psychiatry	722	73	6	24
	Surgery	421	58	5	32
	Others	1 400	107	16	115
	Total	4 838	468	43	318
NTEC	Accident & Emergency	234	23	1	17
	Intensive Care Unit	214	18	0	20
	Medicine	1 541	146	6	98
	Obstetrics & Gynaecology	207	16	1	12
	Orthopaedics & Traumatology	258	30	3	13
	Paediatrics	237	34	3	27
	Psychiatry	393	31	3	11
	Surgery	472	32	2	30
	Others	1 188	69	15	63
	Total	4 744	399	34	291
NTWC	Accident & Emergency	217	28	3	24
	Intensive Care Unit	157	21	0	20
	Medicine	931	85	9	58
	Obstetrics & Gynaecology	138	3	1	8
	Orthopaedics & Traumatology	154	6	1	10
	Paediatrics	170	20	1	16

Cluster	Major Specialty	Manpower Strength (As at 31.3.2024) (Include FT and PT)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Psychiatry	750	55	9	31
	Surgery	202	17	1	9
	Others	1 351	99	6	67
	Total	4 071	334	31	243

2024-25

Cluster	Major Specialty	Manpower Strength (As at 31.12.2024) (Include FT and PT)	Intake No. (April – December 2024) (Include FT and PT)	Full-time Attrition (Wastage) No. (April – December 2024)	
				Retirement	Non-retirement
HKEC	Accident & Emergency	142	8	0	11
	Intensive Care Unit	143	14	0	9
	Medicine	1 004	95	4	60
	Obstetrics & Gynaecology	109	2	1	4
	Orthopaedics & Traumatology	136	10	2	7
	Paediatrics	112	15	0	6
	Psychiatry	294	16	0	11
	Surgery	265	30	1	10
	Others	860	47	9	44
	Total	3 067	237	17	162
HKWC	Accident & Emergency	60	9	0	4
	Intensive Care Unit	79	1	3	5
	Medicine	795	51	9	45
	Obstetrics & Gynaecology	139	8	0	6
	Orthopaedics & Traumatology	81	10	1	2
	Paediatrics	156	8	0	5
	Psychiatry	142	1	2	4
	Surgery	485	52	5	28
	Others	986	96	6	46
	Total	2 924	236	26	145
KCC	Accident & Emergency	201	17	2	10
	Intensive Care Unit	147	5	4	8
	Medicine	1 508	119	19	73
	Obstetrics & Gynaecology	279	2	8	7
	Orthopaedics & Traumatology	187	5	2	3
	Paediatrics	537	46	6	22

Cluster	Major Specialty	Manpower Strength (As at 31.12.2024) (Include FT and PT)	Intake No. (April – December 2024) (Include FT and PT)	Full-time Attrition (Wastage) No. (April – December 2024)	
				Retirement	Non-retirement
	Psychiatry	299	24	2	17
	Surgery	484	46	5	20
	Others	2 329	264	24	98
	Total	5 970	528	72	258
KEC	Accident & Emergency	164	7	2	6
	Intensive Care Unit	204	3	0	10
	Medicine	1 217	105	3	47
	Obstetrics & Gynaecology	106	11	0	8
	Orthopaedics & Traumatology	204	17	0	10
	Paediatrics	162	12	0	7
	Psychiatry	227	5	0	3
	Surgery	231	29	0	13
	Others	1 084	38	1	37
	Total	3 599	227	6	141
KWC	Accident & Emergency	327	20	1	15
	Intensive Care Unit	196	12	3	14
	Medicine	1 341	134	4	68
	Obstetrics & Gynaecology	114	2	1	8
	Orthopaedics & Traumatology	234	26	0	11
	Paediatrics	199	22	1	9
	Psychiatry	722	40	3	17
	Surgery	473	76	3	21
	Others	1 390	112	9	73
	Total	4 994	444	25	236
NTEC	Accident & Emergency	243	21	1	9
	Intensive Care Unit	228	15	0	10
	Medicine	1 518	165	7	53
	Obstetrics & Gynaecology	212	11	1	10
	Orthopaedics & Traumatology	251	18	3	14
	Paediatrics	245	23	1	10
	Psychiatry	420	41	2	5
	Surgery	445	44	2	33
	Others	1 245	58	17	43
	Total	4 808	396	34	187
NTWC	Accident & Emergency	235	36	0	19
	Intensive Care Unit	153	17	1	13
	Medicine	961	112	3	49

Cluster	Major Specialty	Manpower Strength (As at 31.12.2024) (Include FT and PT)	Intake No. (April – December 2024) (Include FT and PT)	Full-time Attrition (Wastage) No. (April – December 2024)	
				Retirement	Non-retirement
	Obstetrics & Gynaecology	138	4	1	6
	Orthopaedics & Traumatology	153	5	0	4
	Paediatrics	177	18	0	14
	Psychiatry	770	53	5	21
	Surgery	213	22	2	5
	Others	1 338	39	10	37
	Total	4 138	306	22	168

Note:

- (1) The manpower figures above are calculated on full-time equivalent basis including permanent, contract and temporary staff in the HA. Individual figures may not add up to the total due to rounding.
- (2) Starting from January 2024, full-time equivalent for temporary part-time staff is calculated based on their actual working hours. The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.
- (3) Intake refers to the total number of permanent and contract staff joining the HA on headcount basis during the period. Transfer, promotion and staff movement within the HA are not regarded as Intake.
- (4) From January 2024 onwards, the HA excludes those staff under the EER arrangement when compiling the statistics of Intake. The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.
- (5) Attrition (Wastage) includes all types of cessation of service (including retirement) from the HA for permanent and contract staff on headcount basis.
- (6) From January 2024 onwards, the HA excludes those staff under the EER arrangement when compiling the statistics of Attrition (Wastage). The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.
- (7) The strength of nurses includes senior nursing officers, department operations managers, nurse consultants, associate nurse consultants, ward managers, nursing officers, advanced practice nurses, registered nurses, enrolled nurses, nursing trainees, etc.

The tables below set out the manpower strength, intake number and full-time attrition (wastage) number of allied health professionals by major grade in each hospital cluster of HA from 2022-23 to 2024-25 (April – December 2024):

2022-23

Cluster	Major Grade	Manpower Strength (As at 31.3.2023) (Include FT and PT)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
HKEC	Medical Laboratory Technologist	143	15	3	14
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	126	9	1	8
	Social Workers	50	4	0	2
	Occupational Therapist	98	15	3	11
	Physiotherapist	144	21	0	6
	Pharmacist	89	8	0	4
	Dispenser	165	14	3	5
	Others	114	5	2	3
	Total	928	91	12	53
HKWC	Medical Laboratory Technologist	262	28	8	22
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	130	9	3	7
	Social Workers	55	10	2	6
	Occupational Therapist	93	8	1	8
	Physiotherapist	119	18	2	17
	Pharmacist	82	10	0	2
	Dispenser	145	10	0	5
	Others	146	25	3	11
	Total	1 032	118	19	78
KCC	Medical Laboratory Technologist	467	35	16	24
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	248	25	6	27
	Social Workers	93	7	0	5
	Occupational Therapist	176	26	0	19
	Physiotherapist	259	40	5	31
	Pharmacist	158	18	3	4
	Dispenser	308	16	3	13
	Others	230	30	3	19
	Total	1 937	197	36	142
KEC	Medical Laboratory Technologist	177	16	1	7

Cluster	Major Grade	Manpower Strength (As at 31.3.2023) (Include FT and PT)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	112	4	2	4
	Social Workers	57	6	2	4
	Occupational Therapist	115	13	0	13
	Physiotherapist	165	23	3	14
	Pharmacist	85	8	1	1
	Dispenser	160	7	3	4
	Others	135	16	3	9
	Total	1 007	93	15	56
KWC	Medical Laboratory Technologist	253	26	6	13
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	196	15	4	13
	Social Workers	72	11	2	3
	Occupational Therapist	200	21	0	25
	Physiotherapist	181	37	3	26
	Pharmacist	140	14	2	2
	Dispenser	269	21	2	8
	Others	171	21	4	11
	Total	1 482	166	23	101
NTEC	Medical Laboratory Technologist	300	20	5	9
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	210	17	2	13
	Social Workers	42	10	0	4
	Occupational Therapist	171	25	1	17
	Physiotherapist	211	22	1	28
	Pharmacist	119	10	1	4
	Dispenser	256	12	3	4
	Others	170	18	2	10
	Total	1 479	134	15	89
NTWC	Medical Laboratory Technologist	203	24	7	16
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	173	16	2	4
	Social Workers	42	5	1	4

Cluster	Major Grade	Manpower Strength (As at 31.3.2023) (Include FT and PT)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Occupational Therapist	142	26	0	21
	Physiotherapist	162	25	0	16
	Pharmacist	101	9	2	4
	Dispenser	209	15	8	6
	Others	161	16	3	12
	Total	1 192	136	23	83

2023-24

Cluster	Major Grade	Manpower Strength (As at 31.3.2024) (Include FT and PT)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
HKEC	Medical Laboratory Technologist	145	13	6	1
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	133	13	1	4
	Social Workers	56	12	0	2
	Occupational Therapist	109	18	1	11
	Physiotherapist	153	26	1	11
	Pharmacist	90	9	0	7
	Dispenser	166	17	3	7
	Others	120	9	0	9
	Total	971	117	12	52
HKWC	Medical Laboratory Technologist	269	26	5	10
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	135	6	1	2
	Social Workers	62	9	2	3
	Occupational Therapist	97	8	3	2
	Physiotherapist	126	15	2	15
	Pharmacist	88	4	2	1
	Dispenser	143	5	3	3
	Others	147	14	0	11
	Total	1 066	87	18	47
KCC	Medical Laboratory Technologist	492	40	13	22

Cluster	Major Grade	Manpower Strength (As at 31.3.2024) (Include FT and PT)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	245	14	1	18
	Social Workers	97	6	1	5
	Occupational Therapist	175	24	1	20
	Physiotherapist	274	47	6	26
	Pharmacist	164	14	0	5
	Dispenser	313	29	2	11
	Others	230	16	4	8
	Total	1 988	190	28	115
KEC	Medical Laboratory Technologist	190	20	3	8
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	113	2	0	0
	Social Workers	65	9	1	1
	Occupational Therapist	119	16	1	9
	Physiotherapist	173	24	0	20
	Pharmacist	90	5	0	0
	Dispenser	164	13	1	2
	Others	141	16	0	8
	Total	1 054	105	6	48
KWC	Medical Laboratory Technologist	259	17	0	12
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	197	11	2	8
	Social Workers	69	14	0	12
	Occupational Therapist	214	29	0	16
	Physiotherapist	201	27	1	13
	Pharmacist	145	13	3	8
	Dispenser	283	14	1	8
	Others	176	11	3	6
	Total	1 544	136	10	83
NTEC	Medical Laboratory Technologist	308	21	3	10
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	214	13	5	10
	Social Workers	47	10	2	5
	Occupational Therapist	181	22	1	12

Cluster	Major Grade	Manpower Strength (As at 31.3.2024) (Include FT and PT)	Intake No. (Include FT and PT)	Full-time Attrition (Wastage) No.	
				Retirement	Non-retirement
	Physiotherapist	241	44	1	22
	Pharmacist	123	10	1	4
	Dispenser	264	21	6	9
	Others	170	14	2	7
	Total	1 549	155	21	79
NTWC	Medical Laboratory Technologist	216	25	1	13
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	178	15	1	8
	Social Workers	48	9	0	5
	Occupational Therapist	148	22	1	18
	Physiotherapist	173	34	0	24
	Pharmacist	107	8	1	1
	Dispenser	214	13	1	4
	Others	159	8	2	7
	Total	1 242	134	7	80

2024-25

Cluster	Major Grade	Manpower Strength (As at 31.12.2024) (Include FT and PT)	Intake No. (April – December 2024) (Include FT and PT)	Full-time Attrition (Wastage) No. (April – December 2024)	
				Retirement	Non-retirement
HKEC	Medical Laboratory Technologist	154	11	1	1
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	147	13	0	3
	Social Workers	58	2	0	2
	Occupational Therapist	112	10	0	8
	Physiotherapist	163	22	2	11
	Pharmacist	96	6	0	3
	Dispenser	173	12	1	5
	Others	121	9	0	6
	Total	1 022	85	4	39
HKWC	Medical Laboratory Technologist	283	28	2	14

Cluster	Major Grade	Manpower Strength (As at 31.12.2024) (Include FT and PT)	Intake No. (April – December 2024) (Include FT and PT)	Full-time Attrition (Wastage) No. (April – December 2024)	
				Retirement	Non-retirement
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	137	5	2	3
	Social Workers	59	3	1	4
	Occupational Therapist	95	6	1	5
	Physiotherapist	134	23	3	7
	Pharmacist	91	5	0	2
	Dispenser	145	8	2	1
	Others	152	11	0	7
	Total	1 097	89	11	43
KCC	Medical Laboratory Technologist	504	34	2	13
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	255	16	4	5
	Social Workers	95	3	1	2
	Occupational Therapist	181	24	2	12
	Physiotherapist	297	43	3	12
	Pharmacist	169	12	0	9
	Dispenser	316	19	3	10
	Others	243	18	1	8
	Total	2 060	169	16	71
KEC	Medical Laboratory Technologist	196	23	6	6
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	117	5	0	1
	Social Workers	67	6	0	7
	Occupational Therapist	123	15	0	14
	Physiotherapist	190	31	2	8
	Pharmacist	94	6	0	1
	Dispenser	168	9	4	4
	Others	144	10	0	6
	Total	1 100	105	12	47
KWC	Medical Laboratory Technologist	273	23	4	7
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	201	15	3	6

Cluster	Major Grade	Manpower Strength (As at 31.12.2024) (Include FT and PT)	Intake No. (April – December 2024) (Include FT and PT)	Full-time Attrition (Wastage) No. (April – December 2024)	
				Retirement	Non-retirement
	Social Workers	68	6	0	7
	Occupational Therapist	224	16	0	6
	Physiotherapist	213	35	1	22
	Pharmacist	152	12	1	4
	Dispenser	289	19	2	5
	Others	180	14	0	7
	Total	1 600	140	11	64
NTEC	Medical Laboratory Technologist	322	25	0	8
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	237	23	1	4
	Social Workers	48	3	0	1
	Occupational Therapist	191	19	0	6
	Physiotherapist	262	36	2	9
	Pharmacist	129	9	0	3
	Dispenser	269	15	4	10
	Others	171	10	2	9
	Total	1 629	140	9	50
NTWC	Medical Laboratory Technologist	224	8	2	0
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	177	10	0	7
	Social Workers	49	3	0	2
	Occupational Therapist	157	19	0	8
	Physiotherapist	194	36	0	10
	Pharmacist	111	8	0	4
	Dispenser	220	10	1	1
	Others	162	7	0	4
	Total	1 294	101	3	36

Note:

- (1) The manpower figures above are calculated on full-time equivalent basis including permanent, contract and temporary staff in the HA. Individual figures may not add up to the total due to rounding.
- (2) Starting from January 2024, full-time equivalent for temporary part-time staff is calculated based on their actual working hours. The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.

- (3) Intake refers to the total number of permanent and contract staff joining the HA on headcount basis during the period. Transfer, promotion and staff movement within the HA are not regarded as Intake.
- (4) From January 2024 onwards, the HA excludes those staff under the EER arrangement when compiling the statistics of Intake. The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.
- (5) Attrition (Wastage) includes all types of cessation of service (including retirement) from the HA for permanent and contract staff on headcount basis.
- (6) From January 2024 onwards, those staff under the EER arrangement are excluded from the statistics of Attrition (Wastage). The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.
- (7) For allied health professionals, the category of “Others” includes audiology technicians, bioinformatician, clinical psychologists, dental technicians, dietitians, genetic counsellors, mould laboratory technicians, optometrists, orthoptists, physicists, podiatrists, prosthetists & orthotists, scientific officers (medical)-pathology, scientific officers (medical)-audiology, scientific officers (medical)-radiology, scientific officers (medical)-radiotherapy and speech therapists.
- (8) Pharmacists includes Interns appointed as Resident Pharmacists.

2.

The tables below set out the attrition (wastage) number of full-time doctors by major specialty, years of service and rank group from 2022-23 to 2024-25 (rolling 12 months from January 2024 to December 2024):

2022-23

Major Specialty	Year of Service	CON	SMO/AC	MO/R	Total
Accident & Emergency	< 1 year	0	1	2	3
	1 - < 6 years	0	0	12	12
	6 - < 11 years	0	0	2	2
	11 - < 16 years	0	2	4	6
	16 - < 21 years	0	4	0	4
	21 - < 26 years	0	6	0	6
	26 - < 31 years	3	7	4	14
	31 years or above	0	1	1	2
	Total	3	21	25	49
Anaesthesia	< 1 year	0	0	1	1
	1 - < 6 years	1	1	7	9
	6 - < 11 years	0	2	1	3
	11 - < 16 years	0	8	0	8
	16 - < 21 years	1	2	0	3
	21 - < 26 years	1	4	0	5
	26 - < 31 years	3	0	0	3
	31 years or above	1	0	0	1
	Total	7	17	9	33
Cardiothoracic Surgery	< 1 year	0	0	0	0

Major Specialty	Year of Service	CON	SMO/AC	MO/R	Total
	1 - < 6 years	0	0	0	0
	6 - < 11 years	0	0	1	1
	11 - < 16 years	0	0	0	0
	16 - < 21 years	1	0	0	1
	21 - < 26 years	2	0	0	2
	26 - < 31 years	1	0	0	1
	31 years or above	0	0	0	0
	Total	4	0	1	5
Family Medicine	< 1 year	0	0	2	2
	1 - < 6 years	0	0	13	13
	6 - < 11 years	0	1	11	12
	11 - < 16 years	0	1	2	3
	16 - < 21 years	0	9	1	10
	21 - < 26 years	1	0	0	1
	26 - < 31 years	0	0	5	5
	31 years or above	0	0	0	0
	Total	1	11	34	46
Intensive Care Unit	< 1 year	0	0	1	1
	1 - < 6 years	0	0	0	0
	6 - < 11 years	0	0	2	2
	11 - < 16 years	0	0	0	0
	16 - < 21 years	1	3	0	4
	21 - < 26 years	0	1	0	1
	26 - < 31 years	1	0	0	1
	31 years or above	0	0	0	0
	Total	2	4	3	9
Medicine	< 1 year	0	0	1	1
	1 - < 6 years	2	0	12	14
	6 - < 11 years	0	0	7	7
	11 - < 16 years	0	12	5	17
	16 - < 21 years	2	17	3	22
	21 - < 26 years	0	6	0	6
	26 - < 31 years	9	7	2	18
	31 years or above	2	0	1	3
	Total	15	42	31	88
Neurosurgery	< 1 year	0	0	0	0
	1 - < 6 years	0	0	1	1
	6 - < 11 years	0	0	0	0
	11 - < 16 years	0	0	0	0
	16 - < 21 years	0	0	0	0

Major Specialty	Year of Service	CON	SMO/AC	MO/R	Total
	21 - < 26 years	1	0	0	1
	26 - < 31 years	2	0	1	3
	31 years or above	0	0	0	0
	Total	3	0	2	5
Obstetrics & Gynaecology	< 1 year	0	1	0	1
	1 - < 6 years	2	0	5	7
	6 - < 11 years	0	2	0	2
	11 - < 16 years	0	5	0	5
	16 - < 21 years	2	1	0	3
	21 - < 26 years	0	0	0	0
	26 - < 31 years	1	1	0	2
	31 years or above	0	0	0	0
	Total	5	10	5	20
Ophthalmology	< 1 year	0	0	0	0
	1 - < 6 years	0	2	1	3
	6 - < 11 years	0	5	0	5
	11 - < 16 years	0	1	0	1
	16 - < 21 years	0	2	0	2
	21 - < 26 years	0	0	0	0
	26 - < 31 years	2	0	0	2
	31 years or above	0	0	0	0
	Total	2	10	1	13
Orthopaedics & Traumatology	< 1 year	0	0	0	0
	1 - < 6 years	0	0	1	1
	6 - < 11 years	0	1	2	3
	11 - < 16 years	0	6	1	7
	16 - < 21 years	0	0	0	0
	21 - < 26 years	0	0	0	0
	26 - < 31 years	1	0	0	1
	31 years or above	0	0	0	0
	Total	1	7	4	12
Paediatrics	< 1 year	0	0	0	0
	1 - < 6 years	3	0	8	11
	6 - < 11 years	0	1	2	3
	11 - < 16 years	0	4	0	4
	16 - < 21 years	0	0	0	0
	21 - < 26 years	0	0	0	0
	26 - < 31 years	6	0	0	6
	31 years or above	0	0	0	0
	Total	9	5	10	24

Major Specialty	Year of Service	CON	SMO/AC	MO/R	Total
Pathology	< 1 year	0	0	0	0
	1 - < 6 years	2	1	1	4
	6 - < 11 years	1	3	1	5
	11 - < 16 years	2	2	0	4
	16 - < 21 years	1	0	0	1
	21 - < 26 years	1	0	0	1
	26 - < 31 years	2	2	0	4
	31 years or above	0	0	0	0
	Total	9	8	2	19
Psychiatry	< 1 year	0	0	1	1
	1 - < 6 years	0	0	3	3
	6 - < 11 years	0	1	5	6
	11 - < 16 years	0	5	0	5
	16 - < 21 years	0	2	2	4
	21 - < 26 years	0	1	1	2
	26 - < 31 years	0	0	1	1
	31 years or above	0	1	0	1
	Total	0	10	13	23
Radiology	< 1 year	0	0	0	0
	1 - < 6 years	2	0	0	2
	6 - < 11 years	2	6	1	9
	11 - < 16 years	3	2	0	5
	16 - < 21 years	1	0	0	1
	21 - < 26 years	1	0	0	1
	26 - < 31 years	4	0	0	4
	31 years or above	1	0	0	1
	Total	14	8	1	23
Surgery	< 1 year	0	0	1	1
	1 - < 6 years	1	0	9	10
	6 - < 11 years	0	2	1	3
	11 - < 16 years	0	7	1	8
	16 - < 21 years	2	7	0	9
	21 - < 26 years	2	1	0	3
	26 - < 31 years	3	0	0	3
	31 years or above	1	0	0	1
	Total	9	17	12	38
Others	< 1 year	0	0	1	1
	1 - < 6 years	1	0	6	7
	6 - < 11 years	0	2	2	4
	11 - < 16 years	1	9	0	10

Major Specialty	Year of Service	CON	SMO/AC	MO/R	Total
	16 - < 21 years	0	4	0	4
	21 - < 26 years	0	1	0	1
	26 - < 31 years	1	0	0	1
	31 years or above	1	0	0	1
	Total	4	16	9	29

2023-24

Major Specialty	Year of Service	CON	SMO/AC	MO/R	Total
Accident & Emergency	< 1 year	0	1	2	3
	1 - < 6 years	1	1	12	14
	6 - < 11 years	0	1	8	9
	11 - < 16 years	0	3	1	4
	16 - < 21 years	0	1	0	1
	21 - < 26 years	0	0	0	0
	26 - < 31 years	1	1	1	3
	31 years or above	1	0	0	1
	Total	3	8	24	35
Anaesthesia	< 1 year	0	0	1	1
	1 - < 6 years	1	0	9	10
	6 - < 11 years	0	1	2	3
	11 - < 16 years	0	12	0	12
	16 - < 21 years	3	7	0	10
	21 - < 26 years	2	2	0	4
	26 - < 31 years	0	0	0	0
	31 years or above	0	0	0	0
	Total	6	22	12	40
Cardiothoracic Surgery	< 1 year	1	0	1	2
	1 - < 6 years	0	1	0	1
	6 - < 11 years	0	1	0	1
	11 - < 16 years	0	0	0	0
	16 - < 21 years	0	0	0	0
	21 - < 26 years	1	0	0	1
	26 - < 31 years	0	0	0	0
	31 years or above	0	0	0	0
	Total	2	2	1	5
Family Medicine	< 1 year	0	1	1	2
	1 - < 6 years	0	2	15	17
	6 - < 11 years	0	0	9	9
	11 - < 16 years	0	1	4	5

Major Specialty	Year of Service	CON	SMO/AC	MO/R	Total
	16 - < 21 years	0	5	3	8
	21 - < 26 years	0	1	1	2
	26 - < 31 years	0	0	0	0
	31 years or above	0	0	0	0
	Total	0	10	33	43
Intensive Care Unit	< 1 year	1	0	0	1
	1 - < 6 years	0	0	1	1
	6 - < 11 years	0	0	1	1
	11 - < 16 years	0	0	0	0
	16 - < 21 years	0	0	0	0
	21 - < 26 years	1	0	0	1
	26 - < 31 years	0	1	0	1
	31 years or above	0	0	0	0
	Total	2	1	2	5
Medicine	< 1 year	2	0	3	5
	1 - < 6 years	1	0	24	25
	6 - < 11 years	0	1	9	10
	11 - < 16 years	0	8	2	10
	16 - < 21 years	3	3	0	6
	21 - < 26 years	1	2	0	3
	26 - < 31 years	3	1	0	4
	31 years or above	2	4	0	6
	Total	12	19	38	69
Neurosurgery	< 1 year	0	0	0	0
	1 - < 6 years	0	1	0	1
	6 - < 11 years	0	0	0	0
	11 - < 16 years	0	0	0	0
	16 - < 21 years	0	0	0	0
	21 - < 26 years	0	0	0	0
	26 - < 31 years	0	1	0	1
	31 years or above	0	0	0	0
	Total	0	2	0	2
Obstetrics & Gynaecology	< 1 year	0	0	0	0
	1 - < 6 years	0	1	2	3
	6 - < 11 years	0	0	1	1
	11 - < 16 years	1	4	0	5
	16 - < 21 years	1	0	0	1
	21 - < 26 years	0	0	0	0
	26 - < 31 years	0	0	0	0
	31 years or above	0	0	0	0

Major Specialty	Year of Service	CON	SMO/AC	MO/R	Total
	Total	2	5	3	10
Ophthalmology	< 1 year	0	0	0	0
	1 - < 6 years	0	0	1	1
	6 - < 11 years	0	1	0	1
	11 - < 16 years	1	3	1	5
	16 - < 21 years	1	0	0	1
	21 - < 26 years	1	1	0	2
	26 - < 31 years	1	1	0	2
	31 years or above	1	0	0	1
	Total	5	6	2	13
Orthopaedics & Traumatology	< 1 year	0	0	0	0
	1 - < 6 years	1	0	1	2
	6 - < 11 years	0	0	3	3
	11 - < 16 years	0	6	0	6
	16 - < 21 years	0	0	0	0
	21 - < 26 years	0	0	0	0
	26 - < 31 years	2	0	0	2
	31 years or above	0	0	0	0
	Total	3	6	4	13
Paediatrics	< 1 year	0	0	0	0
	1 - < 6 years	0	0	6	6
	6 - < 11 years	0	0	5	5
	11 - < 16 years	0	4	2	6
	16 - < 21 years	0	3	0	3
	21 - < 26 years	0	3	0	3
	26 - < 31 years	1	0	0	1
	31 years or above	0	0	0	0
	Total	1	10	13	24
Pathology	< 1 year	0	0	0	0
	1 - < 6 years	2	0	2	4
	6 - < 11 years	1	1	0	2
	11 - < 16 years	1	0	1	2
	16 - < 21 years	0	0	0	0
	21 - < 26 years	0	0	0	0
	26 - < 31 years	1	1	0	2
	31 years or above	0	0	0	0
	Total	5	2	3	10
Psychiatry	< 1 year	0	0	0	0
	1 - < 6 years	0	0	1	1
	6 - < 11 years	0	5	1	6

Major Specialty	Year of Service	CON	SMO/AC	MO/R	Total
	11 - < 16 years	0	6	0	6
	16 - < 21 years	0	4	0	4
	21 - < 26 years	0	0	0	0
	26 - < 31 years	0	0	0	0
	31 years or above	0	0	0	0
	Total	0	15	2	17
Radiology	< 1 year	0	1	0	1
	1 - < 6 years	1	0	1	2
	6 - < 11 years	0	2	0	2
	11 - < 16 years	0	0	1	1
	16 - < 21 years	1	0	0	1
	21 - < 26 years	0	0	0	0
	26 - < 31 years	1	0	0	1
	31 years or above	0	0	0	0
	Total	3	3	2	8
Surgery	< 1 year	1	0	0	1
	1 - < 6 years	1	1	3	5
	6 - < 11 years	0	2	3	5
	11 - < 16 years	1	8	2	11
	16 - < 21 years	2	4	0	6
	21 - < 26 years	2	0	0	2
	26 - < 31 years	1	0	0	1
	31 years or above	1	0	0	1
	Total	9	15	8	32
Others	< 1 year	0	0	2	2
	1 - < 6 years	1	0	3	4
	6 - < 11 years	0	2	1	3
	11 - < 16 years	0	0	1	1
	16 - < 21 years	0	2	0	2
	21 - < 26 years	0	1	0	1
	26 - < 31 years	0	0	0	0
	31 years or above	1	0	0	1
	Total	2	5	7	14

2024-25 (Rolling 12 months from January 2024 to December 2024)

Major Specialty	Year of Service	CON	SMO/AC	MO/R	Total
Accident & Emergency	< 1 year	0	1	1	2
	1 - < 6 years	0	2	13	15
	6 - < 11 years	0	0	6	6
	11 - < 16 years	0	3	0	3
	16 - < 21 years	0	2	0	2
	21 - < 26 years	0	0	1	1
	26 - < 31 years	0	2	2	4
	31 years or above	0	0	2	2
	Total	0	10	25	35
Anaesthesia	< 1 year	1	1	2	4
	1 - < 6 years	1	0	3	4
	6 - < 11 years	0	1	2	3
	11 - < 16 years	0	8	0	8
	16 - < 21 years	1	2	0	3
	21 - < 26 years	4	2	0	6
	26 - < 31 years	0	1	0	1
	31 years or above	0	0	1	1
	Total	7	15	8	30
Cardiothoracic Surgery	< 1 year	0	0	0	0
	1 - < 6 years	0	0	0	0
	6 - < 11 years	0	0	0	0
	11 - < 16 years	0	0	0	0
	16 - < 21 years	0	0	0	0
	21 - < 26 years	0	0	0	0
	26 - < 31 years	0	0	0	0
	31 years or above	0	0	0	0
	Total	0	0	0	0
Clinical Oncology	< 1 year	0	0	0	0
	1 - < 6 years	0	0	0	0
	6 - < 11 years	0	0	0	0
	11 - < 16 years	0	1	0	1
	16 - < 21 years	0	0	0	0
	21 - < 26 years	0	0	0	0
	26 - < 31 years	0	0	0	0
	31 years or above	0	0	0	0
	Total	0	1	0	1
Ear, Nose & Throat/Otorhinolaryngology	< 1 year	0	0	0	0
	1 - < 6 years	0	0	1	1
	6 - < 11 years	0	1	0	1

Major Specialty	Year of Service	CON	SMO/AC	MO/R	Total
	11 - < 16 years	0	0	0	0
	16 - < 21 years	0	2	0	2
	21 - < 26 years	0	0	0	0
	26 - < 31 years	0	1	0	1
	31 years or above	0	0	0	0
	Total	0	4	1	5
Family Medicine	< 1 year	0	0	1	1
	1 - < 6 years	0	0	14	14
	6 - < 11 years	0	0	6	6
	11 - < 16 years	0	1	3	4
	16 - < 21 years	0	4	1	5
	21 - < 26 years	0	1	3	4
	26 - < 31 years	0	0	0	0
	31 years or above	0	0	0	0
	Total	0	6	28	34
Intensive Care Unit	< 1 year	1	0	0	1
	1 - < 6 years	0	0	1	1
	6 - < 11 years	0	1	1	2
	11 - < 16 years	0	0	1	1
	16 - < 21 years	0	0	0	0
	21 - < 26 years	0	0	0	0
	26 - < 31 years	1	0	0	1
	31 years or above	0	0	0	0
	Total	2	1	3	6
Medicine	< 1 year	3	8	6	17
	1 - < 6 years	1	0	26	27
	6 - < 11 years	0	1	13	14
	11 - < 16 years	0	3	0	3
	16 - < 21 years	1	2	0	3
	21 - < 26 years	1	0	0	1
	26 - < 31 years	2	1	0	3
	31 years or above	3	2	0	5
	Total	11	17	45	73
Neurosurgery	< 1 year	0	0	0	0
	1 - < 6 years	0	0	0	0
	6 - < 11 years	0	0	0	0
	11 - < 16 years	0	0	0	0
	16 - < 21 years	0	0	0	0
	21 - < 26 years	0	0	0	0
	26 - < 31 years	0	0	0	0

Major Specialty	Year of Service	CON	SMO/AC	MO/R	Total
	31 years or above	0	0	0	0
	Total	0	0	0	0
Obstetrics & Gynaecology	< 1 year	0	0	1	1
	1 - < 6 years	0	1	2	3
	6 - < 11 years	0	3	2	5
	11 - < 16 years	0	2	0	2
	16 - < 21 years	5	2	0	7
	21 - < 26 years	0	0	0	0
	26 - < 31 years	1	0	0	1
	31 years or above	0	0	0	0
	Total	6	8	5	19
Ophthalmology	< 1 year	0	2	0	2
	1 - < 6 years	1	1	0	2
	6 - < 11 years	0	4	0	4
	11 - < 16 years	1	1	0	2
	16 - < 21 years	0	2	0	2
	21 - < 26 years	0	0	0	0
	26 - < 31 years	1	0	0	1
	31 years or above	0	0	0	0
	Total	3	10	0	13
Orthopaedics & Traumatology	< 1 year	0	0	1	1
	1 - < 6 years	1	0	2	3
	6 - < 11 years	0	1	1	2
	11 - < 16 years	0	4	1	5
	16 - < 21 years	0	0	0	0
	21 - < 26 years	0	1	0	1
	26 - < 31 years	4	1	0	5
	31 years or above	0	0	0	0
	Total	5	7	5	17
Paediatrics	< 1 year	0	0	4	4
	1 - < 6 years	1	0	8	9
	6 - < 11 years	0	2	7	9
	11 - < 16 years	0	4	2	6
	16 - < 21 years	0	2	0	2
	21 - < 26 years	0	1	0	1
	26 - < 31 years	1	0	0	1
	31 years or above	0	0	0	0
	Total	2	9	21	32
Pathology	< 1 year	0	1	0	1
	1 - < 6 years	2	0	2	4

Major Specialty	Year of Service	CON	SMO/AC	MO/R	Total
	6 - < 11 years	0	4	3	7
	11 - < 16 years	1	0	0	1
	16 - < 21 years	1	2	0	3
	21 - < 26 years	0	0	0	0
	26 - < 31 years	1	1	0	2
	31 years or above	0	1	0	1
	Total	5	9	5	19
Psychiatry	< 1 year	0	0	0	0
	1 - < 6 years	0	0	3	3
	6 - < 11 years	0	3	2	5
	11 - < 16 years	0	3	0	3
	16 - < 21 years	0	1	0	1
	21 - < 26 years	0	0	0	0
	26 - < 31 years	0	1	0	1
	31 years or above	0	0	0	0
	Total	0	8	5	13
Radiology	< 1 year	1	2	0	3
	1 - < 6 years	1	1	0	2
	6 - < 11 years	1	6	0	7
	11 - < 16 years	2	3	0	5
	16 - < 21 years	1	0	0	1
	21 - < 26 years	0	0	0	0
	26 - < 31 years	2	0	0	2
	31 years or above	1	0	0	1
	Total	9	12	0	21
Surgery	< 1 year	0	0	2	2
	1 - < 6 years	0	2	1	3
	6 - < 11 years	0	2	3	5
	11 - < 16 years	2	8	1	11
	16 - < 21 years	4	2	0	6
	21 - < 26 years	2	0	0	2
	26 - < 31 years	1	0	0	1
	31 years or above	0	0	0	0
	Total	9	14	7	30
Others	< 1 year	0	1	0	1
	1 - < 6 years	0	0	0	0
	6 - < 11 years	0	0	1	1
	11 - < 16 years	0	0	0	0
	16 - < 21 years	0	0	0	0
	21 - < 26 years	0	0	0	0

Major Specialty	Year of Service	CON	SMO/AC	MO/R	Total
	26 - < 31 years	0	0	0	0
	31 years or above	0	0	0	0
	Total	0	1	1	2

Note:

- (1) Attrition (Wastage) includes all types of cessation of service (including retirement) from the HA for permanent and contract staff on headcount basis.
- (2) From January 2024 onwards, those staff under the EER arrangement are excluded from the statistics of Attrition (Wastage). The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.
- (3) Doctors exclude Interns and Dental Officers.
- (4) Starting from 2024-25, Ear, Nose & Throat/Otorhinolaryngology and Clinical Oncology will no longer be classified in the category of “Others”. The related figures of this category before 2024-25 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.

The tables below set out the attrition (wastage) number of full-time nurses by major specialty, year of service and rank group from 2022-23 to 2024-25 (rolling 12 months from January 2024 to December 2024):

2022-23

Major Specialty	Year of Service	DOM/NC/ SNO and Above	APN/NS/ NO/WM/ ANC	RN	EN/ Others	Total
Accident & Emergency	< 1 year	0	2	4	2	8
	1 - < 6 years	0	3	63	2	68
	6 - < 11 years	0	1	29	1	31
	11 - < 16 years	0	7	12	0	19
	16 - < 21 years	0	3	2	0	5
	21 - < 26 years	0	3	1	0	4
	26 - < 31 years	0	14	7	1	22
	31 years or above	1	6	0	0	7
	Total	1	39	118	6	164
Intensive Care Unit	< 1 year	0	1	7	0	8
	1 - < 6 years	0	0	52	0	52
	6 - < 11 years	0	2	37	0	39
	11 - < 16 years	0	3	9	0	12
	16 - < 21 years	0	1	2	0	3
	21 - < 26 years	0	3	3	0	6
	26 - < 31 years	1	6	5	0	12
	31 years or above	2	4	3	0	9
	Total	3	20	118	0	141

Major Specialty	Year of Service	DOM/NC/ SNO and Above	APN/NS/ NO/WM/ ANC	RN	EN/ Others	Total
Medicine	< 1 year	0	2	53	41	96
	1 - < 6 years	0	9	278	51	338
	6 - < 11 years	0	11	111	8	130
	11 - < 16 years	0	14	19	0	33
	16 - < 21 years	0	13	2	0	15
	21 - < 26 years	0	14	18	0	32
	26 - < 31 years	4	56	69	15	144
	31 years or above	1	15	9	6	31
	Total	5	134	559	121	819
Obstetrics & Gynaecology	< 1 year	0	0	2	0	2
	1 - < 6 years	0	0	41	0	41
	6 - < 11 years	0	0	45	0	45
	11 - < 16 years	0	5	4	0	9
	16 - < 21 years	0	1	3	0	4
	21 - < 26 years	0	2	5	0	7
	26 - < 31 years	4	15	16	0	35
	31 years or above	0	6	3	0	9
	Total	4	29	119	0	152
Orthopaedics & Traumatology	< 1 year	0	1	6	4	11
	1 - < 6 years	0	2	20	5	27
	6 - < 11 years	0	1	23	1	25
	11 - < 16 years	0	1	10	0	11
	16 - < 21 years	0	2	1	0	3
	21 - < 26 years	0	2	0	0	2
	26 - < 31 years	0	11	3	1	15
	31 years or above	0	2	1	0	3
	Total	0	22	64	11	97
Paediatrics	< 1 year	0	1	11	2	14
	1 - < 6 years	0	1	91	3	95
	6 - < 11 years	0	2	34	0	36
	11 - < 16 years	0	6	6	0	12
	16 - < 21 years	0	1	0	0	1
	21 - < 26 years	0	2	3	0	5
	26 - < 31 years	0	13	10	0	23
	31 years or above	0	2	1	0	3
	Total	0	28	156	5	189
Psychiatry	< 1 year	0	0	12	5	17
	1 - < 6 years	0	4	32	15	51

Major Specialty	Year of Service	DOM/NC/ SNO and Above	APN/NS/ NO/WM/ ANC	RN	EN/ Others	Total
	6 - < 11 years	0	4	13	3	20
	11 - < 16 years	0	3	6	2	11
	16 - < 21 years	0	1	7	0	8
	21 - < 26 years	0	4	5	0	9
	26 - < 31 years	6	36	22	21	85
	31 years or above	0	11	4	6	21
	Total	6	63	101	52	222
Surgery	< 1 year	0	0	13	14	27
	1 - < 6 years	0	0	85	14	99
	6 - < 11 years	0	4	44	1	49
	11 - < 16 years	0	7	11	1	19
	16 - < 21 years	0	3	1	0	4
	21 - < 26 years	0	4	6	1	11
	26 - < 31 years	4	18	17	4	43
	31 years or above	1	5	4	0	10
	Total	5	41	181	35	262
Others	< 1 year	0	2	88	20	110
	1 - < 6 years	0	14	278	26	318
	6 - < 11 years	0	14	102	6	122
	11 - < 16 years	0	13	43	2	58
	16 - < 21 years	0	6	9	1	16
	21 - < 26 years	1	14	31	2	48
	26 - < 31 years	16	76	65	35	192
	31 years or above	3	10	13	4	30
	Total	20	149	629	96	894

2023-24

Major Specialty	Year of Service	DOM/NC/ SNO and Above	APN/NS/ NO/WM/ ANC	RN	EN/ Others	Total
Accident & Emergency	< 1 year	0	1	3	4	8
	1 - < 6 years	0	2	58	1	61
	6 - < 11 years	0	4	26	0	30
	11 - < 16 years	0	4	4	1	9
	16 - < 21 years	0	2	1	0	3
	21 - < 26 years	0	1	0	0	1
	26 - < 31 years	1	8	2	0	11
	31 years or above	0	4	2	0	6
	Total	1	26	96	6	129

Major Specialty	Year of Service	DOM/NC/ SNO and Above	APN/NS/ NO/WM/ ANC	RN	EN/ Others	Total
Intensive Care Unit	< 1 year	0	1	5	0	6
	1 - < 6 years	0	0	43	0	43
	6 - < 11 years	0	1	30	0	31
	11 - < 16 years	0	0	5	0	5
	16 - < 21 years	0	1	1	0	2
	21 - < 26 years	0	1	2	0	3
	26 - < 31 years	1	5	3	0	9
	31 years or above	0	3	1	0	4
	Total	1	12	90	0	103
Medicine	< 1 year	0	5	42	42	89
	1 - < 6 years	0	7	215	40	262
	6 - < 11 years	0	10	103	5	118
	11 - < 16 years	0	8	16	2	26
	16 - < 21 years	0	9	6	0	15
	21 - < 26 years	0	5	6	0	11
	26 - < 31 years	0	16	16	3	35
	31 years or above	4	17	23	9	53
	Total	4	77	427	101	609
Obstetrics & Gynaecology	< 1 year	0	0	4	0	4
	1 - < 6 years	0	1	19	1	21
	6 - < 11 years	0	2	30	0	32
	11 - < 16 years	0	2	7	0	9
	16 - < 21 years	0	3	1	0	4
	21 - < 26 years	0	2	0	0	2
	26 - < 31 years	1	3	5	0	9
	31 years or above	0	4	3	0	7
	Total	1	17	69	1	88
Orthopaedics & Traumatology	< 1 year	0	0	1	4	5
	1 - < 6 years	0	1	34	3	38
	6 - < 11 years	0	0	13	0	13
	11 - < 16 years	0	4	5	0	9
	16 - < 21 years	0	3	0	0	3
	21 - < 26 years	0	1	0	0	1
	26 - < 31 years	0	5	6	0	11
	31 years or above	0	3	3	0	6
	Total	0	17	62	7	86
Paediatrics	< 1 year	0	0	17	1	18
	1 - < 6 years	0	2	56	1	59
	6 - < 11 years	0	3	31	0	34

Major Specialty	Year of Service	DOM/NC/ SNO and Above	APN/NS/ NO/WM/ ANC	RN	EN/ Others	Total
	11 - < 16 years	0	4	11	0	15
	16 - < 21 years	0	1	2	0	3
	21 - < 26 years	0	2	0	0	2
	26 - < 31 years	2	6	6	0	14
	31 years or above	1	7	2	0	10
	Total	3	25	125	2	155
Psychiatry	< 1 year	0	2	11	6	19
	1 - < 6 years	0	0	35	1	36
	6 - < 11 years	0	2	12	2	16
	11 - < 16 years	0	4	7	0	11
	16 - < 21 years	0	3	1	0	4
	21 - < 26 years	0	0	0	3	3
	26 - < 31 years	0	9	5	4	18
	31 years or above	2	6	4	4	16
	Total	2	26	75	20	123
Surgery	< 1 year	0	1	12	10	23
	1 - < 6 years	0	2	80	6	88
	6 - < 11 years	0	5	34	2	41
	11 - < 16 years	0	4	6	0	10
	16 - < 21 years	0	2	2	0	4
	21 - < 26 years	1	1	5	0	7
	26 - < 31 years	0	4	7	0	11
	31 years or above	1	10	8	2	21
	Total	2	29	154	20	205
Others	< 1 year	1	3	70	13	87
	1 - < 6 years	2	5	262	25	294
	6 - < 11 years	1	8	74	2	85
	11 - < 16 years	2	13	28	2	45
	16 - < 21 years	0	10	6	2	18
	21 - < 26 years	0	8	10	2	20
	26 - < 31 years	9	28	35	7	79
	31 years or above	2	26	22	14	64
	Total	17	101	507	67	692

2024-25 (Rolling 12 months from January 2024 to December 2024)

Major Specialty	Year of Service	DOM/NC/ SNO and Above	APN/NS/ NO/WM/ ANC	RN	EN/ Others	Total
Accident & Emergency	< 1 year	0	1	8	2	11
	1 - < 6 years	0	1	38	1	40
	6 - < 11 years	0	0	24	0	24
	11 - < 16 years	0	5	4	0	9
	16 - < 21 years	1	1	1	0	3
	21 - < 26 years	0	1	0	0	1
	26 - < 31 years	0	5	2	0	7
	31 years or above	1	4	3	1	9
	Total	2	18	80	4	104
Intensive Care Unit	< 1 year	0	0	4	0	4
	1 - < 6 years	0	0	37	0	37
	6 - < 11 years	0	1	29	0	30
	11 - < 16 years	0	0	9	0	9
	16 - < 21 years	0	3	1	0	4
	21 - < 26 years	0	0	0	0	0
	26 - < 31 years	3	4	3	0	10
	31 years or above	2	2	3	0	7
	Total	5	10	86	0	101
Medicine	< 1 year	1	6	54	40	101
	1 - < 6 years	0	6	200	27	233
	6 - < 11 years	0	10	89	6	105
	11 - < 16 years	0	15	23	1	39
	16 - < 21 years	0	5	6	0	11
	21 - < 26 years	0	6	0	0	6
	26 - < 31 years	2	25	13	2	42
	31 years or above	6	23	24	10	63
	Total	9	96	409	86	600
Obstetrics & Gynaecology	< 1 year	0	0	5	0	5
	1 - < 6 years	0	1	25	0	26
	6 - < 11 years	0	0	21	0	21
	11 - < 16 years	0	2	4	0	6
	16 - < 21 years	0	1	0	0	1
	21 - < 26 years	0	1	0	0	1
	26 - < 31 years	0	2	2	0	4
	31 years or above	1	2	9	0	12
	Total	1	9	66	0	76

Major Specialty	Year of Service	DOM/NC/ SNO and Above	APN/NS/ NO/WM/ ANC	RN	EN/ Others	Total
Orthopaedics & Traumatology	< 1 year	0	0	6	2	8
	1 - < 6 years	0	0	38	3	41
	6 - < 11 years	0	0	11	1	12
	11 - < 16 years	0	4	1	0	5
	16 - < 21 years	0	0	0	0	0
	21 - < 26 years	1	0	0	0	1
	26 - < 31 years	0	3	3	0	6
	31 years or above	1	3	4	1	9
	Total	2	10	63	7	82
Paediatrics	< 1 year	0	1	10	1	12
	1 - < 6 years	0	2	43	0	45
	6 - < 11 years	0	1	28	0	29
	11 - < 16 years	0	3	8	0	11
	16 - < 21 years	0	1	2	0	3
	21 - < 26 years	0	0	0	0	0
	26 - < 31 years	0	7	5	0	12
	31 years or above	0	3	4	1	8
	Total	0	18	100	2	120
Psychiatry	< 1 year	0	1	10	2	13
	1 - < 6 years	0	7	32	5	44
	6 - < 11 years	0	2	9	1	12
	11 - < 16 years	0	3	7	1	11
	16 - < 21 years	0	1	3	0	4
	21 - < 26 years	0	1	2	0	3
	26 - < 31 years	0	5	5	1	11
	31 years or above	1	9	4	10	24
	Total	1	29	72	20	122
Surgery	< 1 year	0	0	15	6	21
	1 - < 6 years	0	4	67	7	78
	6 - < 11 years	0	1	27	4	32
	11 - < 16 years	0	10	16	0	26
	16 - < 21 years	0	1	0	0	1
	21 - < 26 years	0	1	2	0	3
	26 - < 31 years	0	1	7	0	8
	31 years or above	2	16	5	2	25
	Total	2	34	139	19	194
Others	< 1 year	1	3	69	15	88
	1 - < 6 years	0	10	188	22	220

Major Specialty	Year of Service	DOM/NC/ SNO and Above	APN/NS/ NO/WM/ ANC	RN	EN/ Others	Total
	6 - < 11 years	0	13	78	3	94
	11 - < 16 years	2	16	30	1	49
	16 - < 21 years	0	9	9	1	19
	21 - < 26 years	0	6	5	1	12
	26 - < 31 years	7	22	29	5	63
	31 years or above	5	37	36	11	89
	Total	15	116	444	59	634

Note:

- (1) Attrition (Wastage) includes all types of cessation of service (including retirement) from the HA for permanent and contract staff on headcount basis.
- (2) From January 2024 onwards, the HA excludes those staff under the EER arrangement when compiling the statistics of Attrition (Wastage). The related figures before January 2024 are for reference only and direct comparison with those derived from the revised calculation method is not appropriate.
- (3) Starting from August 2022, the rank group “DOM/SNO and Above” has been revised to “DOM/ NC/SNO and Above”.
- (4) After the creation of the rank of ANC, the rank group “APN/NS/NO/WM” has been revised to “APN/NS/NO/WM/ANC” since August 2022.

3.

The table below sets out, by year of service, the number of Consultants and Senior Medical Officers/Associate Consultants promoted from 2022-23 to 2024-25 (April – December 2024):

2022-23

Year of Service	CON	SMO/AC
< 1 year	1	2
1 - < 6 years	5	8
6 - < 11 years	11	255
11 - < 16 years	43	52
16 - < 21 years	65	5
21 - < 26 years	22	0
26 - < 31 years	10	1
31 years or above	1	0
Total	158	323

2023-24

Year of Service	CON	SMO/AC
< 1 year	3	4
1 - < 6 years	8	7
6 - < 11 years	16	188

Year of Service	CON	SMO/AC
11 - < 16 years	41	44
16 - < 21 years	34	2
21 - < 26 years	18	0
26 - < 31 years	17	0
31 years or above	3	0
Total	140	245

2024-25 (April – December 2024)

Years of Service	CON	SMO/AC
< 1 year	0	1
1 - < 6 years	2	4
6 - < 11 years	14	120
11 - < 16 years	38	24
16 - < 21 years	30	4
21 - < 26 years	12	1
26 - < 31 years	5	0
31 years or above	2	0
Total	103	154

Note:

- (1) The manpower figure is calculated on headcount basis including permanent and contract staff in the HA.
- (2) Promotion refers to cases of appointment to higher rank with higher maximum pay point or take home pay. Other staff movement cases such as transfer/appointment to other rank or lower rank are excluded.
- (3) Doctors exclude Interns and Dental Officers.

4.

The table below sets out, by year of service, the number of Advanced Practice Nurses promoted during 2022-23 to 2024-25 (April – December 2024):

Rank	Year of Service	2022-23	2023-24	2024-25 (April – December 2024)
APN	< 1 year	11	11	3
	1 - < 6 years	62	55	38
	6 - < 11 years	406	388	266
	11 - < 16 years	182	166	100
	16 - < 21 years	24	26	18
	21 - < 26 years	62	28	8
	26 - < 31 years	63	38	25
	31 years or above	5	11	9
Total		815	723	467

Notes:

- (1) The manpower figure is calculated on headcount basis including permanent and contract staff in the HA.
- (2) Promotion refers to cases of appointment to higher rank with higher maximum pay point or take home pay. Other staff movement cases such as transfer/appointment to other rank or lower rank are excluded.

5.

Over the years, the HA has been closely monitoring its manpower situation and introduced a series of measures to attract, develop and retain talents. The HA has implemented ongoing measures within its overall budget including increasing the number of Resident Trainee posts to recruit local medical graduates, recruiting non-locally trained doctors to supplement local recruitment, improving promotion prospects to retain staff, hiring part-time healthcare staff (e.g. recruitment of locum staff), offering flexible full-time work arrangements, extending employment to suitable staff beyond retirement, enhancing the Home Loan Interest Subsidy Scheme (HLISS) and providing better training opportunities for various grades by establishment of the HA Academy. The above measures have begun to bear fruits, as evidenced by an increase in the number of the HA's healthcare staff in the past 2 years and a fall in attrition rate from the peak over the past 2 years.

In December 2019, the HA established the Task Group (TG) on Sustainability to review strategies for retaining staff. In line with the key directions recommended by the TG, the HA gradually rolled out further staff retention measures in 2023-24 and will continue with the relevant work in 2025-26, including:

- (a) creating opportunities for Associate Consultants (AC) to be promoted to Consultant rank, with 400 AC posts upgraded to Consultant posts as at December 2024, so as to retain experienced medical personnel to address the service, manpower and training needs in the HA;
- (b) providing Specialty Nurse Allowance to eligible registered nurses, with around 4 800 nurses receiving the allowance as at December 2024, so as to retain manpower and encourage professional development of nurses through recognising their specialty qualifications;
- (c) enhancing promotion opportunities of allied health professionals and offering allied health specialist allowances for eligible resident physiotherapists, occupational therapists and radiographers, with about 66 applications received as at December 2024, so as to retain manpower and support specialist service needs and development; and
- (d) continue to implement the policy of EER to attract more retired staff who wish to stay after retirement. As at December 2024, there were 181 doctors, 565 nurses, 113 allied health professionals and 3 020 supporting/other grades staff working at the HA after retirement. Among all doctors / nurses / allied health professionals retiring from 2024-25 to 2028-29, at least 338 doctors, 880 nurses and 200 allied health professionals had indicated interest / agreed to take up full-time or part-time employment after retirement.

The additional financial provision for the above 4 measures is around \$161 million in 2025-26.

The HA will continue to closely monitor the manpower situation and actively adopt measures to attract, develop and retain talents for supporting the overall service demand and development in the HA.

Abbreviations

Cluster

HKEC – Hong Kong East Cluster

HKWC – Hong Kong West Cluster

KCC – Kowloon Central Cluster

KEC – Kowloon East Cluster

KWC – Kowloon West Cluster

NTEC – New Territories East Cluster

NTWC – New Territories West Cluster

Rank group

CON – Consultant

SMO/AC – Senior Medical Officer/Associate Consultant

MO/R – Medical Officer/Resident

DOM/NC/SNO – Department Operations Manager/Nurse Consultant/Senior Nursing Officer

APN/NS/NO/WM/ANC – Advanced Practice Nurse/Nurse Specialist/Nursing Officer/Ward Manager/Associate Nurse Consultant

RN – Registered Nurse

EN – Enrolled Nurse

Others

FT – full-time

PT – part-time

- End -

CONTROLLING OFFICER'S REPLY

HHB194

(Question Serial No. 1336)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding drugs for treating cancers, will the Government advise this Committee on the following:

1. the total number of cancer patients receiving treatment at standard fees and charges from the Hospital Authority and the total drug consumption expenditure involved for all types of cancers in each of the past 3 years; and
2. the number of applications received by the Samaritan Fund and the Community Care Fund, the number of applications approved and the amount of subsidies granted in each of the past 3 years, with a breakdown by cancer type and drug?

Asked by: Hon YANG Wing-kit (LegCo internal reference no.: 14)

Reply:

In line with the Government's public healthcare policy to ensure that citizens are not denied adequate medical care due to lack of means, the Hospital Authority (HA) provides healthcare services and drugs or medical items, which are heavily subsidised by the Government, to patients based on their clinical needs and in accordance with the HA's treatment guidelines.

The Government and the HA will press ahead with the implementation of the fees and charges reform for public healthcare announced recently, which aims to guide the public to make optimal use of healthcare resources through 3 aspects, namely reforming the subsidisation structure, reducing wastage and abuse, and enhancing healthcare protection. It also seeks to strengthen the healthcare protection on all fronts for patients who are "poor, acute, serious or critical". Such measures include enhancing the protection in terms of drugs and medical devices for critically ill patients, including cancer patients, through accelerating the introduction of more effective innovative drugs and devices to the HADF and the coverage of the safety net, with a view to ensuring that the limited healthcare resources can be directed in a more targeted manner to assist those patients most in need. This will thereby enhance the sustainability of the healthcare system so as to serve as a safety net for all.

1.

The total numbers of cancer patients receiving treatment at standard fees in the HA and the total drug expenditure involved in 2022-23, 2023-24 and 2024-25 (full-year projection as at 31 December 2024) are set out in the table below.

Year	Number of Cancer Patients Receiving Treatment in the HA[@]	Drug Expenditure Involved (\$ million)
2022-23	152 800	1,402.8
2023-24	159 500	1,511.9
2024-25 (Full-year Projection as at 31 December 2024)	164 200	1,677.5

[@] Figures rounded to the nearest hundred

Remark:

In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA adjusted its services to cope with the outbreak. This should be taken into consideration when comparing the service throughput of the HA in the years concerned. With the cessation of anti-epidemic measures in early 2023, the public healthcare services of the HA has gradually returned to full normalcy.

2.

The names of the cancer drugs covered by the Samaritan Fund (SF) and the Community Care Fund (CCF) Medical Assistance Programmes, the numbers of applications received and approved, and the amounts of subsidies granted in 2022-23, 2023-24 and 2024-25 (up to 31 December 2024) are set out in the tables below.

SF

2022-23				
Type of cancers	Drug	Number of applications received[#]	Number of applications approved[#]	Amount of subsidies granted (\$ million)
Acute lymphoblastic leukaemia (ALL)	Dasatinib	17	17	4.49
	Ponatinib	8	8	2.22
Acute myeloid leukaemia	Midostaurin	21	21	11.15
Brain cancer	Temozolomide	18	18	0.32
Breast cancer	Trastuzumab	191	191	18.30
	Pertuzumab and Trastuzumab	406	406	97.09
	Trastuzumab emtansine (T-DM1)	61	61	13.86
Chronic lymphocytic leukaemia	Rituximab	2	2	0.04
	Ibrutinib	31	31	8.63

2022-23				
Type of cancers	Drug	Number of applications received [#]	Number of applications approved [#]	Amount of subsidies granted (\$ million)
	Acalabrutinib	11	11	2.92
	Bendamustine	5	5	0.56
	Obinutuzumab	0*	0*	0*
Chronic myeloid leukaemia (CML)	Dasatinib	108	108	22.67
	Nilotinib	130	130	34.26
	Ponatinib	19	19	5.50
Colorectal cancer	Cetuximab	209	209	63.20
	Panitumumab	141	141	29.02
Gastrointestinal stromal tumour (GIST)	Imatinib	146	146	5.65
	Sunitinib	40	40	4.95
Liver cancer	Sorafenib	60	60	2.90
Lung cancer	Afatinib	96	96	11.78
	Ceritinib	1	1	0.33
	Crizotinib	25	25	5.01
	Gefitinib	145	145	13.32
	Alectinib	144	144	56.37
	Brigatinib	5	5	1.83
	Osimertinib	185	185	39.38
Lymphoma	Ibrutinib	11	11	3.85
	Obinutuzumab	61	61	9.53
	Rituximab	158	158	3.89
	Brentuximab Vedotin	1	1	0.20
Myelodysplastic syndromes/ Chronic myelomonocytic leukaemia/ Acute myeloid leukaemia	Azacitidine	73	73	3.61
Myelofibrosis-related splenomegaly or symptoms	Ruxolitinib	92	92	49.27
Myeloma	Bortezomib	135	135	9.72
	Lenalidomide	37	37	4.45
	Carfilzomib	52	52	18.67
	Pomalidomide	39	39	15.08
Prostate cancer	Abiraterone	13	13	1.88
	Enzalutamide	51	51	8.30
Renal cell carcinoma	Axitinib	11	11	0.82
	Pazopanib	72	72	9.64
Total		3 031	3 031	594.66

2023-24				
Type of cancers	Drug	Number of applications received [#]	Number of applications approved [#]	Amount of subsidies granted (\$ million)
Acute lymphoblastic leukaemia (ALL)	Dasatinib	24	24	5.05
	Inotuzumab Ozogamicin	0*	0*	0*
	Ponatinib	12	12	3.44
Acute myeloid leukaemia	Gilteritinib	2	2	1.16
	Midostaurin	20	20	10.15
	Venetoclax and Azacitidine	46	46	15.03
Brain cancer	Temozolomide	12	12	0.24
Breast cancer	Abemaciclib	23	23	3.00
	Abemaciclib and Fulvestrant	22	22	5.34
	Everolimus	19	19	2.62
	Palbociclib	92	92	10.15
	Ribociclib	168	168	27.47
	Ribociclib and Fulvestrant	48	48	9.07
	Trastuzumab	43	43	8.97
	Pertuzumab and Trastuzumab	399	399	93.18
	Trastuzumab emtansine (T-DM1)	130	130	36.72
Chronic lymphocytic leukaemia	Rituximab	3	3	0.04
	Ibrutinib	16	16	4.98
	Acalabrutinib	21	21	6.82
	Bendamustine	5	5	0.53
	Obinutuzumab	5	5	0.22
Chronic myeloid leukaemia (CML)	Dasatinib	127	127	25.98
	Nilotinib	127	127	33.08
	Ponatinib	26	26	7.51
Colorectal cancer	Cetuximab	166	166	53.04
	Panitumumab	177	177	35.91
Gastrointestinal stromal tumour (GIST)	Sunitinib	45	45	5.52
Liver cancer	Sorafenib	78	78	2.68
	Lenvatinib	36	36	6.04
Lung cancer	Afatinib	91	91	11.63
	Alectinib	120	120	43.76

2023-24				
Type of cancers	Drug	Number of applications received [#]	Number of applications approved [#]	Amount of subsidies granted (\$ million)
	Atezolizumab	26	26	9.34
	Brigatinib	14	14	6.75
	Ceritinib	2	2	0.20
	Crizotinib	19	19	4.14
	Durvalumab	34	34	11.35
	Gefitinib	123	123	11.75
	Nivolumab	18	18	4.58
	Osimertinib	213	213	42.84
	Pembrolizumab	85	85	48.88
Lymphoma	Ibrutinib	4	4	1.39
	Obinutuzumab	96	96	13.51
	Rituximab	156	156	3.28
	Brentuximab Vedotin	14	14	3.55
Myelodysplastic syndromes/ Chronic myelomonocytic leukaemia/ Acute myeloid leukaemia	Azacitidine	68	68	2.97
Myelofibrosis-related splenomegaly or symptoms	Ruxolitinib	102	102	55.61
Myeloma	Bortezomib	84	84	6.02
	Lenalidomide	93	93	15.56
	Carfilzomib	40	40	17.18
	Pomalidomide	31	31	9.31
Prostate cancer	Abiraterone	30	30	4.16
	Apalutamide	22	22	4.60
	Enzalutamide	175	175	24.80
Renal cell carcinoma	Axitinib	27	27	1.71
	Pazopanib	68	68	9.46
Skin cancer	Dabrafenib and Trametinib	0*	0*	0*
	Nivolumab	16	16	4.14
Total		3 663	3 663	786.41

2024-25 (up to 31 December 2024)				
Type of cancers	Drug	Number of applications received [#]	Number of applications approved [#]	Amount of subsidies granted (\$ million)
Acute lymphoblastic leukaemia (ALL)	Dasatinib	19	19	4.84
	Inotuzumab Ozogamicin	3	3	0.70
	Ponatinib	8	8	2.21
Acute myeloid leukaemia	Gemtuzumab Ozogamicin	1	1	0.20
	Gilteritinib	9	9	2.74
	Midostaurin	12	12	6.98
	Venetoclax and Azacitidine	63	63	13.27
Brain cancer	Temozolomide	8	8	0.12
Breast cancer	Abemaciclib	59	59	7.19
	Abemaciclib and Fulvestrant	18	18	2.88
	Everolimus	16	16	2.05
	Palbociclib	59	59	7.62
	Ribociclib	218	218	28.97
	Ribociclib and Fulvestrant	58	58	10.74
	Trastuzumab	28	28	6.07
	Pertuzumab and Trastuzumab	300	300	66.05
	Trastuzumab deruxtecan	6	6	2.90
	Trastuzumab emtansine (T-DM1)	121	121	32.63
Chronic lymphocytic leukaemia	Rituximab	1	1	0.01
	Ibrutinib	7	7	1.77
	Acalabrutinib	32	32	10.01
	Bendamustine	6	6	0.24
	Obinutuzumab	2	2	0.21
Chronic myeloid leukaemia (CML)	Dasatinib	97	97	20.42
	Nilotinib	100	100	27.00
	Ponatinib	16	16	4.98
Colorectal cancer	Cetuximab	145	145	44.57
	Panitumumab	148	148	32.23
Gastrointestinal stromal tumour (GIST)	Sunitinib	28	28	3.67

2024-25 (up to 31 December 2024)				
Type of cancers	Drug	Number of applications received [#]	Number of applications approved [#]	Amount of subsidies granted (\$ million)
Liver cancer	Sorafenib	0*	0*	0*
	Lenvatinib	74	74	11.61
Lung cancer	Afatinib	65	65	8.31
	Alectinib	92	92	36.01
	Atezolizumab	53	53	13.10
	Brigatinib	16	16	4.94
	Ceritinib	0*	0*	0*
	Crizotinib	14	14	3.26
	Durvalumab	54	54	15.69
	Gefitinib	73	73	4.03
	Lorlatinib	0*	0*	0*
	Nivolumab	46	46	10.08
	Osimertinib	417	417	88.89
	Pembrolizumab	215	215	116.63
Lymphoma	Ibrutinib	0*	0*	0*
	Obinutuzumab	64	64	6.88
	Rituximab	85	85	1.30
	Brentuximab Vedotin	11	11	3.30
Myelodysplastic syndromes/ Chronic myelomonocytic leukaemia/ Acute myeloid leukaemia	Azacitidine	47	47	1.77
Myelofibrosis-related splenomegaly or symptoms	Ruxolitinib	73	73	39.28
Myeloma	Bortezomib	33	33	1.91
	Lenalidomide	86	86	13.10
	Carfilzomib	13	13	5.69
	Pomalidomide	6	6	1.45
	Lenalidomide and Bortezomib	45	45	9.47
Pancreatic cancer	Paclitaxel (Albumin)	41	41	5.71
Prostate cancer	Abiraterone	33	33	4.35
	Apalutamide	73	73	17.05
	Enzalutamide	214	214	37.22
Renal cell carcinoma	Axitinib	25	25	1.66
	Pazopanib	51	51	6.90

2024-25 (up to 31 December 2024)				
Type of cancers	Drug	Number of applications received[#]	Number of applications approved[#]	Amount of subsidies granted (\$ million)
	Nivolumab and Ipilimumab	5	5	2.60
Skin cancer	Dabrafenib and Trametinib	2	2	0.40
	Nivolumab	37	37	8.68
Waldenstrom's macroglobulinaemia	Zanubrutinib	7	7	1.87
Epithelial ovarian/ fallopian tube/ primary peritoneal cancer	Bevacizumab	1	1	0.26
	Olaparib	33	33	8.52
Bladder cancer	Pembrolizumab	26	26	13.58
Malignant pleural mesothelioma	Nivolumab and Ipilimumab	0*	0*	0*
Esophageal squamous cell carcinoma	Nivolumab	0*	0*	0*
Head and neck cancer	Nivolumab	3	3	0.91
Aggressive systemic mastocytosis / systemic mastocytosis with associated haematological neoplasm / mast cell leukaemia	Midostaurin	1	1	0.99
Total		3 722	3 722	850.67

* No application was received for these drugs in respective years.

The above data do not include withdrawn/cancelled applications.

CCF Medical Assistance Programmes

(including the “First Phase Programme of the CCF Medical Assistance Programmes” and “Subsidy for Eligible Patients to Purchase Ultra-expensive Drugs (Including Those for Treating Uncommon Disorders)”)

2022-23				
Type of cancers	Drug	Number of applications received [#]	Number of applications approved [#]	Amount of subsidies granted (\$ million)
Bladder cancer	Pembrolizumab	40	40	17.91
Breast cancer	Everolimus	18	18	2.36
	Lapatinib	14	14	0.94
	Palbociclib	200	200	26.15
	Ribociclib	119	119	14.68
	Trastuzumab emtansine (T-DM1)	67	67	20.95
	Abemaciclib	117	117	18.07
	Neratinib	8	8	1.06
Colorectal cancer	Bevacizumab	387	387	53.78
Liver cancer	Lenvatinib	219	219	29.29
	Atezolizumab and Bevacizumab	36	36	12.44
Gastric carcinoma	Trastuzumab	8	8	0.91
Head and neck cancer	Nivolumab	39	39	8.40
Leukaemia	Bendamustine	3	3	0.15
	Obinutuzumab	4	4	0.30
	Inotuzumab Ozogamicin	4	4	1.49
	Gemtuzumab Ozogamicin	17	17	2.49
	Tisagenlecleucel	3	3	7.83
Lymphoma	Brentuximab Vedotin	9	9	4.13
	Tisagenlecleucel	17	17	43.99
	Acalabrutinib	2	2	0.73
	Pembrolizumab	4	4	2.85
	Polatuzumab Vedotin and Rituximab and Bendamustine	16	16	3.83
Lung cancer	Alectinib	2	2	0.70
	Ceritinib	3	3	0.15
	Osimertinib	462	462	95.58
	Brigatinib	2	2	0.72
	Durvalumab	64	64	18.51

2022-23				
Type of cancers	Drug	Number of applications received [#]	Number of applications approved [#]	Amount of subsidies granted (\$ million)
	Pembrolizumab	312	312	163.90
	Atezolizumab	105	105	24.77
	Nivolumab	102	102	33.74
	Lorlatinib	34	34	14.14
Myeloma	Ixazomib and Lenalidomide	110	110	35.15
Neuroblastoma	Dinutuximab Beta	4	4	5.76
Ovarian cancer	Pegylated Liposomal Doxorubicin	58	58	3.93
Renal cell carcinoma	Axitinib	21	21	1.27
	Sunitinib	11	11	1.04
	Pazopanib	24	24	2.51
	Nivolumab and Ipilimumab	56	56	29.18
Skin cancer	Nivolumab	34	34	11.40
	Vemurafenib	0*	0*	0*
	Dabrafenib and Trametinib	10	10	4.11
Prostate cancer	Abiraterone	68	68	9.22
	Enzalutamide	124	124	16.45
Epithelial ovarian/ fallopian tube/ primary peritoneal cancer	Bevacizumab	50	50	6.86
	Olaparib	52	52	14.00
Total		3 059	3 059	767.82

2023-24				
Type of cancers	Drug	Number of applications received [#]	Number of applications approved [#]	Amount of subsidies granted (\$ million)
Bladder cancer	Avelumab	6	6	2.18
	Pembrolizumab	39	39	16.75
Breast cancer	Everolimus	3	3	0.35
	Lapatinib	15	15	0.86
	Palbociclib	22	22	2.00
	Ribociclib	20	20	3.29

2023-24				
Type of cancers	Drug	Number of applications received [#]	Number of applications approved [#]	Amount of subsidies granted (\$ million)
	Trastuzumab emtansine (T-DM1)	9	9	1.51
	Abemaciclib	72	72	9.17
	Neratinib	20	20	2.12
Colorectal cancer	Bevacizumab	438	438	57.60
Liver cancer	Lenvatinib	96	96	12.44
	Atezolizumab and Bevacizumab	142	142	37.78
Gastric carcinoma	Trastuzumab	1	1	0.25
Gastric, gastroesophageal junction or esophageal adenocarcinoma	Nivolumab	6	6	1.46
Head and neck cancer	Nivolumab	32	32	5.18
	Pembrolizumab	38	38	16.97
Leukaemia	Inotuzumab Ozogamicin	2	2	0.40
	Gemtuzumab Ozogamicin	20	20	3.21
	Tisagenlecleucel	3	3	7.37
Lymphoma	Brentuximab Vedotin	1	1	0.44
	Tisagenlecleucel	35	35	76.78
	Acalabrutinib	4	4	0.90
	Ibrutinib	6	6	4.40
	Pembrolizumab	6	6	4.24
	Polatuzumab Vedotin and Rituximab and Bendamustine	48	48	7.80
Lung cancer	Osimertinib	436	436	88.65
	Brigatinib	1	1	0.44
	Durvalumab	44	44	13.24
	Pembrolizumab	296	296	142.40
	Atezolizumab	90	90	17.34
	Nivolumab	65	65	13.81
	Nivolumab and Ipilimumab	5	5	1.76
	Lorlatinib	80	80	34.30

2023-24				
Type of cancers	Drug	Number of applications received [#]	Number of applications approved [#]	Amount of subsidies granted (\$ million)
Myeloma	Daratumumab and Bortezomib	59	59	22.75
	Isatuximab and Pomalidomide	31	31	17.98
	Ixazomib and Lenalidomide	130	130	45.40
Neuroblastoma	Dinutuximab Beta	3	3	3.78
Ovarian cancer	Pegylated Liposomal Doxorubicin	66	66	4.01
Renal cell carcinoma	Sunitinib	11	11	1.45
	Nivolumab and Ipilimumab	80	80	32.87
Skin cancer	Nivolumab	15	15	4.23
	Vemurafenib	0*	0*	0*
	Dabrafenib and Trametinib	0*	0*	0*
Prostate cancer	Abiraterone	35	35	4.67
Epithelial ovarian/ fallopian tube/ primary peritoneal cancer	Bevacizumab	29	29	3.55
	Niraparib	22	22	7.48
	Olaparib	56	56	13.81
Thyroid cancer	Lenvatinib	10	10	4.50
Total		2 648	2 648	753.87

2024-25 (up to 31 December 2024)				
Type of cancers	Drug	Number of applications received [#]	Number of applications approved [#]	Amount of subsidies granted (\$ million)
Bladder cancer	Avelumab	13	13	4.50
	Pembrolizumab	10	10	3.19
Breast cancer	Lapatinib	15	15	1.10
	Neratinib	24	24	2.58
Colorectal cancer	Bevacizumab	311	311	42.75
Liver cancer	Atezolizumab and Bevacizumab	156	156	43.22
Gastric carcinoma	Trastuzumab	1	1	0.25

2024-25 (up to 31 December 2024)				
Type of cancers	Drug	Number of applications received [#]	Number of applications approved [#]	Amount of subsidies granted (\$ million)
Gastric, gastroesophageal junction or esophageal adenocarcinoma	Nivolumab	31	31	6.54
Head and neck cancer	Nivolumab	11	11	2.29
	Pembrolizumab	48	48	24.84
Leukaemia	Ibrutinib	0*	0*	0*
	Gemtuzumab Ozogamicin	13	13	2.26
	Tisagenlecleucel	1	1	2.70
Lymphoma	Tisagenlecleucel	19	19	47.20
	Acalabrutinib	9	9	2.87
	Ibrutinib	3	3	1.87
	Pembrolizumab	2	2	1.42
	Polatuzumab Vedotin and Rituximab	25	25	3.20
	Polatuzumab Vedotin and Rituximab and Bendamustine	29	29	4.19
	Zanubrutinib	7	7	1.92
Lung cancer	Osimertinib	176	176	45.44
	Pembrolizumab	127	127	70.52
	Atezolizumab	7	7	2.32
	Nivolumab and Ipilimumab	11	11	3.02
	Lorlatinib	72	72	31.96
Myeloma	Daratumumab and Bortezomib	41	41	14.48
	Daratumumab and Lenalidomide	39	39	24.73
	Isatuximab and Pomalidomide	46	46	26.81
	Ixazomib and Lenalidomide	57	57	15.59
Neuroblastoma	Dinutuximab Beta	5	5	10.12
Ovarian cancer	Pegylated Liposomal Doxorubicin	53	53	1.19
Renal cell carcinoma	Sunitinib	12	12	1.45

2024-25 (up to 31 December 2024)				
Type of cancers	Drug	Number of applications received[#]	Number of applications approved[#]	Amount of subsidies granted (\$ million)
	Nivolumab and Ipilimumab	67	67	28.55
Skin cancer	Vemurafenib	0*	0*	0*
	Dabrafenib and Trametinib	0*	0*	0*
Prostate cancer	Abiraterone	5	5	0.54
Epithelial ovarian/ fallopian tube/ primary peritoneal cancer	Bevacizumab	20	20	3.39
	Niraparib	27	27	9.57
	Olaparib	5	5	1.52
Thyroid cancer	Lenvatinib	14	14	5.67
Neurofibromatosis	Selumetinib	8	8	6.05
Uterine cancer	Lenvatinib and Pembrolizumab	27	27	22.29
Total		1 547	1 547	524.10

* No application was received for these drugs in respective years.

The above data do not include withdrawn/cancelled applications.

- End -

CONTROLLING OFFICER'S REPLY

HHB195

(Question Serial No. 3089)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the enhancement of public healthcare services, will the Government inform this Committee of:

1. the numbers of proposed additional hospital beds, operating theatre sessions and endoscopy examination sessions, the additional quotas for consultation at general out-patient clinics and specialist out-patient clinics, and the total number of Accident and Emergency (A&E) support sessions in hospitals of all clusters in each of the past 3 years with a breakdown by hospital cluster, as well as the expenditures involved; and
2. the waiting time for specialist out-patient services, A&E services and diagnostic radiological investigations in hospitals of all clusters in each of the past 3 years with a breakdown by hospital cluster?

Asked by: Hon YANG Wing-kit (LegCo internal reference no.: 38)

Reply:

1.

The Hospital Authority (HA) has all along, through its Annual Work Plans, strengthened service capacity including provision of additional hospital beds, operating theatres (OTs) and endoscopy sessions, as well as continuous enhancement of the out-patient services to support the growing demand for public healthcare services. When planning and developing its various public healthcare services, the HA will consider a number of factors such as the increase in service demand arising from population growth and demographic changes, manpower availability, facility provision, technological advancement as well as service provision of various clusters. Meanwhile, the HA will monitor the manpower situation and put in place measures to attract, develop and retain talents in support of its overall service needs and development.

Hospital beds

The HA has earmarked \$650 million, \$139 million and \$235 million in 2022-23, 2023-24 and 2024-25 respectively for additional hospital beds, with details tabulated below.

Hospital Cluster	Planned Number of Additional Hospital Beds in 2022-23		
	Acute General	Convalescent / Rehabilitation	Total
HKEC	3	—	3
HKWC	3	—	3
KCC	59	—	59
KEC	38	40	78
KWC	72	—	72
NTEC	52	—	52
NTWC	77	50	127
HA Overall	304	90	394

Hospital Cluster	Planned Number of Additional Hospital Beds in 2023-24			
	Acute General	Convalescent / Rehabilitation	Mentally Ill	Total
HKEC	26	—	—	26
HKWC	—	—	—	—
KCC	6	2	—	8
KEC	10	—	—	10
KWC	—	—	35	35
NTEC	16	—	—	16
NTWC	8	—	—	8
HA Overall	66	2	35	103

Hospital Cluster	Planned Number of Additional Hospital Beds in 2024-25		
	Acute General	Convalescent / Rehabilitation	Total
HKEC	—	—	—
HKWC	—	—	—
KCC	17	—	17
KEC	22	—	22
KWC	31	—	31
NTEC	44	10	54
NTWC	29	—	29
HA Overall	143	10	153

OT sessions, endoscopic sessions, general out-patient clinic (GOPC) attendances, specialist out-patient clinic (SOPC) attendances and Accident & Emergency (A&E) support sessions

The HA earmarked \$530 million, \$120 million and 234 million in 2022-23, 2023-24 and 2024-25 respectively for enhancing the services tabulated below.

<i>(Planned)</i>	2022-23	2023-24	2024-25
Number of additional OT sessions per week	76 (HKEC, KCC, KEC, KWC, NTEC & NTWC)	6 (NTWC)	22 (HKEC, KCC & NTWC)
Number of additional endoscopic sessions per week	13 (HKEC & KWC)	3 (HKEC)	11 (KCC & KWC)
Additional GOPC attendances	11 100 (KEC, KWC, NTEC & NTWC)	(Note 1)	9 500 (KWC)
Additional SOPC attendances	58 000 (All hospital clusters)	223 000 (All hospital clusters)	22 000 (All hospital clusters)
Total number of A&E support sessions (equivalent to number of 4-hour sessions)	Around 3 400 (All hospital clusters)	(Note 2)	(Note 2)

Note:

- (1) The HA's planning focus for 2023-24 was on the preparatory work for the successive commissioning of the newly-built GOPCs/Community Health Centres (CHCs) in the coming financial years. These clinics include the CHCs in the North District, the GOPC in the Joint-user Government Office Building in Tseung Kwan O Area 67 and the CHC in the New Acute Hospital at Kai Tak Development Area, etc. Additional GOPC attendances will be provided in 2024-25 and 2025-26.
- (2) As the A&E Support Session Programme has been incorporated into the overall Special Honorarium Scheme for hospitals to meet service needs since 2023-24, the HA does not maintain the relevant figures.

2.

Specialist out-patient waiting time

The numbers of specialist out-patient new cases triaged under the categories of Priority 1 (urgent), Priority 2 (semi-urgent) and Routine (stable), along with their respective median (50th percentile) waiting time, in each hospital cluster of the HA in 2022-23, 2023-24 and 2024-25 (up to 31 December 2024) are tabulated below:

Hospital Cluster	Specialty	Priority 1		Priority 2		Routine	
		Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)
HKEC	ENT	488	<1	3 502	4	4 910	14
	MED	963	1	3 178	5	10 668	48
	GYN	695	<1	541	6	3 904	25
	OPH	4 482	<1	3 041	5	7 584	52
	ORT	1 311	1	1 293	5	6 688	55
	PAE	76	1	673	4	286	9
	PSY	302	<1	897	3	3 296	19
	SUR	999	1	3 168	7	10 867	46
HKWC	ENT	961	<1	2 085	7	3 605	65
	MED	1 802	<1	1 793	4	11 414	34
	GYN	1 244	<1	907	6	3 859	34
	OPH	2 454	1	1 777	4	6 669	55
	ORT	1 265	1	1 409	4	7 808	20
	PAE	103	<1	361	5	1 122	11
	PSY	363	1	687	4	1 920	41
	SUR	2 441	<1	2 999	4	10 716	26
KCC	ENT	1 985	<1	2 088	4	13 181	37
	MED	1 210	1	3 593	6	21 992	71
	GYN	934	<1	2 944	6	7 482	30
	OPH	6 983	<1	6 604	2	10 388	71
	ORT	1 978	1	1 977	4	11 819	51
	PAE	1 145	<1	1 605	4	2 748	10
	PSY	195	<1	1 318	4	2 347	18
	SUR	2 561	1	5 434	5	27 365	37
KEC	ENT	1 611	<1	2 606	6	6 742	86
	MED	1 804	1	4 788	6	19 030	58
	GYN	1 574	1	834	4	5 798	57
	OPH	5 520	<1	5 238	6	10 786	71
	ORT	2 975	<1	2 571	3	9 969	71
	PAE	731	<1	531	4	2 959	10
	PSY	265	1	2 322	3	5 238	52
	SUR	1 814	1	5 204	7	18 083	71
KWC	ENT	2 024	<1	2 303	5	10 662	62

Hospital Cluster	Specialty	Priority 1		Priority 2		Routine	
		Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)
	MED	1 752	1	5 585	6	15 897	72
	GYN	222	<1	1 595	6	7 468	46
	OPH	6 194	<1	5 886	5	9 144	167
	ORT	1 860	<1	3 251	4	12 632	54
	PAE	1 334	<1	1 138	4	2 840	9
	PSY	232	<1	909	4	13 129	29
	SUR	1 874	1	5 953	5	21 840	52
NTEC	ENT	2 469	<1	3 040	4	12 300	50
	MED	2 407	<1	3 201	6	21 681	48
	GYN	2 216	<1	981	6	7 629	57
	OPH	6 635	<1	4 053	4	15 941	52
	ORT	4 524	<1	1 360	4	14 346	45
	PAE	107	<1	407	6	3 701	16
	PSY	828	1	2 427	4	6 342	64
	SUR	2 166	1	2 992	5	26 850	32
NTWC	ENT	3 808	<1	1 380	4	8 828	61
	MED	1 013	<1	2 404	6	9 591	38
	GYN	1 169	<1	353	6	4 814	62
	OPH	10 901	<1	3 449	4	8 243	59
	ORT	1 896	1	1 793	6	9 791	31
	PAE	265	<1	1 059	6	1 951	23
	PSY	377	1	1 459	3	6 027	55
	SUR	1 986	1	5 057	5	18 527	49
HA Overall	ENT	13 346	<1	17 004	5	60 228	50
	MED	10 951	1	24 542	6	110 273	54
	GYN	8 054	<1	8 155	6	40 954	39
	OPH	43 169	<1	30 048	4	68 755	55
	ORT	15 809	<1	13 654	4	73 053	48
	PAE	3 761	<1	5 774	4	15 607	12
	PSY	2 562	1	10 019	4	38 299	40
	SUR	13 841	1	30 807	5	134 248	46

2023-24

Hospital Cluster	Specialty	Priority 1		Priority 2		Routine	
		Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)
HKEC	ENT	394	<1	3 903	4	5 701	14
	MED	699	1	3 412	5	11 750	37
	GYN	662	<1	559	6	3 903	25
	OPH	4 817	<1	3 799	7	8 817	42
	ORT	1 247	1	1 314	5	6 329	51
	PAE	43	<1	834	6	522	12
	PSY	240	1	766	3	3 655	26
	SUR	878	1	3 078	7	11 116	44
HKWC	ENT	1 154	<1	2 466	7	3 802	26
	MED	1 776	<1	1 946	4	11 123	30
	GYN	1 431	<1	1 046	5	3 385	27
	OPH	2 433	1	1 714	6	6 607	61
	ORT	1 023	1	1 759	4	8 267	20
	PAE	96	1	306	4	1 444	16
	PSY	348	1	811	4	1 914	40
	SUR	2 570	<1	3 218	5	11 190	17
KCC	ENT	1 991	<1	2 218	4	13 327	38
	MED	1 451	1	4 220	6	24 333	57
	GYN	924	<1	2 885	6	8 097	35
	OPH	7 328	<1	6 380	2	13 655	85
	ORT	1 307	1	2 378	3	11 901	36
	PAE	1 090	<1	1 930	6	3 480	12
	PSY	271	<1	1 204	3	2 394	20
	SUR	2 369	1	5 907	5	29 556	33
KEC	ENT	1 996	<1	2 959	4	7 932	70
	MED	1 346	1	5 059	5	21 385	56
	GYN	1 465	1	905	5	5 447	36
	OPH	5 764	<1	5 464	6	12 707	84
	ORT	3 233	<1	2 147	4	11 351	57
	PAE	718	<1	545	4	3 544	12
	PSY	272	1	2 066	3	5 455	47
	SUR	1 953	1	5 616	6	19 290	59

Hospital Cluster	Specialty	Priority 1		Priority 2		Routine	
		Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)
KWC	ENT	2 517	<1	2 966	4	12 440	33
	MED	1 631	1	6 007	6	16 300	62
	GYN	181	<1	1 696	6	7 475	58
	OPH	6 357	<1	4 887	5	7 961	74
	ORT	2 086	<1	2 672	3	13 386	50
	PAE	1 259	<1	1 167	6	3 199	11
	PSY	256	<1	795	3	12 947	26
	SUR	1 872	1	5 506	5	23 999	53
NTEC	ENT	2 404	<1	3 104	5	13 897	36
	MED	1 876	1	3 283	6	20 158	40
	GYN	2 057	<1	1 028	5	7 687	59
	OPH	7 005	<1	3 444	4	18 595	78
	ORT	4 632	<1	1 419	5	14 818	58
	PAE	93	<1	394	7	4 759	23
	PSY	829	1	2 310	4	6 701	73
	SUR	2 246	1	3 236	5	27 342	30
NTWC	ENT	4 317	<1	1 743	4	10 089	35
	MED	1 309	<1	2 517	6	10 474	27
	GYN	1 062	<1	314	5	5 030	60
	OPH	11 555	<1	6 686	3	8 051	82
	ORT	2 006	1	1 990	6	9 961	36
	PAE	210	1	1 052	6	2 929	21
	PSY	390	1	1 597	3	5 873	34
	SUR	1 947	1	4 625	5	19 741	35
HA Overall	ENT	14 773	<1	19 359	5	67 188	36
	MED	10 088	1	26 444	6	115 523	49
	GYN	7 782	<1	8 433	5	41 024	39
	OPH	45 259	<1	32 374	4	76 393	66
	ORT	15 534	<1	13 679	4	76 013	45
	PAE	3 509	<1	6 228	6	19 877	15
	PSY	2 606	1	9 549	3	38 939	40
	SUR	13 835	1	31 186	5	142 234	40

2024-25 (up to 31 December 2024)

Hospital Cluster	Specialty	Priority 1		Priority 2		Routine	
		Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)
HKEC	ENT	491	<1	2 568	5	4 519	26
	MED	586	1	2 496	5	9 484	29
	GYN	481	<1	366	7	3 091	25
	OPH	3 517	<1	2 718	7	6 270	30
	ORT	926	1	975	5	5 254	30
	PAE	40	<1	679	6	436	15
	PSY	106	1	437	3	3 037	39
	SUR	693	1	2 545	7	8 724	39
HKWC	ENT	929	<1	1 907	7	3 148	41
	MED	1 319	<1	1 729	4	8 581	30
	GYN	1 176	1	899	5	2 627	28
	OPH	2 040	1	1 229	6	4 086	61
	ORT	692	1	1 498	4	5 991	23
	PAE	59	1	207	4	1 185	20
	PSY	230	1	569	3	1 522	42
	SUR	1 916	<1	2 641	4	8 889	19
KCC	ENT	1 272	<1	1 388	4	10 035	40
	MED	1 002	1	3 190	6	18 566	61
	GYN	713	<1	2 295	6	6 464	31
	OPH	5 717	<1	4 759	3	10 007	91
	ORT	789	1	1 993	4	8 659	24
	PAE	869	<1	1 742	5	3 468	10
	PSY	212	<1	925	3	1 813	21
	SUR	1 685	1	4 296	5	23 396	37
KEC	ENT	1 472	<1	1 993	4	7 131	80
	MED	922	1	3 331	6	15 866	47
	GYN	1 000	1	785	5	4 508	31
	OPH	4 738	<1	4 216	7	9 079	74
	ORT	2 324	<1	1 494	5	8 781	51
	PAE	498	<1	446	4	2 715	11
	PSY	197	1	1 353	3	4 520	45
	SUR	1 506	1	4 277	6	14 463	58

Hospital Cluster	Specialty	Priority 1		Priority 2		Routine	
		Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)
KWC	ENT	2 523	<1	2 378	4	8 901	39
	MED	1 039	1	4 351	6	12 486	67
	GYN	149	<1	1 259	6	5 982	70
	OPH	4 820	<1	3 807	8	7 815	35
	ORT	1 399	1	2 132	3	10 150	53
	PAE	781	<1	503	6	3 015	17
	PSY	158	<1	395	2	10 266	25
	SUR	1 303	1	3 931	5	19 591	58
NTEC	ENT	1 900	<1	2 570	5	10 775	31
	MED	1 407	1	2 778	6	16 953	49
	GYN	1 475	<1	689	5	6 066	61
	OPH	5 556	<1	2 815	6	13 958	74
	ORT	3 581	<1	1 493	5	10 716	29
	PAE	72	<1	293	6	3 502	36
	PSY	482	1	1 858	4	5 531	78
	SUR	2 147	1	2 767	5	20 216	32
NTWC	ENT	3 090	<1	981	5	8 872	52
	MED	1 158	<1	2 035	6	8 442	38
	GYN	318	<1	273	4	4 224	58
	OPH	9 555	<1	3 314	4	6 521	75
	ORT	1 551	1	1 491	6	8 425	33
	PAE	140	<1	892	5	2 016	28
	PSY	291	<1	1 398	2	4 566	39
	SUR	1 302	1	3 290	5	16 606	39
HA Overall	ENT	11 677	<1	13 785	5	53 381	40
	MED	7 433	1	19 910	6	90 378	48
	GYN	5 312	<1	6 566	6	32 962	36
	OPH	35 943	<1	22 858	5	57 736	64
	ORT	11 262	<1	11 076	4	57 976	35
	PAE	2 459	<1	4 762	5	16 337	17
	PSY	1 676	1	6 935	3	31 255	41
	SUR	10 552	1	23 747	6	111 885	40

Note:

- (1) With effect from 1 October 2022, the waiting time for new case booking at integrated clinics has been incorporated into that at SOPCs.

- (2) In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA has adjusted its services to cope with the outbreak. This should be taken into consideration when comparing the service throughput of the HA in relevant years. With the cessation of anti-epidemic measures in early 2023, the HA's services have returned to normalcy gradually.

A&E Services

The attendances and average waiting time for A&E services under various triage categories in each hospital cluster of the HA in 2022-23, 2023-24 and 2024-25 (up to 31 December 2024) are tabulated below:

A&E attendances

2022-23

Hospital Cluster	A&E Attendance				
	Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
HKEC	2 416	5 119	56 972	92 326	3 193
HKWC	1 256	3 471	38 967	52 844	1 629
KCC	5 966	7 216	132 537	95 754	5 505
KEC	4 592	6 937	105 257	103 206	6 447
KWC	5 089	8 789	147 811	190 003	4 982
NTEC	4 597	9 383	91 884	189 505	4 430
NTWC	2 909	9 937	100 570	179 887	14 655
HA Overall	26 825	50 852	673 998	903 525	40 841

2023-24

Hospital Cluster	A&E Attendance				
	Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
HKEC	2 849	5 769	67 747	109 295	5 245
HKWC	1 320	3 717	45 704	60 653	3 203
KCC	6 870	7 777	164 683	132 339	8 143
KEC	4 324	7 799	123 740	132 599	10 601
KWC	4 935	10 008	180 354	236 593	5 756
NTEC	4 204	11 239	115 605	224 938	7 240
NTWC	3 636	10 257	122 520	229 790	18 777
HA Overall	28 138	56 566	820 353	1 126 207	58 965

2024-25 (up to 31 December 2024)

Hospital Cluster	A&E Attendance				
	Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
HKEC	2 176	3 897	49 076	77 259	3 429
HKWC	915	2 677	34 815	44 200	1 538
KCC	4 626	5 752	115 204	105 286	6 277
KEC	2 949	5 587	88 932	93 400	6 345
KWC	3 507	6 917	130 345	160 375	2 996
NTEC	2 957	8 822	87 638	153 729	3 578
NTWC	1 940	7 936	91 230	161 312	8 195
HA Overall	19 070	41 588	597 240	795 561	32 358

The above A&E attendances under various triage categories in each hospital cluster of the HA exclude (i) first-time visits without triage categories and (ii) follow-up visits to the A&E departments.

Average waiting time for A&E services**2022-23**

Hospital Cluster	Average Waiting Time (Minutes) for A&E Services				
	Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
HKEC	0	6	25	127	170
HKWC	0	9	28	109	155
KCC	0	7	23	98	128
KEC	0	10	29	169	224
KWC	0	6	29	128	131
NTEC	0	10	29	105	127
NTWC	0	7	22	131	159
HA Overall	0	8	26	124	158

2023-24

Hospital Cluster	Average Waiting Time (Minutes) for A&E Services				
	Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
HKEC	0	5	30	172	210
HKWC	0	10	38	168	205
KCC	0	8	28	168	183
KEC	0	10	28	187	227
KWC	0	6	30	165	156

Hospital Cluster	Average Waiting Time (Minutes) for A&E Services				
	Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
NTEC	0	10	32	185	197
NTWC	0	6	22	201	217
HA Overall	0	8	29	180	205

2024-25 (up to 31 December 2024)

Hospital Cluster	Average Waiting Time (Minutes) for A&E Services				
	Triage 1 (Critical)	Triage 2 (Emergency)	Triage 3 (Urgent)	Triage 4 (Semi-urgent)	Triage 5 (Non-urgent)
HKEC	0	6	30	158	204
HKWC	0	9	29	132	175
KCC	0	7	20	139	153
KEC	0	10	25	183	224
KWC	0	6	26	151	157
NTEC	0	10	31	185	184
NTWC	0	6	20	176	205
HA Overall	0	8	25	164	190

Note:

In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA has adjusted its services to cope with the outbreak. This should be taken into consideration when comparing the service throughput of the HA in relevant years. With the cessation of anti-epidemic measures in early 2023, the HA's services have returned to normalcy gradually.

Diagnostic radiological investigation waiting time

The median (50th percentile) waiting time of cases triaged under the categories of Priority 1, Priority 2 and Routine for Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Ultrasonography and Mammogram in each hospital cluster in 2022-23, 2023-24 and 2024-25 (up to 31 December 2024) is tabulated below:

CT

2022-23

Hospital Cluster	Median Waiting Time (Weeks)		
	Priority 1	Priority 2	Routine
HKEC	4	24	51
HKWC	3	34	129
KCC	28	72	71
KEC	3	37	97
KWC	1	26	66

Hospital Cluster	Median Waiting Time (Weeks)		
	Priority 1	Priority 2	Routine
NTEC	<1	62	105
NTWC	3	17	58
HA Overall	3	36	78

2023-24

Hospital Cluster	Median Waiting Time (Weeks)		
	Priority 1	Priority 2	Routine
HKEC	5	19	40
HKWC	3	25	71
KCC	2	51	59
KEC	2	42	112
KWC	1	34	52
NTEC	1	30	65
NTWC	4	20	117
HA Overall	3	29	69

2024-25 (up to 31 December 2024)

Hospital Cluster	Median Waiting Time (Weeks)		
	Priority 1	Priority 2	Routine
HKEC	2	14	34
HKWC	3	27	64
KCC	1	29	52
KEC	2	26	92
KWC	1	45	62
NTEC	2	25	50
NTWC	4	59	165
HA Overall	2	26	64

MRI

2022-23

Hospital Cluster	Median Waiting Time (Weeks)		
	Priority 1	Priority 2	Routine
HKEC	2	20	71
HKWC	<1	10	140
KCC	15	79	98
KEC	<1	35	85
KWC	3	19	31
NTEC	3	33	72
NTWC	4	48	83
HA Overall	3	34	83

2023-24

Hospital Cluster	Median Waiting Time (Weeks)		
	Priority 1	Priority 2	Routine
HKEC	4	42	79
HKWC	<1	7	162
KCC	2	43	52
KEC	1	19	87
KWC	4	29	72
NTEC	2	30	100
NTWC	9	52	101
HA Overall	3	33	92

2024-25 (up to 31 December 2024)

Hospital Cluster	Median Waiting Time (Weeks)		
	Priority 1	Priority 2	Routine
HKEC	4	25	75
HKWC	<1	6	170
KCC	2	33	50
KEC	1	18	78
KWC	3	36	99
NTEC	3	29	91
NTWC	24	76	118
HA Overall	3	33	92

Ultrasonography**2022-23**

Hospital Cluster	Median Waiting Time (Weeks)		
	Priority 1	Priority 2	Routine
HKEC	1	24	51
HKWC	1	25	73
KCC	3	52	30
KEC	<1	23	35
KWC	1	41	142
NTEC	2	26	70
NTWC	1	69	126
HA Overall	1	34	53

2023-24

Hospital Cluster	Median Waiting Time (Weeks)		
	Priority 1	Priority 2	Routine
HKEC	1	16	41
HKWC	<1	23	57
KCC	1	32	38
KEC	6	54	61
KWC	1	46	139
NTEC	2	26	68
NTWC	1	28	147
HA Overall	1	27	58

2024-25 (up to 31 December 2024)

Hospital Cluster	Median Waiting Time (Weeks)		
	Priority 1	Priority 2	Routine
HKEC	1	14	40
HKWC	<1	14	52
KCC	1	33	42
KEC	1	9	61
KWC	1	39	150
NTEC	4	43	91
NTWC	1	28	157
HA Overall	1	26	57

Mammogram**2022-23**

Hospital Cluster	Median Waiting Time (Weeks)		
	Priority 1	Priority 2	Routine
HKEC	2	16	79
HKWC	2	24	145
KCC	3	48	51
KEC	<1	49	70
KWC	1	16	128
NTEC	1	15	96
NTWC	2	13	72
HA Overall	1	25	86

2023-24

Hospital Cluster	Median Waiting Time (Weeks)		
	Priority 1	Priority 2	Routine
HKEC	2	15	61
HKWC	2	15	154
KCC	2	45	50
KEC	<1	10	75
KWC	2	17	150
NTEC	1	17	75
NTWC	2	20	111
HA Overall	2	18	89

2024-25 (up to 31 December 2024)

Hospital Cluster	Median Waiting Time (Weeks)		
	Priority 1	Priority 2	Routine
HKEC	1	11	28
HKWC	2	14	125
KCC	2	46	51
KEC	<1	13	92
KWC	1	15	173
NTEC	1	14	103
NTWC	1	15	133
HA Overall	1	16	99

Note:

In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA has adjusted its services to cope with the outbreak. This should be taken into consideration when comparing the service throughput of the HA in relevant years. With the cessation of anti-epidemic measures in early 2023, the HA's services have returned to normalcy gradually.

Abbreviations

Specialties:

ENT – Ear, Nose & Throat

MED – Medicine

GYN – Gynaecology

OPH – Ophthalmology

ORT – Orthopaedics & Traumatology

PAE – Paediatrics

PSY – Psychiatry

SUR – Surgery

Clusters:

HKEC – Hong Kong East Cluster

HKWC – Hong Kong West Cluster

KCC – Kowloon Central Cluster

KEC – Kowloon East Cluster
KWC – Kowloon West Cluster
NTEC – New Territories East Cluster
NTWC – New Territories West Cluster

- End -

CONTROLLING OFFICER'S REPLY

HHB196

(Question Serial No. 3116)

Head: (37) Department of Health

Subhead (No. & title): (000) Operational expenses

Programme: (4) Curative Care

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

There is a drastic reduction of over 60% in funding for the subvented sector in the revised estimate for 2024-25 and estimate for 2025-26. In this connection, please inform this Committee of the reasons behind this significant decrease over the past 2 consecutive years. It is noted, incidentally, in the pertaining Brief Description that 2 Chinese Medicine Clinics operated by the Tung Wah Group of Hospitals are the main beneficiaries of funding under this Programme.

Asked by: Hon CHAN Chun-ying (LegCo internal reference no.: 3)

Reply:

The provisions for the subvented sector in the revised estimate for 2024-25 and estimate for 2025-26 represent a decrease over the 2024-25 estimate due in large part to the change in the mode of subvention for the Healthy Teeth Collaboration (HTC) since 16 July 2024. Instead of being subvented organisations (i.e. receiving subvention to run the service) to provide free dental services to eligible persons, the non-governmental organisations participating in the HTC now provide such services through a service procurement model to enhance operation efficiency. As a result, the associated funding previously set aside to the subvented sector has been reallocated to the Government sector. As for the 2 Chinese Medicine General Outpatient Clinics operated by the Tung Wah Group of Hospitals under the subvention of the Department of Health, the financial provision in the revised estimate remained unchanged from the original estimate for 2024-25, while the financial provision for the 2025-26 estimate has increased by about 2.5% compared to the 2024-25 revised estimate.

- End -

CONTROLLING OFFICER'S REPLY**HHB197****(Question Serial No. 0573)**Head: (37) Department of HealthSubhead (No. & title): (-) Not SpecifiedProgramme: (8) Personnel Management of Civil Servants Working in Hospital AuthorityControlling Officer: Director of Health (Dr. Ronald LAM)Director of Bureau: Secretary for HealthQuestion:

The Government has indicated that the provision for 2025-26 under Programme (8) will be \$100,000 (0.9%) higher than the revised estimate for 2024-25 mainly due to the increased provision for operating expenses. In this connection, please list in tabular form:

1. the changes in the Department of Health (DH)'s staffing levels in this respect, along with the estimated expenditure, in the past 5 years; and
2. the staff establishment of DH personnel working in the Hospital Authority in the past 5 years.

Asked by: Hon CHAN Han-pan (LegCo internal reference no.: 36)Reply:

1. In the 5 financial years from 2020-21 to 2024-25, the number of staff in the Department of Health (DH) responsible for this programme is 22, comprising 20 in the DH's Hospital Staff Section and 2 in the DH headquarters providing indirect support for this programme. The expenditure incurred by the DH on discharging personnel management responsibility for the civil servants working in the Hospital Authority (HA) in the aforesaid 5 financial years is as follows:

Financial Year	2020-21 (Actual)	2021-22 (Actual)	2022-23 (Actual)	2023-24 (Actual)	2024-25 (Revised Estimate)
Annual Expenditure (\$ million)	10.3	10.2	10.3	11.0	11.4

2. The staff establishment of civil servants working in the HA in the 5 years from 2020 to 2024 is as follows:

As at 1 April of the Year	2020	2021	2022	2023	2024
Staff Establishment	791	643	500	389	306

- End -

CONTROLLING OFFICER'S REPLY**HHB198****(Question Serial No. 0217)**Head: (37) Department of HealthSubhead (No. & title): (-) Not SpecifiedProgramme: (2) Disease PreventionControlling Officer: Director of Health (Dr. Ronald LAM)Director of Bureau: Secretary for HealthQuestion:

Regarding the promotion and implementation of the Elderly Health Care Voucher Scheme (EHVS), please inform this Committee of:

1. the detailed breakdown of the total expenditure on the EHVS over the past 3 years, as well as the estimated expenditure of the scheme for 2025-26;
2. the number of voucher claim transactions, the amount claimed and the average, median as well as the maximum and minimum amount claimed per transaction in the past 3 years, broken down by type of service;
3. the number of healthcare service providers enrolled under the EHVS and the participation rate of each healthcare service provider in the scheme, broken down by type of service;
4. the respective number of complaints against the abuse of vouchers received and investigations conducted by the Department of Health, and prosecutions as a result (by type of healthcare service provider); as well as the respective number of cases with investigation completed, found to be substantiated, and related to fraud or improper voucher claims, and the number of service providers and voucher recipients disqualified from the EHVS for breaching the scheme rules in the past 3 years; and
5. the number of service providers who withdrew from the EHVS over the past 3 years, broken down by type of service.

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 8)

Reply:

1.

The table below shows the actual/estimated expenditure on the Elderly Health Care Voucher Scheme (EHVS) from the financial year 2022-23 to 2024-25:

Year	Actual/Estimated Expenditure on the EHVS (\$ billion)
2022-23	2.79 (Actual)
2023-24	3.33 (Actual)
2024-25	3.45 (Revised Estimate)

The estimated expenditure for 2025-26 for the EHVS is \$4.15 billion.

2.

The tables below show the number of voucher claim transactions, the amount of vouchers claimed and the average, median, maximum and minimum amounts per claim transaction under the EHVS (including the Elderly Health Care Voucher Greater Bay Area Pilot Scheme) by types of healthcare service provider/medical institution in the Greater Bay Area (GBA) enrolled in the EHVS in the past 3 years:

Number of Voucher Claim Transactions

	2022	2023 ^{Note 1}	2024
Healthcare service providers in Hong Kong			
Medical Practitioners	1 954 032	2 325 617	2 444 952
Chinese Medicine Practitioners	1 647 630	1 965 635	2 160 315
Dentists	288 532	331 342	331 567
Occupational Therapists	4 177	4 232	3 003
Physiotherapists	37 603	45 673	43 341
Medical Laboratory Technologists	14 593	15 441	14 503
Radiographers	20 761	22 659	23 285
Nurses	9 376	11 196	10 800
Chiropractors	8 841	10 331	8 724
Optometrists	161 156	230 239	175 563
Audiologists ^{Note 2}	-	784	1 636
Clinical Psychologists ^{Note 2}	-	2	-
Dietitians ^{Note 2}	-	609	1 356
Speech Therapists ^{Note 2}	-	5	7
Sub-total (Hong Kong):	4 146 701	4 963 765	5 219 052
Medical institutions in the GBA:	32 356	38 462	77 918
Total:	4 179 057	5 002 227	5 296 970

Amount of Vouchers Claimed (in HK\$'000)

	2022	2023 ^{Note 1}	2024
Healthcare service providers in Hong Kong			
Medical Practitioners	1,059,052	1,270,495	1,363,308
Chinese Medicine Practitioners	854,324	1,140,988	1,227,911
Dentists	343,327	413,222	402,347
Occupational Therapists	4,518	4,455	3,404
Physiotherapists	17,743	22,726	23,083
Medical Laboratory Technologists	13,393	14,712	13,353
Radiographers	24,635	29,503	34,556
Nurses	9,878	11,168	10,427
Chiropractors	5,080	5,955	5,467
Optometrists	233,912	352,743	255,505
Audiologists ^{Note 2}	-	2,693	5,040
Clinical Psychologists ^{Note 2}	-	4	-

Dietitians ^{Note 2}	-	829	1,110
Speech Therapists ^{Note 2}	-	5	7
Sub-total (Hong Kong):	2,565,862	3,269,498	3,345,518
Medical institutions in the GBA:	10,949	11,883	39,339
Total:	2,576,811	3,281,381	3,384,857

Average Amount of Vouchers per Claim Transaction (HK\$)

	2022	2023 ^{Note 1}	2024
Healthcare service providers in Hong Kong			
Medical Practitioners	542	546	558
Chinese Medicine Practitioners	519	580	568
Dentists	1,190	1,247	1,213
Occupational Therapists	1,082	1,053	1,134
Physiotherapists	472	498	533
Medical Laboratory Technologists	918	953	921
Radiographers	1,187	1,302	1,484
Nurses	1,054	997	965
Chiropractors	575	576	627
Optometrists	1,451	1,532	1,455
Audiologists ^{Note 2}	N/A	3,435	3,081
Clinical Psychologists ^{Note 2}	N/A	2,000	N/A
Dietitians ^{Note 2}	N/A	1,361	819
Speech Therapists ^{Note 2}	N/A	1,000	1,000
Medical institutions in the GBA ^{Note 3}	338	309	505

Median Amount of Vouchers per Claim Transaction (HK\$)

	2022	2023 ^{Note 1}	2024
Healthcare service providers in Hong Kong			
Medical Practitioners	380	400	410
Chinese Medicine Practitioners	310	320	324
Dentists	800	835	800
Occupational Therapists	350	300	300
Physiotherapists	330	320	350
Medical Laboratory Technologists	680	720	700
Radiographers	720	800	900
Nurses	525	500	490
Chiropractors	560	560	600
Optometrists	1,700	1,880	1,748
Audiologists ^{Note 2}	N/A	2,121	1,905
Clinical Psychologists ^{Note 2}	N/A	1,800	N/A
Dietitians ^{Note 2}	N/A	1,105	310
Speech Therapists ^{Note 2}	N/A	1,200	1,000

Medical institutions in the GBA Note 3	123	114	186

Range of Maximum and Minimum Voucher Amounts per Claim Transaction (HK\$)

	Range of Maximum Voucher Amounts per Claim Transaction (HK\$) ^{Note 4}		
	2022	2023 ^{Note 1}	2024
Healthcare service providers in Hong Kong			
Medical Practitioners	7,751 – 8,000	>8,000	>8,000
Chinese Medicine Practitioners	7,751 – 8,000	>8,000	>8,000
Dentists	7,751 – 8,000	>8,000	>8,000
Occupational Therapists	7,501 – 7,750	7,751 – 8,000	7,751 – 8,000
Physiotherapists	7,751 – 8,000	>8,000	>8,000
Medical Laboratory Technologists	7,751 – 8,000	7,751 – 8,000	7,751 – 8,000
Radiographers	7,751 – 8,000	>8,000	>8,000
Nurses	7,751 – 8,000	>8,000	>8,000
Chiropractors	6,501 – 6,750	6,001 – 6,250	7,751 – 8,000
Optometrists	1,751 – 2,000	1,751 – 2,000	1,751 – 2,000
Audiologists ^{Note 2}	N/A	>8,000	>8,000
Clinical Psychologists ^{Note 2}	N/A	1,751 – 2,000	N/A
Dietitians ^{Note 2}	N/A	7,751 – 8,000	4,751 – 5,000
Speech Therapists ^{Note 2}	N/A	1,251 – 1,500	1,751 – 2,000
Medical institutions in the GBA Note 3	7,751 – 8,000	7,251 – 7,500	>8,000

	Range of Minimum Voucher Amounts per Claim Transaction (HK\$)		
	2022	2023 ^{Note 1}	2024
Healthcare service providers in Hong Kong			
Medical Practitioners	1 – 250	1 – 250	1 – 250
Chinese Medicine Practitioners	1 – 250	1 – 250	1 – 250
Dentists	1 – 250	1 – 250	1 – 250
Occupational Therapists	1 – 250	1 – 250	1 – 250
Physiotherapists	1 – 250	1 – 250	1 – 250
Medical Laboratory Technologists	1 – 250	1 – 250	1 – 250
Radiographers	1 – 250	1 – 250	1 – 250
Nurses	1 – 250	1 – 250	1 – 250
Chiropractors	1 – 250	1 – 250	1 – 250
Optometrists	1 – 250	1 – 250	1 – 250
Audiologists ^{Note 2}	N/A	1 – 250	1 – 250
Clinical Psychologists ^{Note 2}	N/A	1,751 – 2,000	N/A
Dietitians ^{Note 2}	N/A	1 – 250	1 – 250
Speech Therapists ^{Note 2}	N/A	501 – 750	1 – 250

Medical institutions in the GBA	1 - 250	1 - 250	1 - 250

Note 1: Starting from 28 July 2023, the EHVS allows shared use of vouchers between 2 eligible elderly persons in spousal relationship upon their mutual consent and completion of procedures to pair up their voucher accounts. Furthermore, a three-year Elderly Health Care Voucher Pilot Reward Scheme (Pilot Reward Scheme) was launched under the EHVS on 13 November 2023.

Note 2: Since 28 April 2023, the coverage of the EHVS has been extended to include primary healthcare services provided by 4 categories of healthcare professions under the Accredited Registers Scheme for Healthcare Professions (AR Scheme) (namely audiologists, clinical psychologists, dietitians and speech therapists).

Note 3: Under the existing EHVS, private healthcare professionals in Hong Kong may enrol in the scheme as healthcare service providers on an individual basis, while medical institutions in the GBA participate in the scheme on a hospital/medical institution basis. Eligible elderly persons may use Elderly Health Care Vouchers to pay for the fee of outpatient healthcare services, such as physical examination, continuous preventive healthcare and chronic disease management, etc., provided by the designated departments at medical institutions in the GBA, and the statistics on the related healthcare services are compiled on the basis of services as provided by the respective designated departments, rather than individual healthcare professions. As such, any direct comparison between the average amount of vouchers per claim transaction for healthcare service providers in Hong Kong and that of medical institutions in the GBA is not appropriate. Nor do the figures reflect the levels of primary healthcare service charges of either region.

Note 4: Due to the shared use of vouchers between spouses under the EHVS starting from 28 July 2023 and the \$500 reward under the Pilot Reward Scheme launched on 13 November in the same year (see Note 1 above) is not subject to the accumulation limit, the maximum voucher amount per claim transaction may exceed \$8,000.

3.

The table below shows the number and participation rate of healthcare service providers in Hong Kong enrolled in the EHVS as at the end of 2024, by types of profession:

	Number of Healthcare Service Providers (Participation Rate ^{Note 1})
Medical Practitioners	3 451 (55%)
Chinese Medicine Practitioners	4 551 (60%)
Dentists	1 569 (73%)
Occupational Therapists	191 (11%)
Physiotherapists	880 (33%)
Medical Laboratory Technologists	54 (4%)
Radiographers	67 (5%)
Nurses	298 (1%)
Chiropractors	171 (59%)
Optometrists	912 (85%)
Audiologists ^{Note 2}	40 (57%)
Clinical Psychologists ^{Note 2}	15 (3%)
Dietitians ^{Note 2}	46 (34%)
Speech Therapists ^{Note 2}	42 (13%)
Total:	12 287

Note 1: In calculating the EHVS participation rate of the first 10 types of healthcare service providers (i.e. medical practitioners, Chinese medicine practitioners, dentists, occupational therapists,

physiotherapists, medical laboratory technologists, radiographers, nurses, chiropractors and optometrists), those healthcare professionals practising in the public sector or are economically inactive (e.g. not practising in Hong Kong) have been excluded.

Note 2: Since 28 April 2023, the coverage of the EHVS has been extended to include primary healthcare services provided by 4 categories of healthcare professions under the AR Scheme (namely audiologists, clinical psychologists, dietitians and speech therapists). In calculating the percentage of participating healthcare service providers of these 4 professions under the EHVS, the numbers of registrants on the registers of the relevant healthcare professional bodies accredited under the AR Scheme of the Government have been used.

4.

The table below shows the number of complaints (including media reports and relevant intelligence) against healthcare service providers enrolled in the EHVS received by the Department of Health (DH) from 2022 to 2024:

	2022	2023	2024	Total
Number of complaints against healthcare service providers enrolled in the EHVS received by the DH	45	54	88	187

These complaint cases, involving operational procedures, suspected fraud, improper voucher claims and issues related to service charges, were mainly against Chinese medicine practitioners, medical practitioners, optometrists and dentists. The DH would conduct investigation into every complaint received and take appropriate actions/measures when violation of the terms and conditions of the EHVS Agreement was found, including issuing advisory/warning letters to the relevant healthcare service providers, withholding reimbursements or recovering paid reimbursements, disqualifying healthcare service providers from participating in the EHVS, and referring cases to the Police and the relevant professional regulatory boards/councils for follow-up as appropriate.

Among the complaint cases against healthcare service providers enrolled under the EHVS received by the DH in the past 3 years, as at end-December 2024, investigation of 29 cases was completed, of which 11 were found to be substantiated or partially substantiated. The DH has disqualified 3 healthcare service providers from participating in the EHVS and has referred 6 cases to the Police for follow-up (of which the investigation of 2 cases was completed with no prosecutions made and 4 cases are still under investigation).

5.

The table below shows the number of healthcare service providers in Hong Kong enrolling in and withdrawing from the EHVS in the past 3 years, by types of profession:

Service Provider Category	2022 Note 1			2023			2024 Note 1		
	Enrolments	Withdrawals	Net Enrolments	Enrolments	Withdrawals	Net Enrolments	Enrolments	Withdrawals	Net Enrolments
Medical Practitioners	365	163	202	226	51	175	218	470	(252)
Chinese Medicine Practitioners	362	169	193	316	30	286	332	147	185
Dentists	77	42	35	154	8	146	120	28	92

Service Provider Category	2022 Note 1			2023			2024 Note 1		
	Enrolments	Withdrawals	Net Enrolments	Enrolments	Withdrawals	Net Enrolments	Enrolments	Withdrawals	Net Enrolments
Occupational Therapists	18	12	6	35	4	31	24	20	4
Physiotherapists	108	31	77	111	13	98	138	84	54
Medical Laboratory Technologists	2	7	(5)	2	3	(1)	4	7	(3)
Radiographers	7	8	(1)	11	1	10	10	6	4
Nurses	45	59	(14)	36	6	30	44	36	8
Chiropractors	9	6	3	31	3	28	13	6	7
Optometrists	23	23	0	56	6	50	52	28	24
Audiologists Note 2	N/A	N/A	N/A	34	1	33	10	3	7
Clinical Psychologists Note 2	N/A	N/A	N/A	13	-	13	2	-	2
Dietitians Note 2	N/A	N/A	N/A	36	-	36	10	-	10
Speech Therapists Note 2	N/A	N/A	N/A	39	-	39	7	4	3
Total:	1 016	520	496	1 100	126	974	984	839	145

Note 1: The number of healthcare service providers withdrawing from the EHVS in 2022 and 2024 is relatively higher as the Health Care Voucher Division of the DH updates the database of healthcare service providers every 2 years.

Note 2: Since 28 April 2023, the coverage of the EHVS has been extended to include primary healthcare services provided by 4 categories of healthcare professions under the AR Scheme (namely audiologists, clinical psychologists, dietitians and speech therapists).

- End -

CONTROLLING OFFICER'S REPLY**HHB199****(Question Serial No. 0220)**Head: (37) Department of HealthSubhead (No. & title): (-) Not SpecifiedProgramme: (2) Disease PreventionControlling Officer: Director of Health (Dr. Ronald LAM)Director of Bureau: Secretary for HealthQuestion:

With regard to the Elderly Health Centres (EHCs) and Woman Health Centres (WHCs) set up by the Department of Health across the territory, please advise on the following:

1. the number of new members in all EHCs and WHCs in each of the past 5 years, the number of people currently waiting for enrolment as members, along with the average and the longest waiting time for such enrolment;
2. the respective number of attendances for various services (namely health assessment, counselling and curative treatment) provided by EHCs and WHCs in each district over the past 5 years; and
3. in view of the upcoming integration of services provided by EHCs and WHCs into the District Health Centres, the estimated timetable of the initiative, its details, the administrative costs and staff establishment in relation to its implementation.

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 26)Reply:

(1)

Elderly Health Centres (EHCs)

The number of new members enrolling with the EHCs and the number of elderly persons waiting for their first health assessment (upon becoming members) in the past 5 years are as follows:

Year	Number of new enrolments	Number of elderly persons waiting for their first health assessment
2020	4 329	22 675
2021	10 496	27 165
2022	8 007	34 259
2023	9 858	35 982
2024*	5 766	37 036

*Provisional figures.

Varying by centre, the median waiting time for the first health assessment at EHCs in 2024 is 30 months, with the longest median waiting time reported at 44.7 months.

Women Health Services (WHS)

Over the past 5 years, the number of enrolment for WHS and the number of attendances at the 3 Woman Health Centres (WHCs) (namely Chai Wan WHC, Lam Tin WHC and Tuen Mun WHC) and the 4 designated Maternal and Child Health Centres (MCHCs) providing such services (namely Ap Lei Chau MCHC, Yaumatei MCHC, Fanling MCHC and Ma On Shan MCHC) are as follows:

Year	Number of enrolment	Number of attendances
2020	775	2 357
2021	3 571	5 450
2022	11 504	21 729
2023	10 694	22 383
2024	8 622	20 766

Currently, when service users schedule an appointment for WHS, the staff of the clinic can immediately provide a consultation date, which allows them to register and receive services at the clinic on the date provided without having to wait in line.

(2)

EHCs

The number of attendances for health assessment, medical consultation and health education activities provided in the 18 EHCs in the past 5 years are as follows:

EHC		2020 [^]	2021 [^]	2022 [^]	2023	2024*
Sai Ying Pun	Health assessment and medical consultation	4 248	6 995	6 009	8 078	6 856
	Health education activities organised by EHCs	3 527	7 316	10 115	13 405	12 136
Shau Kei Wan	Health assessment and medical consultation	3 865	6 114	5 295	7 509	6 156
	Health education activities organised by EHCs	3 067	3 589	4 270	5 306	4 747
Wan Chai	Health assessment and medical consultation	8 172	12 818	10 957	10 595	10 837
	Health education activities organised by EHCs	7 612	14 711	13 484	13 777	13 828
Aberdeen	Health assessment and medical consultation	4 561	7 048	6 022	8 069	6 937
	Health education activities organised by EHCs	5 361	7 649	6 287	7 125	5 906
Nam Shan	Health assessment and	4 719	6 480	5 608	7 600	6 401

	medical consultation					
	Health education activities organised by EHCs	4 705	6 422	5 331	7 166	5 439
Lam Tin	Health assessment and medical consultation	3 806	6 261	5 163	7 011	5 821
	Health education activities organised by EHCs	4 003	7 843	6 420	8 109	8 167
Yau Ma Tei	Health assessment and medical consultation	3 816	5 902	5 100	6 796	5 226
	Health education activities organised by EHCs	5 658	7 643	7 476	10 665	8 991
San Po Kong	Health assessment and medical consultation	4 409	6 327	2 664	6 614	6 451
	Health education activities organised by EHCs	6 400	10 674	761	9 813	13 929
Kowloon City	Health assessment and medical consultation	4 930	6 298	3 964	6 717	6 625
	Health education activities organised by EHCs	7 625	6 903	6 700	7 253	7 976
Lek Yuen	Health assessment and medical consultation	8 434	15 971	11 628	11 125	11 877
	Health education activities organised by EHCs	8 075	9 944	6 406	7 470	7 065
North District#	Health assessment and medical consultation	5 757	6 666	5 892	8 067	6 139
	Health education activities organised by EHCs	4 784	4 373	5 101	5 425	5 569
Tseung Kwan O	Health assessment and medical consultation	4 464	6 137	6 832	7 857	6 566
	Health education activities organised by EHCs	4 309	5 301	4 997	4 800	4 697
Tai Po	Health assessment and medical consultation	5 886	7 141	6 756	8 576	8 135
	Health education activities organised by EHCs	5 283	5 478	5 083	5 998	5 752
Tung Chung	Health assessment and medical consultation	3 571	5 746	4 983	7 347	5 069
	Health education activities organised by EHCs	5 813	10 593	7 348	12 601	8 133
Tsuen Wan	Health assessment and medical consultation	4 640	8 072	6 199	8 388	6 595
	Health education activities organised by EHCs	3 704	6 421	4 230	3 924	3 374
Tuen Mun Wu Hong	Health assessment and medical consultation	5 402	6 767	8 603	8 756	7 644
	Health education activities organised by EHCs	3 111	4 284	7 115	7 394	6 292
	Health assessment and	4 035	6 275	6 006	7 079	6 069

Kwai Shing	medical consultation					
	Health education activities organised by EHCs	2 892	5 376	5 568	6 333	4 904
Yuen Long	Health assessment and medical consultation	3 918	6 196	5 313	7 231	5 464
	Health education activities organised by EHCs	4 893	4 859	4 629	4 968	4 878
Total	Health assessment and medical consultation	88 633	133 214	112 994	143 415	124 868
	Health education activities organised by EHCs	90 822	129 379	111 321	141 532	131 783

^During the COVID-19 pandemic, EHCs had only been able to provide limited service. As a result, the number of attendances for health risk assessment and medical consultation at EHCs had both decreased. The number of elderly waiting for enrolment accumulated, lengthening the waiting time correspondingly. Although services of EHCs have resumed normal since February 2023, their service capacity is still affected by the ongoing shortage of doctors.

* Provisional figures

Shek Wu Hui EHC has been relocated to the 8th floor of the North District Community Health Centre Building, 3 Wai Wo Street, Sheung Shui, with effect from 16 December 2024. The relocated centre is now called North District EHC.

WHS

The number of attendances for WHS at WHCs and designated MCHCs over the past 5 years are as follows:

WHC/MCHC	Number of attendance				
	2020	2021	2022	2023	2024
Chai Wan WHC	579	1 863	8 431	8 226	6 879
Lam Tin WHC	722	1 777	5 966	6 084	7 078
Tuen Mun WHC	802	1 810	7 179	6 635	5 351
Ap Lei Chau MCHC	40	-	44	218	170
Yaumatei MCHC	-	-	-	45	75
Fanling MCHC	117	-	57	772	703
Ma On Shan MCHC	97	-	52	403	510
Total	2 357	5 450	21 729	22 383	20 766

Note: Due to the COVID-19 epidemic, the WHS was suspended from 3 February 2020 to 5 September 2021 for redeployment of staff for various anti-epidemic duties. The service has resumed at the 3 WHCs (namely Chai Wan WHC, Lam Tin WHC and Tuen Mun WHC) since 6 September 2021, and at the 4 designated MCHCs (namely Ap Lei Chau MCHC, Yaumatei MCHC, Fanling MCHC and Ma On Shan MCHC) on sessional basis in phases since 17 October 2022.

The WHS delivers services that promote women's health based on individual needs at various stages of life, including health assessments, relevant screenings and tests. Women may,

depending on their needs and upon doctors' assessment, be offered blood tests and screenings for colorectal, cervical and breast cancers. In addition, the WHS also offers health education and individual counselling for women. The Department of Health (DH) does not maintain data on the number of attendances for each type of service.

(3)

Integration of women and elderly health services under the Department of Health (DH) into the district health network of the PHCC aims to utilise resources more effectively, strengthening the prevention-oriented, district-based, and family-centric primary healthcare network.

The PHCC will commence the integration of women health services within this year in an orderly manner. The services, operated by non-governmental organisations engaged by open tender, will be rendered through three service points named Women Wellness Satellites (WWSs) to provide women primary healthcare services. The three WWSs in Chai Wan, Lam Tin and Tuen Mun will progressively start service in 2025 to replace the Woman Health Centres of the DH. The Chai Wan WWS will commence operation in the second quarter while the Lam Tin and Tuen Mun WWSs are expected to be open in the third quarter. DHCs and DHCEs across all 18 districts will enhance promotion and education on women's health, and provide new dedicated nurse clinics for women's health services to encourage and support members of the public to manage their own health. DHCs and DHCEs will also identify women in need through basic health assessments and individual consultations, and refer them to WWSs or General Out-patient Clinics of the Hospital Authority to receive women's health services.

Specifically, DHCs and DHCEs provide basic women health services, conduct initial assessments and arrange referrals to WWSs for services as necessary. WWSs will provide more personalised primary healthcare services for women. In addition to the existing services such as health assessments, breast cancer and cervical cancer screenings, WWSs will devise personalised preventive care or specific consultation services according to individual health risks and needs for members' selection to enhance prevention-oriented women's health services.

Moreover, to further expand the multidisciplinary primary healthcare service network, the PHCC plans to start the preparation for the integration of the services of Elderly Health Centres under the DH into the district health network in phases from 2025-26, with a view to enhancing service synergy and minimising service duplication. The detailed transitional arrangements will be announced after discussion with the DH.

The above work is carried out by the PHCC as part of its overall functions, and there is no separate staff establishment. Therefore, information on the expenditure and staff establishment involved in the related work is not available.

- End -

CONTROLLING OFFICER'S REPLY

HHB200

(Question Serial No. 1720)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Regarding the enforcement of tobacco control legislation by the Department of Health, please advise on:

1. the number of complaints received, inspections conducted, and warning letters, fixed penalty notices and summonses issued by the Tobacco and Alcohol Control Office (TACO) in relation to smoking in the past 3 years and, among them, the numbers of complaints received, inspections conducted and enforcement action in relation to alternative smoking products;
2. the number of enforcement action taken in food premises, bars, shops, indoor workplaces, public transport facilities, public outdoor places and bus interchanges (broken down by type of statutory no smoking area);
3. the types of products smoked by the prosecuted smokers in no smoking areas (broken down into tobacco cigarettes and alternative smoking products); and
4. the preparatory work of TACO in enforcement in view of the Government's plan to introduce 10 tobacco control measures, whether additional manpower is required, and the manpower and expenditure involved in the relevant tobacco control work.

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 49)

Reply:

1.

The Tobacco and Alcohol Control Office (TACO) of the Department of Health (DH) is the principal enforcement agency for the Smoking (Public Health) Ordinance (Cap. 371) and the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600). The TACO will conduct inspections and investigation in response to smoking and related complaints. In general, the TACO will issue fixed penalty notices (FPNs) to smoking offenders without warning. Apart from smoking offences, the TACO also issued summonses for offences under Cap. 371 (including aiding and abetting smoking offences, offences relating to smoking product advertisements, the promotion, manufacture, sale, or possession for commercial purposes of alternative smoking products (ASPs), obstruction of inspectors, etc.), and for the offence of importing ASPs under the Import and Export Ordinance (Cap. 60). The numbers of complaints/referrals received, inspections conducted, warning letters issued, and

FPNs/summonses issued by TACO for the period from 2022 to 2024 for smoking and other offences are at **Annex 1**.

With effect from 30 April 2022, no person may import, promote, manufacture, sell, or possess for commercial purposes of ASPs, including electronic smoking products, heated tobacco products and herbal cigarettes in accordance with the Smoking (Public Health) Ordinance (Cap. 371) and the Import and Export Ordinance (Cap. 60). The TACO will conduct investigation upon receiving complaints or referrals. Cases in relation to illegally imported ASPs intercepted by the Customs and Excise Department (C&ED) at boundary control points will be referred to the TACO for follow-up. Any person who contravenes the ban will be prosecuted on sufficient evidence.

From 30 April 2022 to 31 December 2024, the TACO has issued 1 272 summonses to offenders for importing ASPs, resulting in 694 convictions in court with fines ranging from \$300 to \$42,000. In addition, the TACO also monitors the sale of ASPs on the Internet and conducts test buy for follow-up investigations, as well as liaises with relevant organisations to assist in removing illegal online content. The TACO issued 24 summonses to offenders who allegedly sold or possessed ASPs for commercial purposes, of which offenders in 20 cases were convicted by court and sentenced to two months' imprisonment at most.

2.

The number of inspections conducted and FPNs/summonses issued by the TACO from 2022 to 2024 for smoking offences in food premises, shops and shopping malls, public transport facilities, bus interchanges and other statutory no smoking areas is at **Annex 2**.

3.

The Smoking (Public Health) Ordinance (Cap. 371) stipulates that any person who smokes in a no smoking area commits an offence and is subject to a fixed penalty of \$1,500. The number of FPNs/summonses issued by the TACO for smoking in statutory no smoking areas between 2022 and 2024 is set out in **Annex 3**.

4.

The Health Bureau (HHB) introduced in June 2024 the new tobacco control strategy, outlining the short, medium and long-term measures to further reduce smoking prevalence incrementally through various measures, with a view to minimising the harmful effects of tobacco products on the community and safeguarding public health through a multi-pronged approach. These measures are formulated around four directions under the tobacco control strategy, namely, reducing the demand for and supply of tobacco products, minimising the attractiveness of tobacco products, protecting the public from the hazard of second-hand smoke and strengthening the provision of smoking cessation services, aiming to take forward the tobacco control process incrementally. The HHB plans to introduce the proposed legislative amendments for the next-phase tobacco control measures to the Legislative Council for scrutiny by the end of this month.

The revised estimate, estimate and approved establishment for the period 2024-25 to 2025-26 in relation to the work on tobacco control by the TACO are set out in **Annex 4** and **Annex 5** respectively. The TACO will continue to closely monitor the market situation and continue law enforcement to crack down on all activities in violation of the Smoking (Public Health) Ordinance. The DH will strive to manage the additional workload using existing resources

or through redeployment, particularly for enforcing the new offences relating to smoking. Appropriate training and support will also be provided to frontline staff.

Numbers of complaints/referrals received, inspections conducted, warning letters issued, and FPNs/summonses issued by TACO for smoking and other offences under the Smoking (Public Health) Ordinance (Cap. 371), the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600) and the Import and Export Ordinance (Cap. 60)

		2020	2021	2022	2023	2024
Complaints/referrals received		11 568	13 424	14 805	20 116	29 205
Inspections conducted		36 129	41 225	35 281	28 817 ^(Note 4)	30 162
Warning letters issued ^(Note 1&2)		16	16	21	10	10
FPNs issued (for smoking offences)		6 587	7 703	6 296	10 261 ^(Note 4)	13 488
Summonses issued	for smoking offences	58	40	35	48	64
	for other offences ^(Note 3)	57	115	130	657	871

Note:

- 1 In general, the TACO will prosecute smoking offenders without prior warning. The TACO will only consider issuing warning letters if the smoking offenders are found to be persons under 15 years old.
- 2 During the 3-month grace period from 30 April to 31 July 2022, warning letters were issued to passengers carrying small quantity of ASPs. After the grace period, any person who imports any quantity of ASPs will be prosecuted when there is sufficient evidence.
- 3 Other offences include willful obstruction, failure to produce identity document, displaying smoking product advertisement, ASP related offences, and aiding and abetting another person committing a smoking offence, etc.
- 4 To effectively mitigate the impact of passive smoking on the public and enhance the deterrent effect against illegal smoking, TACO has flexibly deployed resources and adopted new enforcement strategies since 2023, including extension of the time of surveillance and inspections in no smoking areas, deploying plain-clothes officers to take proactive enforcement actions, strengthening enforcement action in venues (such as bars and food premises) where waterpipes were offered for smoking, as well as prosecuting people inciting, aiding and abetting illegal smoking. The number of prosecutions against illegal smoking has surged due to the new enforcement strategies, reflecting their enhanced effectiveness.

Number of inspections conducted and FPNs/summonses issued by TACO from 2022 to 2024 for smoking offences in food premises, shops and shopping malls, public transport facilities, bus interchanges and other statutory no smoking areas under the Smoking (Public Health) Ordinance (Cap. 371) and the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600)

	2022	2023	2024
Inspections conducted ^(Notes 1 & 2)	35 150	27 371	26 031
- <i>Food premises</i>	1 945	1 897	1 921
- <i>Shops and shopping malls</i>	7 757	5 823	4 965
- <i>Public transport facilities</i>	4 560	3 448	3 876
- <i>Bus interchanges</i>	664	309	428
- <i>Other statutory no smoking areas</i>	20 224	15 894	14 841
FPNs issued ^(Note 1)	6 296	10 261	13 488
- <i>Food premises</i>	262	421	630
- <i>Shops and shopping malls</i>	1 841	2 417	3 138
- <i>Public transport facilities</i>	920	2 493	3 130
- <i>Bus interchanges</i>	64	109	226
- <i>Other statutory no smoking areas</i>	3 209	4 821	6 364
Summonses issued ^(Note 1)	35	48	64
- <i>Food premises</i>	2	1	1
- <i>Shops and shopping malls</i>	4	6	14
- <i>Public transport facilities</i>	10	8	14
- <i>Bus interchanges</i>	1	0	3
- <i>Other statutory no smoking areas</i>	18	33	32

Note 1 : The TACO does not have separate figures on enforcement at indoor workplace.

Note 2 : To effectively mitigate the impact of passive smoking on the public and enhance the deterrent effect against illegal smoking, TACO has flexibly deployed resources and adopted new enforcement strategies since 2023, including extension of the time of surveillance and inspections in no smoking areas, deploying plain-clothes officers to take proactive enforcement actions, strengthening enforcement action in venues (such as bars and food premises) where waterpipes were offered for smoking, as well as prosecuting people inciting, aiding and abetting illegal smoking. The number of prosecutions against illegal smoking has surged due to the new enforcement strategies, reflecting their enhanced effectiveness.

The number of FPNs/summonses issued by the TACO for smoking and other offences under the Smoking (Public Health) Ordinance (Cap. 371), the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600)

	2022		2023		2024	
	Summonses issued	FPNs issued	Summonses issued	FPNs issued	Summonses issued	FPNS issued
Conventional Tobacco Products	35	6 164	47	9 988	62	12 838
ASPs ^(Note)						
- E-cigarettes	0	105	1	206	2	538
- Heated Tobacco Products	0	27	0	67	0	112

Note: There is little difference in appearance between conventional tobacco products and herbal cigarettes, and individuals figures for herbal cigarettes are not available.

Revised Estimate/Estimate for
the Department of Health's Tobacco and Alcohol Control Office

	2024-25 Revised Estimate (\$ million)	2025-26 Estimate (\$ million)
<u>Enforcement</u>		
Programme 1: Statutory Functions	167.4	174.8
<u>Health Education and Smoking Cessation</u>		
Programme 3: Health Promotion	170.5	180.9
<u>(a) General health education and promotion of smoking cessation</u>		
TACO	88.2	87.0
Subvention to Hong Kong Council on Smoking and Health	27.9	27.3
<u>Sub-total</u>	<u>116.1</u>	<u>114.3</u>
<u>(b) Revised estimate/estimate for smoking cessation and related services by Non-Governmental Organisations</u>		
Subvention to Tung Wah Group of Hospitals	14.0	17.8
Subvention to Pok Oi Hospital	17.9	20.9
Subvention to Lok Sin Tong	3.6	3.6
Subvention to United Christian Nethersole Community Health Service	8.9	13.8
Subvention to Life Education Activity Programme	3.0	3.0
Subvention to Christian Family Service Centre	7.0	4.5
Subvention to the University of Hong Kong	-	3.0
<u>Sub-total</u>	<u>54.4</u>	<u>66.6</u>
<u>Total</u>	<u>337.9</u>	<u>355.7</u>

Approved Establishment of
the Department of Health's Tobacco and Alcohol Control Office

Rank	No. of staff in 2024-25 and 2025-26
<u>Head, TACO</u>	
Consultant	1
<u>Enforcement</u>	
Senior Medical & Health Officer	1
Medical & Health Officer	1
Scientific Officer (Medical)	1
Land Surveyor	1
Police Officer	5
Overseer/ Senior Foreman/ Foreman	125
Senior Executive Officer/ Executive Officer	13
<u>Sub-total</u>	<u>147</u>
<u>Health Education and Smoking Cessation</u>	
Senior Medical & Health Officer	1
Medical & Health Officer	1
Scientific Officer (Medical)	2
Nursing Officer/ Registered Nurse	3
Hospital Administrator II	4
<u>Sub-total</u>	<u>11</u>
<u>Administrative and General Support</u>	
Senior Executive Officer/ Executive Officer	4
Clerical and support staff	19
Motor Driver	1
<u>Sub-total</u>	<u>24</u>
<u>Total</u>	<u>183</u>

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CONTROLLING OFFICER'S REPLY

HHB201

(Question Serial No. 1801)

Head: (37) Department of Health

Subhead (No. & title): (700) General non-current

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

There is a balance of \$5.47 billion remaining in the approved commitment of the Department of Health under the general non-recurrent "Procurement and Administration of Coronavirus Disease 2019 Vaccines" for the current year. In this connection, will the Government advise this Committee on:

I. the non-recurrent expenditure on vaccine procurement and administration each year, broken down by type of expenditure, since the implementation of the COVID-19 Vaccination Programme;

II. the quantity of each type of vaccine procured, administered, remaining and disposed of since the implementation of the COVID-19 Vaccination Programme;

III. given the reduced demand for vaccination in the past 2 years, whether the Government will review the use of the remaining account balance, such as returning it to the Treasury or using it for other initiatives on combating infectious diseases like the Government Vaccination Programme?

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 44)

Reply:

The Government has been procuring sufficient quantity of COVID-19 vaccines with reference to vaccination data, recommendations made by the World Health Organization (WHO) and the Scientific Committee on Vaccine Preventable Diseases and Scientific Committee on Emerging and Zoonotic Diseases (also known as the Joint Scientific Committee) under the Centre for Health Protection (CHP) of the Department of Health (DH), demographic data and the supply terms of vaccine suppliers. Since the commencement of the COVID-19 Vaccination Programme (the Vaccination Programme), the vaccines have been distributed from warehouse to various vaccination venues according to the "first-expired, first-out" principle. However, the public demand for vaccines varies with a number of factors, such as the number of persons infected and changes in the epidemic situation. The Government will continue to formulate policies on vaccine supply based on scientific evidence.

I.

The non-recurrent expenditure on vaccine procurement and administration under the Vaccination Programme by financial year with a breakdown by expenditure items is tabulated below:

	Financial Year				
	2020-21	2021-22	2022-23	2023-24	2024-25 (as at 28 February 2025)
	Expenditure (\$million)				
Procurement of vaccine doses (including transport and storage costs)	1,752.4	2,979.9	1,191.3	79.2	83.4
Injection and administrative costs	88.2	1,129.3	1,226.5	112.9	27.8

II.

The number of each type of vaccine doses procured and administered under the Vaccination Programme by financial year is tabulated below:

	Financial Year				
	2020-21	2021-22	2022-23	2023-24	2024-25 (as at 28 February 2025)
	Number of vaccine doses procured (million)				
- CoronaVac (Sinovac)	7.50	0.95	1.01	-	-
- Comirnaty ancestral strain ^{Note 1} (Fosun/BioNTech)	7.50	4.80	0.12	0.01	-
- Comirnaty original/ BA.4-5 bivalent (Fosun/BioNTech)	-	-	1.9	-	-
- Comirnaty XBB.1.5 (Fosun/BioNTech) ^{Note 2}	-	-	-	0.115	0.03
- Spikevax XBB.1.5 (Moderna)	-	-	-	0.1	-
- AZD1222 (AstraZeneca) ^{Note 3}	7.50	-	-	-	-
- Comirnaty JN.1 ^{Note 4} (Fosun/BioNTech)	-	-	-	-	0.115
- Spikevax JN.1 (Moderna)	-	-	-	-	0.11
Total	22.5	5.75	3.03	0.225	0.255

	Financial Year				
	2020-21	2021-22	2022-23	2023-24	2024-25 (as at 28 February 2025)
	Number of vaccine doses administered (million)				
- CoronaVac (Sinovac)	0.35	5.81	2.69	0.10	0.02
- Comirnaty ancestral strain ^{Note 1} (Fosun/BioNTech)	0.15	8.82	2.41	0.01	-
- Comirnaty original/BA.4-5 bivalent (Fosun/BioNTech)	-	-	0.51	0.09	-
- Comirnaty XBB.1.5	-	-	-	0.06	0.04

(Fosun/BioNTech) ^{Note 2}					
- Spikevax XBB.1.5 (Moderna)	-	-	-	0.07	0.01
- Comirnaty JN.1 ^{Note 4} (Fosun/BioNTech)	-	-	-	-	0.02
- Spikevax JN.1 (Moderna)	-	-	-	-	0.01
Total	0.50	14.63	5.61	0.33	0.10

Note 1 : Including the Comirnaty (ancestral strain) adult formulation, the Comirnaty (ancestral strain) paediatric formulation and the Comirnaty (ancestral strain) toddler formulation.

Note 2 : Including the Comirnaty XBB.1.5 adult formulation, the Comirnaty XBB.1.5 paediatric formulation and the Comirnaty XBB.1.5 toddler formulation.

Note 3 : As Hong Kong has secured sufficient supplies of CoronaVac and Comirnaty vaccines, the 7.5 million doses of AZD1222 procured were donated to the COVID-19 vaccine Global Access Facility (COVAX) led by the WHO.

Note 4 : Including the Comirnaty JN.1 adult formulation, the Comirnaty JN.1 paediatric formulation and the Comirnaty JN.1 toddler formulation.

As at 28 February 2025, approximately 87 500 doses of the Comirnaty JN.1 vaccine (adult, paediatric and toddler formulations), around 62 700 doses of the Spikevax JN.1 vaccine and about 6 200 doses of the Comirnaty XBB.1.5 vaccine (paediatric and toddler formulations) remain in the warehouse.

Since the implementation of the Vaccination Programme until now (as at 28 February 2025), about 290 000 doses of the CoronaVac (Sinovac) vaccine (about 3.1% of the procurement total), 1.41 million doses of the Comirnaty (ancestral strain) vaccine (about 11.3% of procurement total), 1.18 million doses of the Comirnaty bivalent vaccine (about 62.1% of the procurement total) and about 900 doses of the Comirnaty XBB.1.5 vaccine (adult formulation) (about 0.6% of the procurement total) had to be disposed of due to expiration in warehouse. This was attributable to, among other factors, the diminished need for old formulations of vaccines resulting from the use of new vaccine strains as recommended by the WHO and the Joint Scientific Committee in response to virus mutation. Overall, the number of vaccines requiring disposal due to expiration in warehouse only accounted for about 12% of the total vaccines procured, which is in line with the standard stipulated by COVAX for the wastage rate of COVID-19 vaccines.

The Government will continue to review the local arrangements of vaccine procurement and make reference to overseas experiences to adopt various feasible measures to make the best use of the procured vaccines.

III.

Based on the latest recommendations by the WHO, member states should continue monitoring COVID-19 situation for risk assessment purposes. High-risk persons should timely receive booster doses of the COVID-19 vaccine to mitigate the risk of severe illness and death. The Government will continue to closely monitor the COVID-19 situation in Hong Kong and assess associated risks. It will also keep abreast of the WHO's latest assessments of the COVID-19 situation and the recommendations by the Joint Scientific Committee, making

adjustments to the Vaccination Programme as necessary with a focus on safeguarding high-risk groups.

- End -

CONTROLLING OFFICER'S REPLY

HHB202

(Question Serial No. 0401)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

One of the statutory functions of the Department of Health (DH) is to ensure the safety, quality and efficacy of pharmaceutical products. In this connection, please advise this Committee on the following information for the past 5 years:

- (1) the number of licensed retail drug premises each year, with a breakdown by Hong Kong's District Council district;
- (2) the number of licensed retail drug premises inspected at least once each year, with a breakdown by Hong Kong's District Council district;
- (3) the number of inspections where unregistered medicines were seized for being sold or possessed illegally and their percentage of the total number of inspections each year;
- (4) the figures for proprietary Chinese medicines among the unregistered medicines seized for being sold or possessed illegally and their percentage in the seizures each year; and
- (5) the total number of times the DH appealed to the public to hand over unregistered medicines to it for disposal, as well as the number of people who did so in response each year.

Asked by: Hon CHAN Kapui, Judy (LegCo internal reference no.: 27)

Reply:

As mentioned in the Chief Executive's Policy Address in 2023 and 2024, the HKSAR Government will enhance the current evaluation and registration mechanism for drugs, and establish an internationally renowned regulatory authority of drugs and medical devices. To this end, the HKSAR Government set up a Preparatory Office for the Hong Kong Centre for Medical Products Regulation (CMPR) in the Department of Health (DH) in June 2024. The Preparatory Office is proactively reviewing the regulatory functions of the DH, including the regulation of Chinese and Western medicines and medical devices; studying the potential restructuring and strengthening of the regulatory and approval regime for medicines, medical devices and medical technology; and putting forward proposals and steps for the establishment of the CMPR which will be a step towards the transition to the "primary evaluation" approach in approving applications for registration of new medical products. This will help accelerate the clinical application of new drugs and medical devices, and foster the development of emerging industries related to the research and development (R&D) as well as testing of medical products. The Preparatory Office is drawing up the timetable for

establishing the CMPR and the roadmap towards adoption of “primary evaluation”, and will announce them in the first half of 2025 as scheduled. The Preparatory Office will also conduct a review of the need for amending existing legislation related to drugs (in respect of, for example, the requirement for an electronic record of drug supply, prohibition to adopt names or descriptions alluding to “pharmacies” or “dispensaries”, etc.) to step up the overall regulation of drugs.

(1) & (2)

The Drug Office of the DH has all along conducted routine and blitz inspections at Authorized Sellers of Poisons (ASPs, commonly known as “pharmacies” or “dispensaries”) and Listed Sellers of Poisons (LSPs, commonly known as “medicine stores”) in accordance with the established mechanism to check whether sellers of pharmaceutical products comply with the statutory requirements, licensing conditions and relevant codes of practice. The Chinese Medicine Regulatory Office of the DH also conducts routine and blitz inspections of licensed retailers of Chinese herbal medicines (Chm) to ensure their compliance with statutory requirements, licensing conditions and relevant practising guidelines.

The DH has all along adopted a risk-based approach to conduct inspections against licensed retailers at various regions in Hong Kong. The numbers of ASPs, LSPs and Chm retailers, as at 31 December 2024, located on Hong Kong Island, in Kowloon and in the New Territories are as follows:

Region*	Number of ASPs	Number of LSPs	Number of Chm Retailers
Hong Kong Island	131	803	1 217
Kowloon	226	1 369	1 774
New Territories	286	1 869	2 177
Total	643	4 041	5 168

* The DH does not maintain the breakdown by District Council district.

The tables below set out the number of the inspections in the past 5 years:

Licensed ASPs and LSPs:

Year	Number of Licensed Retailers		Number of Inspections Conducted#	
	ASPs	LSPs	ASPs	LSPs
2020	610	4 187	1 060	3 268
2021	593	4 170	1 213	6 975
2022	600	4 151	1 250	8 385
2023	623	4 143	1 242	8 348
2024	643	4 041	1 284	8 326

Due to the Coronavirus Disease 2019 pandemic, the number of inspections conducted in 2020 and 2021 was relatively lower.

Licensed Chm retailers:

Year	Number of Licensed Retailers	Number of Inspections Conducted#
2020	5 066	5 378
2021	5 281	5 779

2022	5 334	5 688
2023	5 438	6 181
2024	5 168	5 714

(3) & (4)

In the past 5 years, the DH handled 121 conviction cases involving illegal sale and/or possession of unregistered pharmaceutical products (PP), and 6 conviction cases involving illegal sale and/or possession of unregistered proprietary Chinese medicines (pCm). The table below sets out the yearly breakdown of the relevant conviction cases in the past 5 years:

Yearly breakdown of conviction cases:

Year	Number of Conviction Cases Involving Illegal Sale and/or Possession of Unregistered PP	Number of Conviction Cases involving Illegal Sale and/or Possession of Unregistered pCm
2020	18	1
2021	26	0
2022	18	1
2023	30	2
2024	29	2
Total	121	6

(5)

To protect public health, the DH has been issuing press releases to alert members of the public on incidents such as illegal possession and/or sale of unregistered medicines. To this end, the DH has all along strongly urged members of the public not to buy products of unknown or doubtful composition, or to consume products from unknown sources, as the safety, efficacy and quality of these products are not guaranteed. For those who have purchased unregistered medicines, the DH also urges them to stop consuming the medicines immediately and consult healthcare professionals for advice if feeling unwell after consumption. The DH has also advised the public to submit the unregistered products to the DH for disposal, even though it is not a mandatory requirement. In the past 5 years, 64 press releases of this nature were issued. However, the DH does not maintain statistics on the number of unregistered medicines submitted by members of the public to the DH.

- End -

CONTROLLING OFFICER'S REPLY

HHB203

(Question Serial No. 0647)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

It is stated under this Programme that the Department of Health will integrate services provided by the Woman Health Centres and Elderly Health Centres into the District Health Centres in phases starting from 2025 in accordance with the Primary Healthcare Blueprint. In this connection, please advise this Committee on:

1. the details of and specific timetable for the integration;
2. the staff establishment and estimated expenditure to be involved; and
3. whether the integration will cut operating costs and manpower.

Asked by: Hon CHAN Kin-por (LegCo internal reference no.: 9)

Reply:

(1) to (3)

Integration of women and elderly health services under the Department of Health (DH) into the district health network of the PHCC aims to utilise resources more effectively, strengthening the prevention-oriented, district-based, and family-centric primary healthcare network.

The PHCC will commence the integration of women health services within this year in an orderly manner. The services, operated by non-governmental organisations engaged by open tender, will be rendered through three service points named Women Wellness Satellites (WWSs) to provide women primary healthcare services. The three WWSs in Chai Wan, Lam Tin and Tuen Mun will progressively start service in 2025 to replace the Woman Health Centres of the DH. The Chai Wan WWS will commence operation in the second quarter while the Lam Tin and Tuen Mun WWSs are expected to be open in the third quarter. DHCs and DHCEs across all 18 districts will enhance promotion and education on women's health, and provide new dedicated nurse clinics for women's health services to encourage and support members of the public to manage their own health. DHCs and DHCEs will also identify women in need through basic health assessments and individual consultations, and refer them

to WWSs or General Out-patient Clinics of the Hospital Authority to receive women's health services.

Specifically, DHCs and DHCEs provide basic women health services, conduct initial assessments and arrange referrals to WWSs for services as necessary. WWSs will provide more personalised primary healthcare services for women. In addition to the existing services such as health assessments, breast cancer and cervical cancer screenings, WWSs will devise personalised preventive care or specific consultation services according to individual health risks and needs for members' selection to enhance prevention-oriented women's health services.

Moreover, to further expand the multidisciplinary primary healthcare service network, the PHCC plans to start the preparation for the integration of the services of Elderly Health Centres under the DH into the district health network in phases from 2025-26, with a view to enhancing service synergy and minimising service duplication. The detailed transitional arrangements will be announced after discussion with the DH.

The above work is carried out by the PHCC as part of its overall functions, and there is no separate staff establishment. Therefore, information on the expenditure and staff establishment involved in the related work is not available.

Upon completion of the service integration and staff deployment, the DH will arrange for the deletion of the posts concerned within the establishment in due course and reduce associated resources accordingly.

- End -

CONTROLLING OFFICER'S REPLY

HHB204

(Question Serial No. 0648)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The Department of Health (DH) has stated that it will promote and implement the Elderly Health Care Voucher Scheme (EHVS) in the future. In this connection, will the Government advise this Committee on:

1. the number of Elderly Health Care Voucher (EHCV) claim transactions, the amount claimed and the average amount per claim transaction, broken down by healthcare service provider, in the past 3 years;
2. according to the latest statistics on the three-year Elderly Health Care Voucher Pilot Reward Scheme launched by the Government in November 2023, the number of voucher claims for designated primary healthcare services with the allotment of \$500 reward to elderly persons, and the percentage of such claims in all EHCV claims; and
3. the number of EHCV claim transactions, the amount claimed and the average amount per claim transaction under the Elderly Health Care Voucher Greater Bay Area Pilot Scheme (Pilot Scheme), broken down into the 7 medical institutions enrolled in the Pilot Scheme?

Asked by: Hon CHAN Kin-por (LegCo internal reference no.: 10)

Reply:

1. & 3.

The Government launched the Elderly Health Care Voucher Scheme (EHVS) in 2009, which aims at providing financial incentives for elderly persons to choose private primary healthcare services that best suit their health needs, so as to provide them with additional healthcare choices on top of the existing public healthcare services. Currently, the EHVS subsidises eligible Hong Kong elderly persons aged 65 and over with an annual Elderly Health Care Voucher (EHCV) amount of \$2,000 (accumulation limit of \$8,000) to use private primary healthcare services provided by 14 types of healthcare professionals.

The tables below show the number of voucher claim transactions, the amount of vouchers claimed and the average amount per claim transaction under the EHVS (including the Elderly Health Care Voucher Greater Bay Area Pilot Scheme (Pilot Scheme)) by types of healthcare service provider/medical institution in the Greater Bay Area (GBA) enrolled in the EHVS in the past 3 years:

Number of Voucher Claim Transactions

	2022	2023 ^{Note 1}	2024
Healthcare service providers in Hong Kong			
Medical Practitioners	1 954 032	2 325 617	2 444 952
Chinese Medicine Practitioners	1 647 630	1 965 635	2 160 315
Dentists	288 532	331 342	331 567
Occupational Therapists	4 177	4 232	3 003
Physiotherapists	37 603	45 673	43 341
Medical Laboratory Technologists	14 593	15 441	14 503
Radiographers	20 761	22 659	23 285
Nurses	9 376	11 196	10 800
Chiropractors	8 841	10 331	8 724
Optometrists	161 156	230 239	175 563
Audiologists ^{Note 2}	-	784	1 636
Clinical Psychologists ^{Note 2}	-	2	-
Dietitians ^{Note 2}	-	609	1 356
Speech Therapists ^{Note 2}	-	5	7
Sub-total (Hong Kong):	4 146 701	4 963 765	5 219 052
Medical institutions in the GBA ^{Note 3}			
University of Hong Kong - Shenzhen Hospital (HKU-SZH) (including Huawei Li Zhi Yuan Community Health Service Center (Huawei CHC), an offsite medical institution)	32 356	38 462	62 450
The First Affiliated Hospital, Sun Yat-sen University (FAH-SYSU) (Since 28 June 2024)	-	-	1 865
Zhongshan Chen Xinghai Hospital of Integrated Traditional Chinese and Western Medicine (ZSCXH) (Since 18 July 2024)	-	-	2 052
Shenzhen New Frontier United Family Hospital (NFUFH) (Since 14 August 2024)	-	-	1 402
Dongguan Tungwah Hospital (Tungwah Hospital) (Since 6 September 2024)	-	-	790
Nansha Division of The First Affiliated Hospital, Sun Yat-sen University (FAH-NS) (Since 6 September 2024)	-	-	246

	2022	2023 ^{Note 1}	2024
Shenzhen C.K.J Stomatological Hospital (CKJSH) (Since 14 August 2024)	-	-	8 903
Dental Bauhinia Specialty Service Center (Shenzhen)/ Dental Bauhinia General Care Center (Shenzhen) (Dental Bauhinia) (Since 14 August 2024)	-	-	210
Sub-total (the GBA):	32 356	38 462	77 918
Total:	4 179 057	5 002 227	5 296 970

Amount of Vouchers Claimed (in HK\$'000)

	2022	2023 ^{Note 1}	2024
Healthcare service providers in Hong Kong			
Medical Practitioners	1,059,052	1,270,495	1,363,308
Chinese Medicine Practitioners	854,324	1,140,988	1,227,911
Dentists	343,327	413,222	402,347
Occupational Therapists	4,518	4,455	3,404
Physiotherapists	17,743	22,726	23,083
Medical Laboratory Technologists	13,393	14,712	13,353
Radiographers	24,635	29,503	34,556
Nurses	9,878	11,168	10,427
Chiropractors	5,080	5,955	5,467
Optometrists	233,912	352,743	255,505
Audiologists ^{Note 2}	-	2,693	5,040
Clinical Psychologists ^{Note 2}	-	4	-
Dietitians ^{Note 2}	-	829	1,110
Speech Therapists ^{Note 2}	-	5	7
Sub-total (Hong Kong):	2,565,862	3,269,498	3,345,518
Medical institutions in the GBA ^{Note 3}			
HKU-SZH (including Huawei CHC, an offsite medical institution)	10,949	11,883	19,557
FAH-SYSU (Since 28 June 2024)	-	-	931
ZSCXH (Since 18 July 2024)	-	-	995
NFUFH (Since 14 August 2024)	-	-	1,594
Tungwah Hospital (Since 6 September 2024)	-	-	451
FAH-NS (Since 6 September 2024)	-	-	95

CKJSH (Since 14 August 2024)	-	-	15,264
Dental Bauhinia (Since 14 August 2024)	-	-	452
Sub-total (for the GBA):	10,949	11,883	39,339
Total:	2,576,811	3,281,381	3,384,857

Average Amount of Vouchers per Claim Transaction (HK\$)

	2022	2023 ^{Note 1}	2024
Healthcare service providers in Hong Kong			
Medical Practitioners	542	546	558
Chinese Medicine Practitioners	519	580	568
Dentists	1,190	1,247	1,213
Occupational Therapists	1,082	1,053	1,134
Physiotherapists	472	498	533
Medical Laboratory Technologists	918	953	921
Radiographers	1,187	1,302	1,484
Nurses	1,054	997	965
Chiropractors	575	576	627
Optometrists	1,451	1,532	1,455
Audiologists ^{Note 2}	N/A	3,435	3,081
Clinical Psychologists ^{Note 2}	N/A	2,000	N/A
Dietitians ^{Note 2}	N/A	1,361	819
Speech Therapists ^{Note 2}	N/A	1,000	1,000
Medical institutions in the GBA ^{Note 3}			
HKU-SZH (including Huawei CHC, an offsite medical institution)	338	309	313
FAH-SYSU (Since 28 June 2024)	N/A	N/A	499
ZSCXH (Since 18 July 2024)	N/A	N/A	485
NFUFH (Since 14 August 2024)	N/A	N/A	1,137
Tungwah Hospital (Since 6 September 2024)	N/A	N/A	571
FAH-NS (Since 6 September 2024)	N/A	N/A	386
CKJSH (Since 14 August 2024)	N/A	N/A	1,714
Dental Bauhinia (Since 14 August 2024)	N/A	N/A	2,152

Note 1: Starting from 28 July 2023, the EHVS allows shared use of vouchers between 2 eligible elderly persons in spousal relationship upon their mutual consent and completion of procedures to pair up their voucher accounts. Furthermore, a three-year Elderly Health Care Voucher Pilot Reward Scheme was launched under the EHVS on 13 November 2023.

Note 2: Since 28 April 2023, the coverage of the EHVS has been extended to include primary healthcare services provided by 4 categories of healthcare professions under the Accredited Registers Scheme for Healthcare Professions (namely audiologists, clinical psychologists, dietitians and speech therapists).

Note 3: Under the existing EHVS, private healthcare professionals in Hong Kong may enrol in the scheme as healthcare service providers on an individual basis, while medical institutions in the GBA participate in the scheme on a hospital/medical institution basis. Eligible elderly persons may use EHCVs to pay for the fee of outpatient healthcare services, such as physical examination, continuous preventive healthcare and chronic disease management, etc., provided by the designated departments at medical institutions in the GBA, and the statistics on the related healthcare services are compiled on the basis of services as provided by the respective designated departments, rather than individual healthcare professions. As such, any direct comparison between the average amount of vouchers per claim transaction for healthcare service providers in Hong Kong and that of medical institutions in the GBA is not appropriate. Nor do the figures reflect the levels of primary healthcare service charges of either region.

2.

In accordance with the Primary Healthcare Blueprint (Blueprint) launched in December 2022, the Government will strive to direct resources towards primary healthcare services with an emphasis on strengthening chronic disease management and reinforcing the different levels of prevention. To tie in with the directions set out in the Blueprint, the Government launched the Elderly Health Care Voucher Pilot Reward Scheme (Pilot Reward Scheme) in November 2023 to further incentivise elderly persons by offering rewards to them to make better use of EHCVs for continuous preventive healthcare and chronic disease management services, etc. It is hoped that the policy objective of the EHVS can be achieved through such optimised use of resources to promote primary healthcare and support the healthcare needs of elderly persons.

Under the Pilot Reward Scheme, elderly persons only need to accumulate the use of EHCVs of \$1,000 or more for designated primary healthcare purposes such as disease prevention and health management services within the same year (from January to December), and they will be automatically allotted a \$500 reward to their voucher accounts by the eHealth System (Subsidies), which can be used for the same designated primary healthcare purposes. No further registration is needed. In other words, for elderly persons who meet the above criterion and are allotted the reward, the amount of EHCVs they receive in that year is increased from \$2,000 to \$2,500.

Since the launch of the Pilot Reward Scheme on 13 November 2023 up until 31 December 2024, a total of 788 975 elderly persons have received the reward. The number of voucher claim transactions used on the designated primary healthcare services was 3 507 731, accounting for 60% of the total voucher claim transactions during the same period, whereas that for the period between January 2023 and mid-November 2023, i.e. prior to the launch of the Pilot Reward Scheme, was 48%. This shows that the Pilot Reward Scheme has the effect of encouraging elderly persons to use the designated primary healthcare services. The Government will keep closely monitoring the implementation of the Pilot Reward Scheme and evaluate its effectiveness in promoting the receipt of health assessment, disease screening and chronic disease management services by elderly persons.

- End -

CONTROLLING OFFICER'S REPLY

HHB205

(Question Serial No. 0541)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions, (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The Department of Health implements an array of anti-epidemic measures at various boundary control points (BCPs) to prevent importation and exportation of infectious diseases. In this connection, will the Government inform this Committee of:

1. the manpower arrangement and expenditure for conducting temperature screening for inbound travellers at various BCPs in each of the past 5 years;
2. the number of inbound travellers in whom abnormalities were detected during temperature screening in each of the past 5 years; the follow-up procedure; and whether such travellers were denied entry subsequently; if so, the number of travellers denied entry or sent to hospital immediately in each of these years; and
3. whether the Government has assessed if the above measure has achieved the original policy intent; whether the manpower arrangement and expenditure are economically efficient; and whether the Government will consider rescinding the temperature screening in order to save on manpower and cut costs; if yes, when it will be rescinded; if no, the reasons?

Asked by: Hon CHAN Pui-leung (LegCo internal reference no.: 3)

Reply:

In accordance with the power conferred by the Prevention and Control of Disease Ordinance of Hong Kong and with regard to the guidelines of the International Health Regulations, the Department of Health (DH) enforces various preventive measures at boundary control points (BCPs) to prevent the introduction or spreading of infectious diseases into or out of Hong Kong. The Port Health Division under the DH carries out health screening work at each BCP (including conducting regular body temperature screening for arrivals and setting up health stations). Taking into account the design of each BCP and its traveller and vehicle flow, the Port Health Division deploys manpower as appropriate to conduct body temperature screening for all arrivals; and performs, in accordance with the mechanism, further health assessments for travellers with fever or in need (such as travellers who self-reported being unwell) to understand their symptoms, travel history, contact history, etc., in order to make appropriate referrals and follow-up, including compulsory referral of persons with suspected infection of major infectious diseases to Hong Kong public hospitals for

checking, advising other travellers with fever or in need to seek medical treatment at medical institutions with issuance of referral letters, and assisting persons in need to call for ambulance service for further treatment at Accident and Emergency Department.

The Hong Kong Special Administrative Region (HKSAR) Government has been maintaining close co-operation with entry-exit health inspection and quarantine authorities of the Mainland to safeguard the well-being and safety of residents and travellers of the 2 places. The Health Bureau and the General Administration of Customs of the People's Republic of China (GACC) signed the Co-operation Arrangement for Entry-exit Health Inspection and Quarantine between the GACC and the Health Bureau of the HKSAR Government in 2023. Under the normalisation arrangements for epidemic prevention and control, the 2 parties agreed to focus on the health inspection and quarantine of their respective inbound personnel travelling between the HKSAR and the Mainland BCPs.

The HKSAR Government will maintain close liaison with the relevant Mainland authorities and, taking into account factors such as cost-effectiveness and appropriateness, actively review the entry health inspection and quarantine arrangements (including temperature screening) from the public health perspective.

(1)

From 2020 to 2024, the average number of health screening shifts of the DH per day at various BCPs (some health screening posts involve more than 1 shift according to the operation of BCPs) is as follows:

	2020	2021	2022	2023	2024
Airport	270	244	226	125	122
Lo Wu	40	0	0	40	40
Lok Ma Chau Spur Line	30	0	0	30	30
Lok Ma Chau	90	90	111	94	94
Man Kam To	27	27	41	36	36
Sha Tau Kok	37	37	20	8	0
Shenzhen Bay	137	171	182	116	94
Hong Kong-Zhuhai-Macao Bridge	141	178	178	116	130
Heung Yuen Wai	28	28	28	68	58
Express Rail Link West Kowloon	6	6	31	51	51
Hung Hom	18	18	18	0	0
Macau Ferry Terminal	42	42	45	45	45
China Ferry Terminal	22	22	0	22	22
Total	888	863	880	751	722

Note:

The DH redeploys health screening posts in view of the actual circumstances. Some of the posts at BCPs where operation has been suspended would be redeployed to other BCPs. Health screening service of Kai Tak Cruise Terminal and Ocean Terminal was not included as it was only provided during stopover of cruises.

The expenditure incurred by health screening shifts listed in the table above is set out below (including the actual expenditure as at February 2025 and the estimated expenditure in March 2025):

	Financial Year				
	2020-21	2021-22	2022-23	2023-24	2024-25
Total Expenditure (\$ million (about))	215	205	239	240	205

(2)

From 2020 to 2024, the number of inbound travellers confirmed with fever during temperature screening at BCPs, along with the number of those compulsorily referred to public hospitals upon fulfilling the reporting criteria of any major infectious disease are set out below:

	2020	2021	2022	2023	2024
Total Number of Inbound Travellers with Fever	1 003	30	135	4 759	4 214
Number of Inbound Travellers Compulsorily Referred to Public Hospitals upon Fulfilling Reporting Criteria of Any Major Infectious Disease	1 547	205	250	61	6

Note:

The compulsory isolation arrangement imposed on persons infected with Coronavirus Disease 2019 (COVID-19) has been rescinded with effect from 30 January 2023.

In addition to compulsory referral of persons with suspected infection of major infectious diseases to Hong Kong public hospitals for checking, the DH also, subject to the results of health assessments, offered health advice and issue referral letters to persons having fever but without suspected infection of such diseases. These persons would be advised to seek treatment from medical institutions on their own. The DH, however, did not prohibit the entry of inbound travellers on the grounds that abnormalities had been detected during temperature screening.

(3)

Ongoing health screening, which facilitates early identification of potential infectious diseases imported into Hong Kong, is vital to safeguarding public health. Currently, health screening measures are in place for inbound travellers at all BCPs between Hong Kong and the Mainland.

The DH mainly employs an Infrared Thermal Imaging System at various BCPs to detect the body temperatures of multiple travellers simultaneously to reduce the manpower required for such work. However, drivers and all passengers in a cross-boundary private car are allowed to remain in their vehicle while passing through the kiosks of the Immigration Department, the Customs and Excise Department and the DH without the need to get off from the vehicle or go to the traveller's clearance hall. Due to site constraints, the Infrared Thermal Imaging System cannot be used to measure the forehead temperature of drivers and passengers passing through the vehicle lanes. As a result, hand-held infrared thermometers are used to measure the body temperature of inbound passengers on board the vehicles at the DH vehicle kiosks.

The DH reviews the health screening arrangements from time to time and deploys manpower as appropriate at various BCPs according to the actual circumstances to provide appropriate services for inbound travellers. For instance, the additional personnel deployed during the COVID-19 epidemic in the light of the actual needs have been reduced after the epidemic, and the manpower at relevant BCPs has basically returned to the pre-epidemic level. Meanwhile, the DH also keeps a close eye on technological development and actively explores the adoption of innovative technology in collaboration with other departments at BCPs to reduce the manpower need for health screening and optimise the use of human resources.

- End -

CONTROLLING OFFICER'S REPLY

HHB206

(Question Serial No. 0582)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (4) Curative Care

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The Department of Health mentioned in the Matters Requiring Special Attention in 2025-26 that it would continue to implement the enhanced three-year programme (known as Healthy Teeth Collaboration (HTC)) in collaboration with non-governmental organisations. In this connection, will the Government please advise this Committee on the public expenditure on and the number of participants of the HTC (including patients aged 18 or above with autistic spectrum disorder who have been covered by the programme since July 2024) each year since its launch; the details of the estimated provision earmarked for the HTC in 2025-26; whether the Government has, in view that the new phase of the HTC will end on 31 March 2027, evaluated the effectiveness of the HTC since its implementation, and whether it will regularise HTC in the future?

Asked by: Hon CHAN Pui-leung (LegCo internal reference no.: 26)

Reply:

To safeguard the oral health of the public, the Chief Executive announced in the 2022 Policy Address to conduct a comprehensive review of the dental services provided or subsidised by the Government. The Working Group on Oral Health and Dental Care (Working Group) was subsequently established in end-2022. The Working Group published a final report in end-2024, recommending that the future development of dental services should make reference to the direction of the Primary Healthcare Blueprint emphasising prevention, early identification and timely intervention, with the goal of retention of natural teeth and enhancing the overall level of citizens' oral health.

The Government concurs with the views of the Working Group that providing or subsidising comprehensive curative dental services from public purse to all Hong Kong citizens regardless of their financial means does not align with the policy objectives of developing a prevention-oriented oral health and dental care system and encouraging citizens to take responsibility for their own oral health. This would exacerbate the current shortcomings of the treatment-oriented system, and would be neither cost-effective nor sustainable in terms of utilisation of public resources. It would be financially untenable for the Government and would thin out the resources that could otherwise be used for other healthcare services.

In response to the final report of the Working Group, the Government has adopted the oral health policy that: (1) Oral health is an integral component of general health. The Government's oral health policy aims to enable all Hong Kong citizens to improve their oral hygiene and lifestyle conducive to both oral and overall health levels; (2) Through publicity, education, promotion and development of primary oral health and dental care, the Government facilitates citizens to manage their oral health, and put prevention, early identification and timely intervention of dental diseases into action with the objective of tooth retention; and (3) The Government provides appropriate oral health and dental care services targeting underprivileged groups with financial difficulties and special needs, ensuring these groups have access to essential dental care services.

In the Oral Health Action Plan formulated based on the Working Group's strategic recommendations, the Healthy Teeth Collaboration (HTC) programme is a service focusing on underprivileged groups who have difficulties in accessing dental care under the aforesaid strategy of ensuring these groups have access to essential dental care services.

The Department of Health (DH) has implemented the HTC since July 2018, which provides, through non-governmental organisations (NGOs), free dental services including oral check-ups, dental treatments and oral health education for adults aged 18 or above with intellectual disability. The HTC was further extended from 16 July 2024 to March 2027 with 900 additional quotas for new cases every year and its scope extended to cover persons aged 18 or above with autism spectrum disorder. There are currently 8 participating NGOs, each with at least 1 dentist and 1 dental surgery assistant.

The number of attendances in the past 5 service years is set out as follows:

Service Year ^{Note 1}	2020-21	2021-22	2022-23	2023-24	2024-25 ^{Note 2} (up to January 2025)
Number of Attendances	1 786	4 129	6 121	6 902	5 778

Note 1: A service year refers to the period from 16 July of the current year to 15 July of the following year.

Note 2: The service year 2024-25 runs from 16 July 2024 to 31 March 2025. Starting from 16 July 2024, the HTC programme has been extended to include patients with autism spectrum disorder.

The Government's actual expenditures for implementing the HTC programme in 2020-21, 2021-22, 2022-23 and 2023-24, along with the revised estimate for 2024-25, are set out as follows:

HTC Programme	2020-21 (Actual)	2021-22 (Actual)	2022-23 (Actual)	2023-24 (Actual)	2024-25 (Revised Estimate)
Annual Expenditure (\$ million)	6.80	11.10	22.80	33.40	46.40

For 2025-26, the DH has earmarked \$46.40 million for implementing the HTC. The Government noted that NGOs had faced significant difficulties in recruiting dentists for special care dental services. Due to the limited number of participating dentists, there is room for improvement in service capacity across various programmes. The Government agreed with the Working Group that institutions such as the Faculty of Dentistry of The University of Hong Kong, The Hong Kong Dental Association and The College of Dental Surgeons of Hong Kong should provide more training in Special Care Dentistry to support future development of special care dental services. The Government will continue to keep in view the HTC to further streamline its services.

- End -

CONTROLLING OFFICER'S REPLY

HHB207

(Question Serial No. 0583)

Head: (37) Department of Health

Subhead (No. & title): (000) Operational expenses

Programme: (1) Statutory Functions

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The Department of Health (DH) has stated that the provision for 2025-26 will be \$273.3 million (16%) higher than the revised estimate for 2024-25 mainly due to increased provision for operating expenses and the increased provision for personal emoluments as a result of a net increase of 19 posts. In this connection, will the Government please advise this Committee on:

1. the details of the 19 net-increased posts, including the titles, ranks, duties, staff costs and other staff-related expenses, and the reasons why it is necessary to create these posts;
2. the difference between the above 19 posts and the 19 posts to be net-increased in 2024-25 when the DH stated in its Estimates for 2024-25 that the provision for the year would be \$179.0 million (10.7%) higher than the revised estimate for 2023-24 mainly due to the increased provision for operating expenses and the increased provision for personal emoluments as a result of a net increase of 19 posts; whether the manpower level of 1 122 staff members under the current Programme is sufficient for the work to be taken forward in the future; and whether the DH needs to create more posts in the future; and
3. the specific reasons for the substantial increase in the Estimates for 2025-26 in the provision for departmental expenses on temporary staff, which is \$100.415 million higher than the revised estimate for 2024-25; and the details of the temporary staff, including the number, titles, ranks, duties, staff costs, and lengths of employment?

Asked by: Hon CHAN Pui-leung (LegCo internal reference no.: 27)

Reply:

To enhance the health of the people of Hong Kong, improve healthcare protection and quality, and capitalise on our healthcare professions' strengths, the Government is conducting a comprehensive review on the positioning and objectives of the healthcare system. This includes reforming the functions and division of work among the Hospital Authority (HA), the Department of Health (DH) and the Primary Healthcare Commission (PHC Commission). Among them, the PHC Commission and the DH will strengthen their efforts in health promotion and disease prevention in a bid to shift the emphasis of the present healthcare system from treatment-oriented to prevention-oriented. The DH will also strengthen its role

as the Government's health adviser and public health authority, such as devising health promotion strategies by adopting a life-course framework; strengthening the Whole School Health Programme to recommend targeted school-based measures for physical activities, meals and other matters for each school to improve students' physical and psychological well-being; and continuing its efforts to enhance various vaccination subsidy schemes.

Besides, the Government will continue to support manpower training and technology innovation, helping to uphold the global standing and regional advantages of Hong Kong's healthcare professions. This will also be conducive to the development of Hong Kong into an international health and medical innovation hub (by means of, for example, establishing the Hong Kong Centre for Medical Products Regulation (CMPR) as a step towards "primary evaluation" of medical products), an advanced medical service centre in Asia, a place where medical professionals cluster, as well as a bridge for East-and-West healthcare exchanges.

1.

There will be a net increase of 19 posts, comprising mainly officers from the Pharmacist, Scientific Officer (Medical), Chemist, Science Laboratory Technician grades, as well as administrative/executive and clerical personnel, under Programme (1) of the DH in 2025-26. The new posts serve to bolster manpower to meet operational needs following the completion of the permanent premises of the Government Chinese Medicines Testing Institute. The work to be undertaken includes advancing research and development of testing methods of Chinese medicines and facilitating technology transfer to the industry. The salary expenditure for the net increase of the 19 posts is \$17.42 million in terms of notional annual mid-point salary value.

2.

In 2024-25, the 19 net-increased posts under Programme (1) of the DH mainly supported the establishment of a preparatory office for the CMPR and handled matters related to the registration and regulation of healthcare professionals. The DH will continue to review its manpower needs to support the work under Programme (1).

3.

The increase in the provision for 2025-26 compared to the revised estimate for 2024-25 is attributed in large part to the engagement of additional full-time and part-time Non-Civil Service Contract (NCSC) staff and Post-retirement Service Contract (PRSC) staff to meet the time-limited service needs. The work entails the establishment of the CMPR; enhancing the Elderly Health Care Voucher Scheme (including the Elderly Health Care Voucher Greater Bay Area Pilot Scheme); strengthening public and subsidised dental services; providing temporary manpower support arising from staff turnover, etc. Approximately 190 positions will be created or filled across disciplines, such as contract healthcare personnel, registered pharmacists, research officers, administrative and supporting staff. According to the Government's guiding principles on the employment of NCSC and PRSC staff, the terms and conditions of service of contract staff should be no less favourable than those provided for under the Employment Ordinance (Cap. 57) and no more favourable than those applicable to civil servants in comparable civil service ranks or with a comparable level of responsibility (if any). Depending on the operational and service needs of individual units in the DH, the contract period for newly employed contract staff may vary and is generally set at 1 year.

- End -

CONTROLLING OFFICER'S REPLY

HHB208

(Question Serial No. 0584)

Head: (37) Department of Health

Subhead (No. & title): (-) Not specified

Programme: (8) Personnel Management of Civil Servants Working in Hospital Authority

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The Department of Health has indicated that the provision for 2025-26 will be \$100,000 (0.9%) higher than the revised estimate for 2024-25 mainly due to the increased provision for operating expenses. It has also stated that it will continue to discharge the personnel management responsibility for the civil servants working in the Hospital Authority (HA) in 2025-26. Will the Government please inform the Committee of how the related expenditure will be used in detail, and how the increased expenditure will help discharge the personnel management responsibility for the civil servants working in the HA to maintain their morale and work efficiency; if yes, the details; if no, the reasons?

Asked by: Hon CHAN Pui-leung (LegCo internal reference no.: 28)

Reply:

The day-to-day personnel management functions in respect of civil servants working in the Hospital Authority (HA) have been devolved to the HA. However, the Department of Health (DH) retains certain personnel management responsibilities for these staff, which include maintaining communication with them through regular departmental consultative committee and grade consultative committee meetings; commending outstanding staff through various civil service award schemes such as the Secretary for the Civil Service's Commendation Award Scheme, the Long and Meritorious Service Travel Award Scheme and the Commendation Letter Scheme by the Head of Department to boost morale and work efficiency; and processing cases relating to appointment and promotion under the Shadow Promotion Scheme and matters regarding staff discipline and retirement. The provision for 2025-26 is higher than the revised estimate for 2024-25 mainly due to anticipated increase in staff costs and staff-related expenses concerning the DH staff responsible for this programme.

- End -

CONTROLLING OFFICER'S REPLY**HHB209****(Question Serial No. 0585)**Head: (37) Department of HealthSubhead (No. & title): (000) Operational expensesProgramme: (2) Disease PreventionControlling Officer: Director of Health (Dr. Ronald LAM)Director of Bureau: Secretary for HealthQuestion:

The Department of Health (DH) has stated that the provision for 2025-26 is \$1,243.4 million (17.1%) higher than the revised estimate for 2024-25. This is mainly due to the additional provision for meeting funding requirement for the Elderly Health Care Voucher Scheme (EHVS) and other operating expenses. It is further stated that the enhancement of the Elderly Health Care Voucher Greater Bay Area Pilot Scheme (Pilot Scheme) is one of the matters requiring special attention in 2025-26. In this connection, will the Government advise this Committee on:

1. EHCv claims and the voucher amounts involved in the past 5 financial years in the following table;

Type of Healthcare Service Provider	2020		2021		2022		2023		2024	
	Number of Voucher Claims	Amount of Vouchers Claimed	Number of Voucher Claims	Amount of Vouchers Claimed	Number of Voucher Claims	Amount of Vouchers Claimed	Number of Voucher Claims	Amount of Vouchers Claimed	Number of Voucher Claims	Amount of Vouchers Claimed
Medical Practitioners										
Chinese Medicine Practitioners										
Dentists										
Occupational Therapists										
Physiotherapists										
Medical Laboratory Technologists										
Radiographers										
Nurses										
Chiropractors										
Optometrists	Not applicable									
Audiologists	Not applicable									

Clinical Psychologists	Not applicable									
Dietitians	Not applicable									
Speech Therapists	Not applicable									
University of Hong Kong - Shenzhen Hospital (including the Huawei Li Zhi Yuan Community Health Service Center)										
Total										

2. the number of complaints received about voucher claims and usage, the subject matters of the complaints, the types of services and the voucher claim amounts involved in each of the past 5 years;

3. whether there were voucher claims and usage in 2024 in relation to the 7 medical institutions in the Guangdong-Hong Kong-Macao Greater Bay Area which were included in the Pilot Scheme last year; if yes, the details; if no, the reasons;

4. given that the provision for 2025-26 is \$1,243.4 million (17.1%) higher than the revised estimate for 2024-25, the estimated expenditure of the EHVS for 2025-26, and out of which the expenditure arising from the Pilot Scheme; and

5. given that the provision of \$15,424,626,000 under Subhead 000 Operational expenses for 2025-26 represents an increase of \$2,041,925,000 (15.3%) over the revised estimate for 2024-25 mainly due to the additional provision for meeting the funding requirement for the EHVS, etc. and since the EHVS is currently administered by the Health Care Voucher Division of the DH, details of the Division's staff establishment, the expenditure involved and of which the expenditure on meeting the funding requirement for the EHVS in 2025-26.

Asked by: Hon CHAN Pui-leung (LegCo internal reference no.: 29)

Reply:

1. and 3.

The tables below show the number of voucher claim transactions and the amount of vouchers claimed under the Elderly Health Care Voucher Scheme (EHVS) (including the Elderly Health Care Voucher Greater Bay Area Pilot Scheme (Pilot Scheme)) by types of healthcare service provider/medical institution in the Greater Bay Area (GBA) enrolled in the EHVS in the past 5 years:

Type of Healthcare Service Provider	2020		2021		2022		2023 ^{Note 1}		2024	
	Number of Voucher Claims	Amount of Vouchers Claimed (HK\$'000)	Number of Voucher Claims	Amount of Vouchers Claimed (HK\$'000)	Number of Voucher Claims	Amount of Vouchers Claimed (HK\$'000)	Number of Voucher Claims	Amount of Vouchers Claimed (HK\$'000)	Number of Voucher Claims	Amount of Vouchers Claimed (HK\$'000)
Medical Practitioners	1 957 092	947,488	1 917 943	1,027,990	1 954 032	1,059,052	2 325 617	1,270,495	2 444 952	1,363,308
Chinese Medicine Practitioners	1 376 436	634,851	1 542 578	788,617	1 647 630	854,324	1 965 635	1,140,988	2 160 315	1,227,911

Dentists	246 844	276,556	308 343	355,444	288 532	343,327	331 342	413,222	331 567	402,347
Occupational Therapists	4 640	5,383	7 224	7,503	4 177	4,518	4 232	4,455	3 003	3,404
Physiotherapists	39 669	15,191	48 107	19,238	37 603	17,743	45 673	22,726	43 341	23,083
Medical Laboratory Technologists	15 324	13,706	20 033	20,552	14 593	13,393	15 441	14,712	14 503	13,353
Radiographers	14 386	14,700	19 373	22,603	20 761	24,635	22 659	29,503	23 285	34,556
Nurses	6 903	8,753	11 295	11,049	9 376	9,878	11 196	11,168	10 800	10,427
Chiropractors	8 826	5,127	9 357	5,760	8 841	5,080	10 331	5,955	8 724	5,467
Optometrists	158 127	225,903	196 046	284,753	161 156	233,912	230 239	352,743	175 563	255,505
Audiologists Note 2	-	-	-	-	-	-	784	2,693	1 636	5,040
Clinical Psychologists Note 2	-	-	-	-	-	-	2	4	-	-
Dietitians Note 2	-	-	-	-	-	-	609	829	1 356	1,110
Speech Therapists Note 2	-	-	-	-	-	-	5	5	7	7
Sub-total (Hong Kong):	3 828 247	2,147,658	4 080 299	2,543,509	4 146 701	2,565,862	4 963 765	3,269,498	5 219 052	3,345,518
Medical institutions in the GBA:	18 962	5,507	35 953	12,103	32 356	10,949	38 462	11,883	77 918	39,339
Total:	3 847 209	2,153,165	4 116 252	2,555,612	4 179 057	2,576,811	5 002 227	3,281,381	5 296 970	3,384,857

Note 1: Starting from 28 July 2023, the EHVS allows shared use of vouchers between 2 eligible elderly persons in spousal relationship upon their mutual consent and completion of procedures to pair up their voucher accounts. Furthermore, a three-year Elderly Health Care Voucher Pilot Reward Scheme (Pilot Reward Scheme) was launched under the EHVS on 13 November 2023.

Note 2: Since 28 April 2023, the coverage of the EHVS has been extended to include primary healthcare services provided by 4 categories of healthcare professions under the Accredited Registers Scheme for Healthcare Professions (AR Scheme) (namely audiologists, clinical psychologists, dietitians and speech therapists).

2.

The table below shows the number of complaints against healthcare service providers enrolled in the EHVS received by the Department of Health (DH) in the past 5 years:

	2020	2021	2022	2023	2024	Total
Number of complaints against healthcare service providers enrolling in the EHVS	69	105	45	54	88	361

These complaint cases, involving operational procedures, suspected fraud, improper voucher claims and issues related to service charges, were mainly against Chinese medicine practitioners, medical practitioners, optometrists and dentists. The DH would investigate such cases and take appropriate actions/measures when violation of the terms and conditions

of the EHVS Agreement was found, including issuing advisory/warning letters to the relevant healthcare service providers, withholding reimbursements or recovering paid reimbursements, disqualifying healthcare service providers from participating in the EHVS, and referring cases to the Police and the relevant professional regulatory boards/councils for follow-up as appropriate. The DH does not maintain the statistics on the voucher claim amount involved in these complaint cases.

4.

The estimated expenditure for 2025-26 on the EHVS is \$4.15 billion, which includes the possible claim amount relating to the Pilot Scheme. The expenditure on the Pilot Scheme is subsumed under the overall provision for the EHVS and will not be separately identified.

5.

The EHVS is managed by the DH's Health Care Voucher Division (HCVD), which is responsible for the scheme's administration and monitoring. There are 55 posts in the approved establishment of HCVD. In 2025-26, the HCVD's estimated administrative expenditure for the administration and monitoring of the EHVS is \$68.7 million, which includes the resources for engaging additional contract staff to cope with the extra workload arising from various enhancement measures introduced to the EHVS in recent years, including the Pilot Reward Scheme, the shared use of vouchers between spouses, the extension of coverage of the EHVS to healthcare professionals under the AR Scheme, as well as the implementation of the Pilot Scheme.

- End -

CONTROLLING OFFICER'S REPLY

HHB210

(Question Serial No. 0586)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The Department of Health mentioned in the Matters Requiring Special Attention in 2025-26 under this Programme that it would take forward the next phase of tobacco control measures and strengthen the enforcement of the Smoking (Public Health) Ordinance (Cap. 371) and the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600). With regard to their enforcement and effectiveness in Hong Kong, will the Government please advise this Committee on:

1. the smoking prevalence among men and women in Hong Kong and the respective average number of cigarettes smoked per day in the past 5 years in tabular form by sex and age group (namely i) 15-19; ii) 20-29; iii) 30-39; iv) 40-49; v) 50-59 and 60 or above);
2. the numbers of i) complaints received; ii) inspections conducted; iii) fixed penalty notices and summonses issued by the Tobacco and Alcohol Control Office regarding offences such as smoking, displaying or publishing of tobacco advertisements in each of the past 5 years;
3. as the provision for 2025-26 is \$273.3 million (16.0%) higher than the revised estimate for 2024-25, which is mainly due to increased provision for operating expenses and the increased provision for personal emoluments as a result of a net increase of 19 posts in 2025-26, whether this net increase of 19 posts is related to taking forward the next phase of tobacco control measures, and the details of these 19 posts, including the titles, ranks, duties, salary expenditure, whether they are permanent or supernumerary, and their job descriptions?

Asked by: Hon CHAN Pui-leung (LegCo internal reference no.: 30)

Reply:

1.

The Census and Statistics Department (C&SD) conducts Thematic Household Surveys (THS) from time to time to study the smoking prevalence in the population. After the Government increased the tobacco duty in February 2023, the results of the THS on the smoking pattern conducted by the C&SD from May to August that year showed that the smoking prevalence dropped from 10.2% in 2019 and 9.5% in 2021 to 9.1% in 2023. The average number of cigarettes smoked per day by smokers also decreased from 12.7 sticks in 2019 and 2021 to 12.1 sticks in 2023. The Government further increased the tobacco duty in 2024. In this connection, a THS will be conducted later and it is expected that the reduction in the demand for tobacco products will be reflected in the survey. The C&SD conducted and completed

2 rounds of THS on the pattern of smoking in the past 5 years, with a breakdown of the smoking prevalence and the number of cigarettes consumed by smokers daily (by age group and sex) set out at **Annex 1**.

2.

The Tobacco and Alcohol Control Office (TACO) of the Department of Health (DH) is the principal enforcement agency for the Smoking (Public Health) Ordinance (Cap. 371) and the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600). The TACO will conduct inspections and investigation in response to smoking and related complaints. In general, the TACO will issue fixed penalty notices (FPNs) to smoking offenders without warning. Apart from smoking offences, the TACO also issued summonses for offences under Cap. 371 (including aiding and abetting smoking offences, offences relating to smoking product advertisements, the promotion, manufacture, sale, or possession for commercial purposes, of alternative smoking products (ASPs), obstruction of inspectors, etc.), and for the offence of importing ASPs under the Import and Export Ordinance (Cap. 60). The numbers of complaints / referrals received, inspections conducted, warning letters issued, and FPNs / summonses issued by the TACO for the period from 2020 to 2024 for smoking and other offences are at **Annex 2**.

3. There will be a net increase of 19 posts under Programme (1) of the Department of Health in 2025-26 to strengthen manpower for operational needs following the completion of the permanent premises of the Government Chinese Medicines Testing Institute. The work to be undertaken includes advancing research and development of testing methods of Chinese medicines and facilitating technology transfer to the industry. The new posts comprise mainly officers from the Pharmacist, Scientific Officer (Medical), Chemist and Science Laboratory Technician grades, as well as administrative/executive and clerical personnel. The salary expenditure for the net increase of the 19 posts is \$17.42 million in terms of notional annual mid-point salary value.

Prevalence* of Daily Cigarette Smokers by Age Group and Sex in 2021 and 2023

Age group	Male		Female		Overall	
	2021	2023	2021	2023	2021	2023
Aged 15 to 19	#	#	#	#	#	#
Aged 20 to 29	9.6%	9.3%	2.1%	1.7%	5.9%	5.5%
Aged 30 to 39	15.3%	16.2%	4.5%	3.6%	9.5%	9.7%
Aged 40 to 49	24.6%	21.9%	5.8%	5.0%	14.2%	12.6%
Aged 50 to 59	22.0%	23.5%	3.2%	4.1%	11.7%	12.7%
Aged ≥60	15.7%	15.3%	1.2%	0.9%	8.2%	7.7%
Overall	16.7%	16.4%	3.0%	2.7%	9.5%	9.1%

* As a percentage of all persons in the respective age group. For example, among all males aged 20 to 29, 9.6% were daily cigarette smokers based on the survey conducted in 2021.

The figures are not released due to large sampling error.

Source: Thematic Household Survey Report Nos. 75 and 79, Census and Statistics Department.

**Average Daily Consumption of Cigarettes (number of sticks of cigarettes)
by Age Group and Sex in 2021 and 2023**

	2021	2023
Age group		
Aged 15 to 19	#	#
Aged 20 to 29	11.2	11.2
Aged 30 to 39	11.5	11.5
Aged 40 to 49	12.7	11.8
Aged 50 to 59	13.7	12.6
Aged ≥60	13.0	12.5
Sex		
Male	13.2	12.6
Female	10.5	9.3
Overall	12.7	12.1

The figures are not released due to large sampling error.

Source: Thematic Household Survey Report Nos. 75 and 79, Census and Statistics Department.

Numbers of complaints / referrals received, inspections conducted, warning letters issued, and FPNs / summonses issued by TACO for smoking and other offences under the Smoking (Public Health) Ordinance (Cap. 371), the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600) and the Import and Export Ordinance (Cap. 60)

		2020	2021	2022	2023	2024
Complaints/referrals received		11 568	13 424	14 805	20 116	29 205
Inspections conducted		36 129	41 225	35 281	28 817 (Note 4)	30 162
Warning letters issued ^(Note 1&2)		16	16	21	10	10
FPNs issued (for smoking offences)		6 587	7 703	6 296	10 261 (Note 4)	13 488
Summonses issued	for smoking offences	58	40	35	48	64
	for other offences ^(Note 3)	57	115	130	657	871

Note:

- 1 In general, the TACO will prosecute smoking offenders without prior warning. The TACO will only consider issuing warning letters if the smoking offenders are found to be persons under 15 years old.
- 2 During the 3-month grace period from 30 April to 31 July 2022, warning letters were issued to passengers carrying small quantity of ASPs. After the grace period, any person who imports any quantity of ASPs will be prosecuted when there is sufficient evidence.
- 3 Other offences include willful obstruction, failure to produce identity document, displaying smoking product advertisement, ASP related offences, and aiding and abetting another person committing a smoking offence, etc.
- 4 To effectively mitigate the impact of passive smoking on the public and enhance the deterrent effect against illegal smoking, TACO has flexibly deployed resources and adopted new enforcement strategies since 2023, including extension of the time of surveillance and inspections in no smoking areas, deploying plain-clothes officers to take proactive enforcement actions, strengthening enforcement action in venues (such as bars and food premises) where waterpipes were offered for smoking, as well as prosecuting people inciting, aiding and abetting illegal smoking. The number of prosecutions against illegal smoking has surged due to the new enforcement strategies, reflecting their enhanced effectiveness.

- End -

CONTROLLING OFFICER'S REPLY**HHB211****(Question Serial No. 0630)**Head: (37) Department of HealthSubhead (No. & title): (-) Not SpecifiedProgramme: (1) Statutory FunctionsControlling Officer: Director of Health (Dr. Ronald LAM)Director of Bureau: Secretary for HealthQuestion:

The Government mentioned in the Matters Requiring Special Attention in 2025-26 under this Programme that it would continue the enforcement work against commercial sale and supply of alcohol to minors. In this connection, will the Government please advise this Committee on:

1. the number of violations, prosecutions and convictions regarding the sale and supply of alcohol to minors in the past 3 years in the following table:

Contravention	2022	2023	2024
Number of violations related to the sale of alcohol to minors			
Number of violations related to the supply of alcohol to minors			
Number of prosecutions for the sale of alcohol to minors			
Number of prosecutions for the supply of alcohol to minors			
Number of convictions for the sale of alcohol to minors			
Number of convictions for the supply of alcohol to minors			

2. the current establishment for and staff costs on the enforcement work, and whether the Government has assessed the effectiveness of the enforcement and inspection efforts; if yes, the details and if no, the reasons?

Asked by: Hon CHAN Pui-leung (LegCo internal reference no.: 31)

Reply:

(1) & (2)

The sale and supply of intoxicating liquor to minors in the course of business are prohibited under Part 5 of the Dutiable Commodities (Liquor) Regulations (Cap. 109B). In 2024, the Tobacco and Alcohol Control Office (TACO) of the Department of Health conducted more than 4 000 inspections to check retailers' compliance with such legal requirements and carried out investigation and enforcement actions upon receipt of intelligence or complaints. Over the past 3 years, the TACO received 63 complaints regarding the sale or supply of intoxicating liquor to minors in the course of business. No violation was found upon plainclothes patrol and follow-up investigation.

Apart from the stipulation above, Cap. 109B also requires vendors which sell or supply intoxicating liquor in face-to-face distributions to display a prescribed notice in a prominent position at the premises in the course of business. The Tobacco and Alcohol Control Inspectors will conduct inspections at these premises to ensure that vendors comply with this requirement. Over the past 3 years, the TACO issued 10 summonses to offenders in this respect.

The approved establishment of the TACO is at Annex, with the staff costs of \$81.27 million in 2024-25. The manpower and resources for the implementation of alcohol and tobacco control initiatives cannot be separately identified.

Approved Establishment of
the Department of Health's Tobacco and Alcohol Control Office

Rank	No. of staff in 2024-25
<u>Head, TACO</u>	
Consultant	1
<u>Enforcement</u>	
Senior Medical & Health Officer	1
Medical & Health Officer	1
Scientific Officer (Medical)	1
Land Surveyor	1
Police Officer	5
Overseer/ Senior Foreman/ Foreman	125
Senior Executive Officer/ Executive Officer	13
<i>Sub-total</i>	<u>147</u>
<u>Health Education and Smoking Cessation</u>	
Senior Medical & Health Officer	1
Medical & Health Officer	1
Scientific Officer (Medical)	2
Nursing Officer/ Registered Nurse	3
Hospital Administrator II	4
<i>Sub-total</i>	<u>11</u>
<u>Administrative and General Support</u>	
Senior Executive Officer/ Executive Officer	4
Clerical and support staff	19
Motor Driver	1
<i>Sub-total</i>	<u>24</u>
Total	<u>183</u>

- End -

CONTROLLING OFFICER'S REPLY

HHB212

(Question Serial No. 2701)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

It is mentioned in the Budget that the Government will, in the first half of this year, put forward the timetable for establishing the Hong Kong Centre for Medical Products Regulation (CMPR). In this connection, will the Government please advise this Committee on: (i) the staff establishment, salary expenditure and operating expenditure in respect of the CMPR; and (ii) whether the Government has earmarked any resources to tie in with the establishment of the CMPR; if yes, the details?

Asked by: Hon CHAN Wing-kwong (LegCo internal reference no.: 7)

Reply:

(1) & (2):

As mentioned in the Chief Executive's Policy Address in 2023 and 2024, the HKSAR Government will enhance the current evaluation and registration mechanism for drugs, and establish an internationally renowned regulatory authority of drugs and medical devices. To this end, the HKSAR Government set up a Preparatory Office for the Hong Kong Centre for Medical Products Regulation (CMPR) in the Department of Health (DH) in June 2024. The Preparatory Office is proactively reviewing the regulatory functions of the DH, including the regulation of Chinese and Western medicines and medical devices; studying the potential restructuring and strengthening of the regulatory and approval regime for medicines, medical devices and medical technology; and putting forward proposals and steps for the establishment of the CMPR which will be a step towards the transition to the "primary evaluation" approach in approving applications for registration of new medical products. This will help accelerate the clinical application of new drugs and medical devices, and foster the development of emerging industries related to the research and development (R&D) as well as testing of medical products. The Preparatory Office is drawing up the timetable for establishing the CMPR and the roadmap towards adoption of "primary evaluation", and will announce them in the first half of 2025 as scheduled.

The Legislative Council has approved the creation by the DH of 4 directorate permanent posts/non-civil service positions (including 1 Controller, 1 Deputy Controller and 2 Assistant Controller positions) in 2025-26 to provide dedicated support for the CMPR to launch various

initiatives, as well as to formulate and introduce more stringent regulatory and approval regimes for medicines and medical devices in accordance with the “primary evaluation” approach. The creation of the above positions will be accompanied by the deletion of 4 existing permanent Consultant posts.

In addition, the DH will consolidate and re-organise the existing functions in relation to the regulation of Chinese and Western medicines and medical devices, and then put them under the purview of the CMPR to be established. This can make fuller use of the existing highly efficient regulatory regime to bring about greater benefits and synergies. In this way, the CMPR can also centralise relevant expertise and optimise resource allocation, with the aim of supporting the approval of innovative medical products, promoting the scientific advancement of medicines, medical devices and medical technology, and expediting their clinical application, thereby driving the development of industries relating to the R&D as well as testing of medical products. The said reorganisation involves the redeployment of 7 existing permanent directorate posts (including 2 Assistant Directors, 3 Chief Pharmacists and 2 Principal Medical and Health Officers) and about 420 non-directorate posts.

The financial provision for the CMPR in 2025-26 is \$41.63 million. The DH will continue reviewing the integration of the various functions of the CMPR, as well as the manpower and resources required.

- End -

CONTROLLING OFFICER'S REPLY

HHB213

(Question Serial No. 2844)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

According to the Budget Speech, the Department of Health will launch the Primary Dental Co-Care Pilot Scheme for Adolescents in 2025-26. In this connection, will the Government please advise on the preparatory work for implementing the scheme, the detailed timetable of its implementation, the estimated expenditure and the number of adolescents expected to benefit from it?

Asked by: Hon CHAN Wing-kwong (LegCo internal reference no.: 20)

Reply:

To safeguard the oral health of the public, the Chief Executive announced in the 2022 Policy Address to conduct a comprehensive review of the dental services provided or subsidised by the Government. The Working Group on Oral Health and Dental Care (Working Group) was subsequently established in end-2022. The Working Group published a final report in end-2024, recommending that the future development of dental services should make reference to the direction of the Primary Healthcare Blueprint emphasising prevention, early identification and timely intervention, with the goal of retention of natural teeth and enhancing the overall level of citizens' oral health.

The Government concurs with the views of the Working Group that providing or subsidising comprehensive curative dental services from public purse to all Hong Kong citizens regardless of their financial means does not align with the policy objectives of developing a prevention-oriented oral health and dental care system and encouraging citizens to take responsibility for their own oral health. This would exacerbate the current shortcomings of the treatment-oriented system, and would be neither cost-effective nor sustainable in terms of utilisation of public resources. It would be financially untenable for the Government and would thin out the resources that could otherwise be used for other healthcare services.

In response to the final report of the Working Group, the Government has adopted the oral health policy that: (1) Oral health is an integral component of general health. The Government's oral health policy aims to enable all Hong Kong citizens to improve their oral

hygiene and lifestyle conducive to both oral and overall health levels; (2) Through publicity, education, promotion and development of primary oral health and dental care, the Government facilitates citizens to manage their oral health, and put prevention, early identification and timely intervention of dental diseases into action with the objective of tooth retention; and (3) The Government provides appropriate oral health and dental care services targeting underprivileged groups with financial difficulties and special needs, ensuring these groups have access to essential dental care services.

In view of the Working Group's strategic recommendations, the Government has formulated an Oral Health Action Plan, under which the Primary Dental Co-care Pilot Scheme for Adolescents (PDCC) is rolled out to actively develop prevention-oriented primary oral healthcare according to the strategy of community-wide preventive primary oral health care.

The Department of Health (DH) launched the three-year PDCC on 20 March this year as an interface with the School Dental Care Service by providing partial subsidies for private dental check-up services for adolescents via a co-payment model to foster their establishment of partnership with dentists so as to promote their life-long habit of regular dental check-ups for prevention of dental diseases. Eligible adolescents can receive subsidised services once every calendar year. While the Government will provide a subsidy of \$200 each time, participants have to pay a co-payment fee as determined by their selected dentists. The co-payment for the subsidised services each time recommended by the Government is \$200. As at 18 March, there are around 270 registered dentists whose application to participate in the PDCC has been accepted by the DH, providing services at over 370 service locations. Among these dentists, over 67% charge a co-payment amount of \$200 or less while the minimum co-payment amount is \$50. The scope of subsidised services includes:

- i) Oral check-up;
- ii) Oral health risk assessment;
- iii) Dental scaling;
- iv) Personalised oral care advice;
- v) Fluoride application based on risk assessment; and
- vi) Oral check-up report.

To enhance the transparency of dental service fees other than the co-payment fee, the DH required dentists to disclose the fees for X-ray examinations, tooth fillings and extractions as charged under the PDCC.

The DH held 2 online briefing sessions for registered dentists in February and March to introduce the background, contents and dentist registration procedures of the PDCC. It also introduced the PDCC through a seminar organised by the Hong Kong Dental Association in mid-March.

Adolescents from age 13 to 17 (or will turn 13 in the calendar year when applying to join the PDCC) who hold a valid Hong Kong Identity Card and have registered in the Electronic Health Record Sharing System (eHealth) are eligible to join the PDCC. Eligible adolescents and their parents may, via the eHealth mobile application, access the thematic website and promotional videos launched by the DH in early March to learn about and participate in the PDCC. The DH has also disseminated letters through the Education Bureau to reach out to all secondary school students and their parents in the territory to publicise and promote the

PDCC, while also approaching students visiting Student Health Service Centres and School Dental Clinics to publicise the scheme. About 370 000 adolescents are eligible to join each year, though the final number of participants will depend on the response from adolescents and their parents.

Adolescents and their parents who are interested in joining the PDCC can refer to the thematic webpage to view the list of registered dentists participating in the PDCC. After selecting a dentist, they can contact the relevant clinic directly to make an appointment for receiving the subsidised services. Details about the clinic addresses, telephone numbers, professional qualifications and the co-payment amount required from scheme participants are also set out on the list of dentists. All clinics participating in the PDCC will display the signage of the scheme outside their premises or at a prominent place for easy identification.

The DH will continuously monitor the utilisation rates of the service and gather feedback from service users as well as the data on their oral health conditions to review the effectiveness of the PDCC in due course.

The Government's financial provision for implementing the PDCC and the Community Dental Support Programme in 2025-26 is \$136.3 million.

- End -

CONTROLLING OFFICER'S REPLY**HHB214****(Question Serial No. 2847)**Head: (37) Department of HealthSubhead (No. & title): (-) Not SpecifiedProgramme: (1) Statutory FunctionsControlling Officer: Director of Health (Dr. Ronald LAM)Director of Bureau: Secretary for HealthQuestion:

In view of the completion of the permanent premises of the Government Chinese Medicines Testing Institute (GCMTI) this year, the Government mentioned in the Budget that the Department of Health would commence relocation of GCMTI to the permanent premises upon its completion to conduct research on reference standards and testing methods of Chinese medicines. In this connection, please advise on:

- (1) whether the Government has earmarked resources in the light of the completion of the permanent premises of the GCMTI; if yes, the details;
- (2) the staff establishment and estimated expenditure with respect to the GCMTI and its *Hong Kong Chinese Materia Medica Standards* project, laboratories, Chinese Medicines Herbarium, training and technology transfer centre in 2025-26; and
- (3) the research projects of the GCMTI undertaken at the temporary site, along with the research findings and the expenditure incurred over the past 3 years.

Asked by: Hon CHAN Wing-kwong (LegCo internal reference no.: 21)Reply:

(1) & (2)

The approved establishment of the Government Chinese Medicines Testing Institute (GCMTI) at present is 31, with a breakdown according to the section as follows:

<u>Section/Unit</u>	<u>Rank</u>	<u>Number of Post</u>
Hong Kong Chinese Materia Medica Standards Section	Scientific Officer (Medical)	9
Research and Development Section (including Chemistry Laboratory and DNA Laboratory)	Senior Chemist	1
	Chemist	4
	Science Laboratory Technologist	1
	Science Laboratory Technician I	3
	Science Laboratory Technician II	3
	Laboratory Attendant	1

Section/Unit	Rank	Number of Post
Macroscopic and Microscopic Identification Laboratory	Scientific Officer (Medical)	1
Chinese Medicines Herbarium Section	Scientific Officer (Medical)	4
Collaboration and Training Unit	Pharmacist	1
Administration Section	Senior Executive Officer	1
	Executive Officer II	1
	Assistant Clerical Officer	1
Total:		<u>31</u>

A net increase of 19 posts in 2025-26 has been approved to strengthen manpower for operational needs following the completion of the permanent premises of the GCMTI within this year of which the GCMTI will begin commissioning in phases by the end of this year. The new posts comprise mainly officers from the Pharmacist, Scientific Officer (Medical), Chemist and Science Laboratory Technician grades, as well as administrative/executive and clerical personnel. An additional financial provision of about \$50.8 million has been allocated for the GCMTI in 2025-26 to cover the expenditure of personal emoluments arising from the civil service post changes set out above, as well as the daily operation and research work of the GCMTI.

(3)

One of the key activities of the GCMTI is to take forward the project on the Hong Kong Chinese Materia Medica Standards (HKCMMS). So far, reference standards for a total of 344 Chinese Materia Medica (CMM) have been established and released. The actual expenditures involved in the HKCMMS in the past 3 years are tabulated below:

Financial Year	2022-23	2023-24	2024-25 (Revised Estimate)
Expenditure (\$ million)	6.3	7.9	9.8

Moreover, the Department of Health (DH) set up the GCMTI Advisory Committee in 2017 as a platform for stakeholders to advise on the long-term development strategies, measures and specific research proposals of the GCMTI. With the support of the Committee, the GCMTI has completed 10 research and thematic projects in the past 3 years with another 8 projects underway, details of which are set out in the **Annex**. As most research projects are maintained by internal resources allocation, the expenditures on manpower and outsourcing of services are subsumed under the overall expenditure of the Chinese Medicine Regulatory Office of the DH. Therefore, the total expenditure on research projects cannot be set out in full.

Completed and Ongoing Research and Thematic projects of the GCMTI**(i) Projects completed between 2022-23 and 2024-25**

Research/Thematic Projects	Commencement Date	Completion Date	Achievements
DNA method for identification of Bulbus Fritillariae Ussuriensis – a common adulterant found in Bulbus Fritillariae Cirrhosae	October 2019	May 2022	Published the analytical method of the real time polymerase chain reaction (PCR) of Bulbus Fritillariae Ussuriensis
Study on the identification of Ziziphi Spinosae Semen and its commonly confused species	June 2021	November 2022	Published 5 monographs on Ziziphi Spinosae Semen and its commonly confused CMM species
Consolidation of the Preliminary Index of CMM Resources in Hong Kong under the Fourth National Survey of CMM Resources	June 2022	December 2022	A series of tasks including literature reviews, surveys, consultations, fieldwork and the consolidation of the Preliminary Index of CMM Resources in Hong Kong were completed at the request of the National Administration of Traditional Chinese Medicine
Analysis of chemical markers of CMM in Baifeng Wan	December 2021	June 2023	Published a total of 12 analytical methods for the 8 CMM in Baifeng Wan
Building of the Digitalised Chinese Medicines Information Platform (Phase II)	March 2022	December 2023	Built the Digital Herbarium for Chinese Medicines (DHCM) platform and public website featuring 220 commonly used CMM, 3-Dimensional (3D) images, virtual reality tours and special topics on knowledge related to Chinese medicines, etc.

Research/Thematic Projects	Commencement Date	Completion Date	Achievements
Identification of tiny seed and fruit types of CMM	April 2022	May 2024	Published 30 monographs on tiny seed and fruit types of CMM with corresponding identification key
Pilot Study on the Analysis of Chemical Markers in Compound Chinese Medicine Granules	January 2024	September 2024	Provided reliable information in related fields for future research and application, and determined the feasibility of new studies
Analysis of chemical markers in proprietary Chinese medicines (pCms) containing Psoraleae and Ginseng	July 2023	December 2024	Developed a set of highly versatile testing methods for the analysis of chemical markers that can extensively test different formulations and dosage forms of pCms categorised as nourishing and Yang invigorating
Study on the identification of Ziziphi Spinosae Semen and its commonly confused species by DNA method	June 2023	December 2024	Developed a testing method using PCR-restriction fragment length polymorphism (PCR-RFLP) technology for quickly and effectively distinguishing Ziziphi Spinosae Semen from its commonly confused CMM species
Survey of CMM Resources under the Fourth National Survey of CMM Resources (Phase II) – Survey on Hong Kong's CMM market and traditional knowledge	May 2023	March 2025	Conducted literature reviews, online surveys, questionnaires, interviews and on-site surveys to gather information on the CMM (including decoction pieces) available in Hong Kong's CMM market, as well as application knowledge of regional medicines inherited in the local context

(ii) Ongoing projects

- Collection of specimens of Daodi medicinal materials of China and South Eastern Asia herbal medicines for the CMs Herbarium of the GCMTI
- Collection of specimens of Western herbal medicines and Lingnan herbal medicines for the CMs Herbarium of the GCMTI
- Building of 3D CMM Images for the DHCM
- Establishment of reference DNA Sequence Library for CMM (Phase II)
- Survey of CMM Resources under the Fourth National Survey of CMM Resources (Phase II) – Collection of medicinal plant specimens of Hong Kong (Winter and Spring)
- Macroscopic and Microscopic Identification of Cortex type of Decoction Pieces Commonly Found in Hong Kong
- Study on the Identification of Radix or Rhizoma Podophylli emodis and its Confused Species by DNA Method
- Analysis of Chemical Markers in Compound Chinese Medicine Granules

- End -

CONTROLLING OFFICER'S REPLY

HHB215

(Question Serial No. 2851)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

One aspect of work undertaken by the Department of Health is to ensure the safety, quality and efficacy of pharmaceutical products through product registration and licensing control. In this connection, will the Government please advise this Committee on:

- (1) the establishment of and the expenditure on the personnel responsible for vetting and approving the registration applications of proprietary Chinese medicines (pCms) or providing assistance for the trade concerning their registration;
- (2) the number of registration applications of the pCms received by the Chinese Medicines Board under the Chinese Medicine Council of Hong Kong, the number of applications rejected/withdrawn, as well as the respective numbers of the pCms issued with "Notice of confirmation of transitional registration of the pCms" and "Certificate of registration of the pCms", in the past 3 years; and
- (3) whether the Government will deploy additional resources and manpower in 2025-26 to expedite the vetting and approval of the registration applications of the pCms or provide assistance for the trade concerning their registration?

Asked by: Hon CHAN Wing-kwong (LegCo internal reference no.: 22)

Reply:

(1)

The Chinese Medicine Council of Hong Kong (the Council) is a statutory body established under the Chinese Medicine Ordinance (Cap. 549) implementing regulatory measures for Chinese medicine. The manpower for the registration of proprietary Chinese medicines (pCms) in the Council Secretariat cannot be separately identified as the staff members discharging such duties are also responsible for other matters related to Chinese medicines.

At the same time, the Chinese Medicine Regulatory Office (CMRO) of the Department of Health (DH) provides professional and administrative support to the Council, which includes handling matters related to the registration of pCms, licensing of Chinese medicines traders, import and export control, Certificate for Clinical Trial and Medicinal Test of pCms and Certificate for Manufacturer (Good manufacturing practice in respect of pCms) (GMP). The

Chinese Medicines Management Division of the CMRO is responsible for such work, and its approved establishment for the registration of pCms as broken down by rank is set out below:

<u>Rank</u>	<u>No. of posts</u>
Senior Pharmacist	2
Pharmacist	2
Scientific Officer (Medical)	10
Clerical Officer	3
Assistant Clerical Officer	<u>6</u>
Total:	<u>23</u>

As for the breakdown of expenditure, the DH does not maintain such data as the relevant expenditure on the registration of pCms are subsumed under the CMRO's overall provision.

(2)

As at 28 February 2025, the Chinese Medicines Board has received a total of 18 821 applications for the registration of pCms, among which 474 applications were received between 2022 and 2024. Of all the applications, 10 385 were withdrawn or rejected due to various reasons.

Out of the remaining 8 436 applications, 1 901 and 6 313 pCms have been issued with the still valid "Notice of confirmation of transitional registration of pCms" (HKP) and "Certificate of registration of pCms" (HKC) respectively, and 222 new applications of HKC are being processed.

(3)

The DH has earmarked about \$13.8 million for 2025-26 to continue the engagement of non-civil service contract (NCSC) staff to expedite the processing of applications for the conversion of HKP to HKC. Reaching its final stage, the vetting process is expected to conclude by 2025, by which time the NCSC positions will lapse upon completion of all relevant procedures.

- End -

CONTROLLING OFFICER'S REPLY

HHB216

(Question Serial No. 2855)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

It is mentioned in the Estimates of the Department of Health that one of the matters requiring special attention in 2025-26 is to enhance the Elderly Health Care Voucher Scheme (EHVS) including the Elderly Health Care Voucher Greater Bay Area Pilot Scheme (Pilot Scheme). In this connection, will the Government advise this Committee on:

- (1) the estimated financial provision for the EHVS in 2025-26, and of which the estimated administrative expenses for administering and monitoring the Scheme;
- (2) the respective amount of vouchers claimed and the total amount of unspent vouchers of the elderly in the past 3 years;
- (3) the number of voucher claim transactions, the amount of vouchers claimed and the average amount per claim transaction by type of healthcare service provider enrolled in the EHVS in the past 3 years in table form;
- (4) the current manpower and estimated expenditure involved in handling complaints about the EHVS; and
- (5) the number of complaints about the EHVS received, the respective numbers of cases with investigation completed, found to be substantiated, and related to fraud or improper voucher claims, and the number of service providers disqualified from the EHVS for violating the Scheme rule, broken down by type of service, in each of the past 3 years?

Asked by: Hon CHAN Wing-kwong (LegCo internal reference no.: 12)

Reply:

(1)&(4)

The estimated expenditure for 2025-26 on the Elderly Health Care Voucher Scheme (EHVS) is \$4.15 billion.

The EHVS is managed by the Department of Health (DH)'s Health Care Voucher Division (HCVD), which is responsible for administration and monitoring of the EHVS (including the handling of complaints). There are 55 posts in the approved establishment of HCVD. In 2025-26, the HCVD's estimated administrative expenditure on the administration and monitoring of the EHVS is \$68.7 million. The manpower dedicated to and the expenditure involved in handling complaints about the EHVS cannot be separately identified.

(2)&(3)

The tables below show the number of voucher claim transactions, the amount of vouchers claimed and the average amount per claim transaction under the EHVS (including the Elderly Health Care Voucher Greater Bay Area Pilot Scheme (Pilot Scheme)) by type of healthcare service provider/medical institution in the Greater Bay Area (GBA) enrolled in the EHVS in the past 3 years:

Number of Voucher Claim Transactions

	2022	2023 ^{Note 1}	2024
Healthcare service providers in Hong Kong			
Medical Practitioners	1 954 032	2 325 617	2 444 952
Chinese Medicine Practitioners	1 647 630	1 965 635	2 160 315
Dentists	288 532	331 342	331 567
Occupational Therapists	4 177	4 232	3 003
Physiotherapists	37 603	45 673	43 341
Medical Laboratory Technologists	14 593	15 441	14 503
Radiographers	20 761	22 659	23 285
Nurses	9 376	11 196	10 800
Chiropractors	8 841	10 331	8 724
Optometrists	161 156	230 239	175 563
Audiologists ^{Note 2}	-	784	1 636
Clinical Psychologists ^{Note 2}	-	2	-
Dietitians ^{Note 2}	-	609	1 356
Speech Therapists ^{Note 2}	-	5	7
Sub-total (Hong Kong):	4 146 701	4 963 765	5 219 052
Medical institutions in the GBA:	32 356	38 462	77 918
Total:	4 179 057	5 002 227	5 296 970

Amount of Vouchers Claimed (in HK\$'000)

	2022	2023 ^{Note 1}	2024
Healthcare service providers in Hong Kong			
Medical Practitioners	1,059,052	1,270,495	1,363,308
Chinese Medicine Practitioners	854,324	1,140,988	1,227,911
Dentists	343,327	413,222	402,347
Occupational Therapists	4,518	4,455	3,404
Physiotherapists	17,743	22,726	23,083
Medical Laboratory Technologists	13,393	14,712	13,353
Radiographers	24,635	29,503	34,556
Nurses	9,878	11,168	10,427
Chiropractors	5,080	5,955	5,467
Optometrists	233,912	352,743	255,505
Audiologists ^{Note 2}	-	2,693	5,040
Clinical Psychologists ^{Note 2}	-	4	-
Dietitians ^{Note 2}	-	829	1,110
Speech Therapists ^{Note 2}	-	5	7

Sub-total (Hong Kong):	2,565,862	3,269,498	3,345,518
Medical institutions in the GBA:	10,949	11,883	39,339
Total:	2,576,811	3,281,381	3,384,857

Average Amount of Vouchers per Claim Transaction (HK\$)

	2022	2023^{Note 1}	2024
Healthcare service providers in Hong Kong			
Medical Practitioners	542	546	558
Chinese Medicine Practitioners	519	580	568
Dentists	1,190	1,247	1,213
Occupational Therapists	1,082	1,053	1,134
Physiotherapists	472	498	533
Medical Laboratory Technologists	918	953	921
Radiographers	1,187	1,302	1,484
Nurses	1,054	997	965
Chiropractors	575	576	627
Optometrists	1,451	1,532	1,455
Audiologists ^{Note 2}	N/A	3,435	3,081
Clinical Psychologists ^{Note 2}	N/A	2,000	N/A
Dietitians ^{Note 2}	N/A	1,361	819
Speech Therapists ^{Note 2}	N/A	1,000	1,000
Medical institutions in the GBA Note 3	338	309	505

In addition, the table below shows the amount of unspent vouchers of eligible elderly persons who have used vouchers in the past 3 years:

Unspent Balance of Voucher Recipients (in \$'000)

	2022	2023^{Note 1}	2024
Total number of eligible elderly persons who have used vouchers (as at end of the year)	1 492 000	1 610 000	1 714 000
Total amount of unspent vouchers of eligible elderly persons who have used vouchers (in \$'000) (as at end of the year)	4,097,000	3,883,000	4,036,000

Note 1: Starting from 28 July 2023, the EHVS allows shared use of vouchers between 2 eligible elderly persons in spousal relationship upon their mutual consent and completion of procedures to pair up their voucher accounts. Furthermore, a three-year Elderly Health Care Voucher Pilot Reward Scheme was launched under the EHVS on 13 November 2023.

Note 2: Since 28 April 2023, the coverage of the EHVS has been extended to include primary healthcare services provided by 4 categories of healthcare professions under the Accredited Registers Scheme for Healthcare Professions (namely audiologists, clinical psychologists, dietitians and speech therapists).

Note 3: Under the existing EHVS, private healthcare professionals in Hong Kong may enrol in the scheme as healthcare service providers on an individual basis, while medical institutions in the GBA participate in the scheme on a hospital/medical institution basis. Eligible elderly persons may use EHCVs to pay for the fee of outpatient healthcare services, such as physical examination, continuous preventive healthcare and chronic disease management, etc., provided by the designated departments at medical institutions in the GBA, and the statistics on the related healthcare services are compiled on the basis of services as provided by the respective designated departments, rather than individual healthcare professions. As such, any direct comparison between the average amount of vouchers per claim transaction for healthcare service providers in Hong Kong and that of medical institutions in the GBA is not appropriate. Nor do the figures reflect the levels of primary healthcare service charges of either region.

(5)
The table below shows the number of complaints (including media reports and relevant reports) against healthcare service providers enrolled in the EHVS received by the DH in the past 3 years (from 2022 to 2024):

	2022	2023	2024	Total
Number of complaints against healthcare service providers enrolling in the EHVS received by the DH	45	54	88	187

These complaint cases, involving operational procedures, suspected fraud, improper voucher claims and issues related to service charges, were mainly against Chinese medicine practitioners, medical practitioners, optometrists and dentists. The DH would conduct investigation into every complaint received and take appropriate actions/measures when violation of the terms and conditions of the EHVS Agreement was found, including issuing advisory/warning letters to the relevant healthcare service providers, withholding reimbursements or recovering paid reimbursements, disqualifying healthcare service providers from participating in the EHVS, and referring cases to the Police and the relevant professional regulatory boards/councils for follow-up as appropriate.

Among the complaint cases against healthcare service providers enrolled under the EHVS received by the DH in the past 3 years, as at end-December 2024, investigation of 29 cases was completed, of which 11 were found to be substantiated or partially substantiated. The DH has disqualified 3 healthcare service providers from participating in the EHVS and has referred 6 cases to the Police for follow-up (of which the investigation of 2 cases was completed with no prosecutions made and 4 cases are still under investigation).

- End -

CONTROLLING OFFICER'S REPLY

HHB217

(Question Serial No. 2857)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions, (3) Health Promotion

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The Department of Health (DH) mentioned in the Matters Requiring Special Attention in 2025-26 under this Programme that it would take forward the next phase of tobacco control measures. In this connection, will the Government please advise this Committee on:

- (1) the measures implemented by the DH on smoking prevention and cessation, the manpower and the provision for the expenditure involved in the past 3 years;
- (2) the manpower and estimated provision involved for implementing smoking prevention and cessation services in 2025-26;
- (3) the staff establishment and actual expenditure of the Tobacco and Alcohol Control Office (TACO) in the past 3 years, its respective establishment and estimated expenditure in 2025-26;
- (4) the smoking prevalence among different age groups of men and women in Hong Kong and the respective average number of cigarettes smoked per day in the past 3 years; and
- (5) the number of complaints received, inspections conducted, fixed penalty notices and summonses issued by the TACO regarding offences such as smoking, displaying or publishing of tobacco advertisements in each of the past 3 years?

Asked by: Hon CHAN Wing-kwong (LegCo internal reference no.: 24)

Reply:

(1), (2) & (3)

The Government's tobacco control policy seeks to safeguard public health by discouraging smoking, containing the proliferation of tobacco use and minimising the impact of passive smoking on the public. To this end, the Government adopts a progressive and multi-pronged approach comprising legislation, enforcement, publicity, education, smoking cessation services and taxation.

The Government announced in June 2024 its plan to introduce 10 tobacco control measures in the short term. Among these initiatives, the Government has proposed to strengthen

smoking cessation services as well as publicity and education through measures including increasing the number of smoking cessation service points, enhancing Chinese medicine smoking cessation services, offering smoking cessation services through District Health Centres (DHCs) with a case-management model, enhancing smoking cessation training for primary healthcare practitioners, assisting people in smoking cessation through mobile applications, and incorporating more elements related to the harm of smoking into regular school curriculum.

Over the years, the Government has been actively promoting a tobacco-free environment through publicity for smoking prevention and cessation services. To leverage community effort, the Department of Health (DH) collaborates with the Hong Kong Council on Smoking and Health (COSH), non-governmental organisations (NGOs) and healthcare professionals to promote smoking cessation, provide smoking cessation services and organise publicity programmes on smoking prevention.

Apart from operating an integrated Smoking Cessation Hotline (Quitline: 1833 183) to handle general enquiries and provide professional counselling on smoking cessation, the DH coordinates the provision of smoking cessation services in Hong Kong. It arranges referrals to various smoking cessation services in the territory, including those provided by public clinics under the Hospital Authority (HA) (helping patients, especially those with chronic diseases, to quit smoking), and community-based cessation programmes operated by NGOs. There are a total of 15 full-time and 55 part-time centres operated by the HA which have been providing smoking cessation services to the general public since 2002, and there are 5 smoking cessation clinics for civil servants operated by the DH. Furthermore, the DH also collaborates with NGOs to provide a range of community-based smoking cessation services including counselling, consultations by doctors (including free postal delivery of smoking cessation drugs) or Chinese medicine practitioners, and designated services for smokers from different ethnicities, immigrant smokers and workplace smokers. For young smokers, the DH collaborates with local universities to operate a hotline to provide them with dedicated counselling services over the phone. Besides, the DH has subvented 2 more service providers (from 2 to 4 in total) since 2023 to operate smoking cessation clinics with a focus on counselling and pharmacotherapy, and 3 more Chinese medicine smoking cessation service providers (from 1 to 4 in total) starting from this year to operate smoking cessation clinics with an emphasis on counselling and acupuncture. It is expected that the number of service users of the former type of clinics will increase by about 40% and the number regarding the latter type will double.

The DH subvents the COSH to organise publicity and education programmes in schools, such as health talks, training programmes and theatre programmes, to raise students' awareness of smoking hazards, including hazards from alternative smoking products. To prevent youngsters from picking up smoking, the DH collaborates with NGOs to organise health promotional activities at schools. By using interactive teaching materials and setting up mobile classrooms, the programmes enlighten students in respect of the tactics used by the tobacco industry to market tobacco products, and equip them with the skills to resist picking up smoking due to peer pressure. The DH has also launched publicity campaigns through mass media to spread the message that smoking brings risks of serious illnesses. To encourage smokers to try quitting, it distributes free trial packs of smoking cessation drugs (nicotine replacement therapy) for 1 week at community pharmacies, smoking cessation clinics, DHCs and District Health Centre Expresses (DHC Expresses) during the Quit in June

annual campaign starting from 2023. During the Quit in June campaign in 2024, the DH implemented the Chinese Medicine Ear Points Patches for Smoking Cessation Trial Programme at designated Chinese medicine smoking cessation clinics. To encourage and help all healthcare professionals to provide support and treatment for smokers who are quitting, the DH organises online and face to face training courses, compiles the Practical Handbook for Smoking Cessation Treatments and a clinical guide on smoking cessation with Chinese medicine and acupuncture, and provides related resources, among other initiatives.

Smoking cessation services and counselling for smokers are currently available at all DHCs/DHC Expresses in the 18 districts, which collaborate with smoking cessation service providers in their respective districts to provide information or arrange referrals for smokers in need.

In 2022, 2023 and 2024, the quitlines operated by the DH and local universities handled 9 216, 11 051 and 10 875 enquiries respectively. During these 3 years, there were 20 406, 27 715 and 28 512 smokers receiving smoking cessation services via quitlines, at cessation clinics under the HA and through community-based programmes operated by NGOs.

Smokers who receive smoking cessation treatment receive 52-week follow-up services to assess their quit status. For smokers who receive smoking cessation services via quitlines, at cessation clinics under the HA and through community-based programmes operated by NGOs, their 52-week quit rates, which refer to the percentage of service users self-reporting to have stayed quit in the past 7 days, range from 20% to 60%, which are comparable to those in overseas countries. Discrepancies in the quit rates concerning different smoking cessation programmes are due to differences in terms of their target groups and treatment methods (which include counselling, pharmacotherapy, and Chinese medicine with acupuncture). To become a successful quitter, smokers are encouraged to choose the cessation service that best caters for their personal needs.

The expenditures and provision / revised estimate for tobacco control initiatives taken forward by the Tobacco and Alcohol Control Office (TACO) of the DH, as well as the approved establishment of the TACO from 2020-21 to 2025-26 are at **Annex 1** and **Annex 2** respectively.

(4)

The Census and Statistics Department (C&SD) conducts Thematic Household Surveys (THS) regularly to study the smoking prevalence in the population since 1982. The latest THS, which ran from May to August 2023, was conducted after the Government increased the tobacco duty in February that year. The results of the THS on smoking pattern showed that the smoking prevalence dropped from 10.2% in 2019 and 9.5% in 2021 to 9.1% in 2023. The average number of cigarettes smoked per day by smokers also decreased from 12.7 sticks in 2019 and 2021 to 12.1 sticks in 2023. The Government further increased the tobacco duty in 2024. In this connection, a THS will be conducted later and it is expected that the reduction in the demand for tobacco products will be reflected in the survey. The C&SD conducted and completed 2 rounds of THS on the pattern of smoking in the past 5 years, with a breakdown of the smoking prevalence and the number of cigarettes consumed by smokers daily (by age group and sex) set out at **Annex 3**.

(5)

The TACO of the DH is the principal enforcement agency for the Smoking (Public Health) Ordinance (Cap. 371) and the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600). The TACO will conduct inspections and investigation in response to smoking and related complaints. In general, the TACO will issue fixed penalty notices (FPNs) to smoking offenders without warning. Apart from smoking offences, the TACO also issued summonses for offences under Cap. 371 (including aiding and abetting smoking offences, offences relating to smoking product advertisements, the promotion, manufacture, sale, or possession for commercial purposes of alternative smoking products (ASPs), obstruction of inspectors, etc.), and for the offence of importing ASPs under the Import and Export Ordinance (Cap. 60).

The numbers of complaints / referrals received, inspections conducted, warning letters issued, and FPNs / summonses issued by TACO for the period from 2020 to 2024 for smoking and other offences are at **Annex 4**.

The TACO will continue to closely monitor the market situation and take stringent enforcement actions against violation of the Smoking (Public Health) Ordinance.

Expenditures on/Provision for
the Department of Health's Tobacco and Alcohol Control Office

	2020-21 (\$ million)	2021-22 (\$ million)	2022-23 (\$ million)	2023-24 (\$ million)	2024-25 Revised Estimate (\$ million)	2025-26 Estimate (\$ million)
<u>Enforcement</u>						
Programme 1: Statutory Functions	<u>102.2</u>	<u>101.3</u>	<u>100.4</u>	<u>123.3</u>	<u>167.4</u>	<u>174.8</u>
<u>Health Education and Smoking Cessation</u>						
Programme 3: Health Promotion	<u>141.2</u>	<u>138.9</u>	<u>149.0</u>	<u>151.4</u>	<u>170.5</u>	<u>180.9</u>
<u>(a) General health education and promotion of smoking cessation</u>						
TACO	64.5	62.8	73.0	83.7	88.2	87.0
Subvention to Hong Kong Council on Smoking and Health (COSH)	26.0	26.2	26.8	26.6	27.9	27.3
Sub-total	<u>90.5</u>	<u>89.0</u>	<u>99.8</u>	<u>110.3</u>	<u>116.1</u>	<u>114.3</u>
<u>(b) Provision for smoking cessation and related services by Non-Governmental Organisations</u>						
Subvention to Tung Wah Group of Hospitals	30.6	30.8	29.4	10.2	14.0	17.8
Subvention to Pok Oi Hospital	7.4	7.5	7.6	14.8	17.9	20.9
Subvention to Po Leung Kuk	1.7	0.7	-	-	-	-
Subvention to Lok Sin Tong	3.0	3.2	3.3	3.6	3.6	3.6
Subvention to United Christian Nethersole Community Health Service	4.4	4.9	5.8	6.1	8.9	13.8
Subvention to Life Education Activity Programme	2.7	2.8	2.8	2.9	3.0	3.0
Subvention to Christian Family Service Centre	-	-	-	3.5	7.0	4.5

<i>Subvention to The University of Hong Kong</i>	<i>0.9</i>	<i>-</i>	<i>0.3</i>	<i>-</i>	<i>-</i>	<i>3.0</i>
<i>Sub-total</i>	<u>50.7</u>	<u>49.9</u>	<u>49.2</u>	<u>41.1</u>	<u>54.4</u>	<u>66.6</u>
Total	<u>243.4</u>	<u>240.2</u>	<u>249.4</u>	<u>274.7</u>	<u>337.9</u>	<u>355.7</u>

Approved Establishment of
the Department of Health's Tobacco and Alcohol Control Office

Rank	No. of Staff from 2020-21 to 2025-26
<u>Head, TACO</u>	
Consultant	1
<u>Enforcement</u>	
Senior Medical & Health Officer	1
Medical & Health Officer	1
Scientific Officer (Medical)	1
Land Surveyor	1
Police Officer	5
Overseer/ Senior Foreman/ Foreman	125
Senior Executive Officer/ Executive Officer	13
<i>Sub-total</i>	<u>147</u>
<u>Health Education and Smoking Cessation</u>	
Senior Medical & Health Officer	1
Medical & Health Officer	1
Scientific Officer (Medical)	2
Nursing Officer/ Registered Nurse	3
Hospital Administrator II	4
<i>Sub-total</i>	<u>11</u>
<u>Administrative and General Support</u>	
Senior Executive Officer/ Executive Officer	4
Clerical and support staff	19
Motor Driver	1
<i>Sub-total</i>	<u>24</u>
Total	<u>183</u>

Prevalence* of Daily Cigarette Smokers by Age Group and Sex in 2021 and 2023

Age group	Male		Female		Overall	
	2021	2023	2021	2023	2021	2023
Aged 15 to 19	#	#	#	#	#	#
Aged 20 to 29	9.6%	9.3%	2.1	1.7%	5.9%	5.5%
Aged 30 to 39	15.3%	16.2%	4.5%	3.6%	9.5%	9.7%
Aged 40 to 49	24.6%	21.9%	5.8%	5.0%	14.2%	12.6%
Aged 50 to 59	22.0%	23.5%	3.2%	4.1%	11.7%	12.7%
Aged ≥60	15.7%	15.3%	1.2%	0.9%	8.2%	7.7%
Overall	16.7%	16.4%	3.0%	2.7%	9.5%	9.1%

* As a percentage of all persons in the respective age group. For example, among all males aged 20 to 29, 9.6% were daily cigarette smokers based on the survey conducted in 2021.

Statistics are not released due to large sampling error.

Source: Thematic Household Survey Report Nos. 75 and 79, Census and Statistics Department.

**Average Daily Consumption of Cigarettes (number of sticks of cigarettes)
by Age Group and Sex in 2021 and 2023**

	2021	2023
Age group		
Aged 15 to 19	#	#
Aged 20 to 29	11.2	11.2
Aged 30 to 39	11.5	11.5
Aged 40 to 49	12.7	11.8
Aged 50 to 59	13.7	12.6
Aged ≥60	13.0	12.5
Sex		
Male	13.2	12.6
Female	10.5	9.3
Overall	12.7	12.1

Statistics are not released due to large sampling error.

Source: Thematic Household Survey Report Nos. 75 and 79, Census and Statistics Department.

Numbers of complaints / referrals received, inspections conducted, warning letters issued, and FPNs / summonses issued by TACO for smoking and other offences under the Smoking (Public Health) Ordinance (Cap. 371), the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600) and the Import and Export Ordinance (Cap. 60)

		2020	2021	2022	2023	2024
Complaints/referrals received		11 568	13 424	14 805	20 116	29 205
Inspections conducted		36 129	41 225	35 281	28 817 ^(Note 4)	30 162
Warning letters issued ^(Note 1, 2)		16	16	21	10	10
FPNs issued (for smoking offences)		6 587	7 703	6 296	10 261 ^(Note 4)	13 488
Summonses issued	for smoking offences	58	40	35	48	64
	for other offences ^(Note 3)	57	115	130	657	871

Note

- 1 In general, the TACO will prosecute smoking offenders without prior warning. The TACO will only consider issuing warning letters if the smoking offenders are found to be persons under 15 years old.
- 2 During the 3-month grace period from 30 April to 31 July 2022, warning letters were issued to passengers carrying small quantity of ASPs. After the grace period, any person who imports any quantity of ASPs will be prosecuted when there is sufficient evidence.
- 3 Other offences include willful obstruction, failure to produce identity document, displaying smoking product advertisement, ASP related offences, and aiding and abetting another person committing a smoking offence, etc.
- 4 To effectively mitigate the impact of passive smoking on the public and enhance the deterrent effect against illegal smoking, TACO has flexibly deployed resources and adopted new enforcement strategies since 2023, including extension of the time of surveillance and inspections in no smoking areas, deploying plain-clothes officers to take proactive enforcement actions, strengthening enforcement action in venues (such as bars and food premises) where waterpipes were offered for smoking, as well as prosecuting people inciting, aiding and abetting illegal smoking. The number of prosecutions against illegal smoking has surged due to the new enforcement strategies, reflecting their enhanced effectiveness.

- End -

CONTROLLING OFFICER'S REPLY

HHB218

(Question Serial No. 2858)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Regarding the various vaccination programmes/schemes under the Department of Health, will the Government please advise on the target and actual numbers of vaccine recipients, and the expenditure incurred in the past 3 years, with a breakdown of free or subsidised vaccination programmes/schemes?

Asked by: Hon CHAN Wing-kwong (LegCo internal reference no.: 25)

Reply:

Details of the regularised vaccination programmes/schemes under the Department of Health (DH) (namely the seasonal influenza (SI) vaccination/Pneumococcal vaccination scheme and the Hong Kong Childhood Immunisation Programme (HKCIP)) are as follows:

(a) Programmes/schemes for SI vaccination/Pneumococcal vaccination

The Scientific Committee on Vaccine Preventable Diseases (SCVPD) under the Centre for Health Protection (CHP) of the DH issues recommendations on the SI vaccines to be used and the priority groups for receiving vaccination in regard to the influenza season in Hong Kong on an annual basis after reviewing scientific evidence, local data, latest recommendations of the World Health Organization and overseas practices.

Based on the recommendations of the SCVPD, the DH has been administering the following vaccination programmes/schemes to provide free or subsidised SI vaccination/Pneumococcal vaccination to eligible persons:

- Government Vaccination Programme (GVP), which provides free SI vaccination to eligible children, elderly and other target groups, as well as free Pneumococcal vaccination to eligible elderly persons aged 65 or above, at clinics of the DH and the Hospital Authority;

- Seasonal Influenza Vaccination School Outreach Programme (SIVSOP), which provides free or subsidised SI vaccination to eligible school children through the public-private partnership outreach teams or the DH's outreach team; and
- Vaccination Subsidy Scheme (VSS), which provides subsidised SI vaccination to eligible persons, including persons aged 50 or above, pregnant women and children aged between 6 months and below 18 years of age, as well as subsidised Pneumococcal vaccination to elderly persons aged 65 or above, through private doctors participating in the VSS.

The target population, the number of vaccine recipients and the expenditure on subsidy for the eligible groups under each vaccination programme/scheme in the past 3 seasons are detailed at **Annex**. As some target group members may have, at their own expense, received SI vaccination/Pneumococcal vaccination at private clinics outside the Government's vaccination programmes/schemes, they are not included in the statistics concerned.

(b) The HKCIP

The DH provides free vaccination services for eligible children under the HKCIP for the prevention of 12 communicable diseases with public health significance, namely Tuberculosis, Hepatitis B (Hep B), Poliomyelitis, Tetanus, Pertussis, Measles, Diphtheria, Mumps, Rubella, Varicella, Pneumococcal Disease and Human Papilloma Virus (HPV) Infection. With a view to preventing children from contracting communicable diseases, Bacillus Calmette-Guerin (BCG) vaccine and the first dose of Hep B vaccine are first given to newborn babies in hospitals under the current arrangement. Pre-school children (aged 0 to 5) then receive different types of vaccines and boosters at recommended ages of vaccination at the DH's Maternal and Child Health Centres (MCHCs). As for primary school children, vaccination is provided at schools by the DH's outreach School Immunisation Teams (SITs). The Student Health Service (SHS) of the DH also provides free mop-up vaccination at Student Health Service Centres (SHSCs) for secondary school students who have not completed immunisation as recommended.

i. Number of vaccines administered

Eligible newborn babies to children aged 5

Eligible newborn babies to children aged 5 can receive vaccination free-of-charge at the MCHCs. Over 90% of local newborn babies receive services including vaccination at the MCHCs each year. The number of vaccines administered at the MCHCs under the HKCIP for newborn babies to children aged 5 over the past 3 years (2022 to 2024) are tabulated below:

Calendar year	Target population#	Doses of vaccines administered*
2022	32 950	323 000
2023	33 288	315 000
2024	36 767	319 000

Total registered live births

* The number only includes children who received vaccines under the HKCIP at the MCHCs (rounded to the nearest thousand)

Eligible primary school children

The SITs of the DH provide free vaccination to eligible Primary 1 school children, Primary 5 school girls and Primary 6 school children across the territory under the HKCIP. Over the past 3 years (2022 to 2024), the number of vaccines administered by the SITs under the HKCIP for school children are tabulated below:

Calendar year	Target population#	Doses of vaccines administered*
2022	139 560	201 000
2023	135 605	210 000
2024	133 130	202 000

The number includes all Primary 1 and 6 students and all Primary 5 girls. The number of registered students for 2022 and 2023 is obtained from the Education Bureau's website at https://www.edb.gov.hk/attachment/en/about-edb/publications-stat/figures/Enrol_2023.pdf while the number of registered students for 2024 is an estimate.

* rounded to the nearest thousand

Eligible secondary school students

The number of mop-up vaccines administered by the SHS under the HKCIP for secondary school students over the past 3 years (2022 to 2024) are tabulated below:

Calendar year	Doses of mop-up vaccines administered^
2022	447
2023	2 673
2024	4 408

^ The number of students served by the SHS was higher in 2023 than that in 2022 due to the SHS's limited services as a result of COVID-19 in 2022.

ii. Vaccination coverage rate

Eligible newborn babies to children aged 5

The DH conducts territory-wide surveys on immunisation coverage on a regular basis to monitor the vaccination rates among pre-school children in Hong Kong (i.e. the percentage of children having received vaccination as recommended under the HKCIP) and carries out random inspections of children's immunisation records. The latest survey covering pre-school children born between 2018 and 2020 is still underway and the results are expected to be released in the second quarter of 2025.

The results of the survey conducted in 2021 on the overall immunisation coverage of vaccination under the HKCIP (among pre-school children born between 2015 and 2017) are tabulated below:

Type of vaccine^	Year of birth		
	2015	2016	2017
BCG Vaccine	99.9%	99.5%	99.3%
Received Hep B vaccine	99.5%	99.2%	98.9%
Received Poliomyelitis vaccine	98.0%	97.9%	97.4%
Received Diphtheria-Pertussis-Tetanus vaccine	98.7%	98.0%	97.5%
Received Measles vaccine	99.9%	99.0%	99.1%
Received Mumps vaccine	99.9%	99.0%	99.1%
Received Rubella vaccine	99.9%	99.0%	99.1%
Received Varicella vaccine	99.1%	98.7%	98.7%
Received Pneumococcal vaccine	93.5%	94.7%	94.9%

^ includes vaccines received in private healthcare organisations and outside of Hong Kong

Eligible primary school children

The SITs check immunisation records of students while visiting schools. The overall immunisation coverage rates among primary school students based on these records are tabulated below:

Type of vaccine		School year		
		2021/22	2022/23	2023/24
Primary 1	Received Diphtheria, Tetanus, acellular Pertussis & Inactivated Poliovirus vaccine	96.9%	97.2%	96.9%
	Received Measles, Mumps, Rubella & Varicella vaccine	95.8%	95.4%	95.3%
Primary 5	HPV vaccine (female students)	88.9%	93.5%	93.5%
Primary 6	Received Diphtheria, Tetanus, acellular Pertussis (reduced dose) & Inactivated Poliovirus vaccine	96.1%	96.0%	96.2%
	Received Measles, Mumps & Rubella vaccine	97.9%	98.5%	98.2%
	Received Hep B vaccine	98.8%	99.3%	99.2%
	Received HPV vaccine (female students)	89.3%	91.9%	92.0%

The DH does not maintain data on vaccination coverage rates other than those under the HKCIP.

The expenditure for the HKCIP, dispersed across multiple cost components, cannot be separately identified.

Target group	Programme/ scheme for provision of SI vaccination	2022/23			2023/24			2024/25 (as at 23 March 2025)		
		Target Population*	No. of SI vaccine recipients under each vaccination programme/ scheme	Subsidy@ claimed (\$ million)	Target Population*	No. of SI vaccine recipients under each vaccination programme/ scheme	Subsidy@ claimed (\$ million)	Target Population*	No. of SI vaccine recipients under each vaccination programme/ scheme	Subsidy@ claimed (\$ million)
Elderly aged 65 or above	GVP	1 520 100	452 900	Not applicable	1 637 600	513 100	Not applicable	1 715 400	515 500	Not applicable
	VSS		281 300	73.1		329 700	85.7		364 400	94.7
Persons aged between 50 and 64	GVP	1 796 700	49 200	Not applicable	1 824 900	6 100	Not applicable	1 815 300	115 700	Not applicable
	VSS		271 000	70.5		343 400	89.3		343 300	89.3
Children aged between 6 months and under 18	GVP	917 900	1 400	Not applicable	929 600	800	Not applicable	911 400	6 900	Not applicable
	VSS		104 700	30.3		169 500	50.5		189 900	53.3
	SIVSOP		259 200	28.8		322 000	36.1		369 100	40.6
Others ^	GVP/VSS	#	112 300	1.5	#	140 200	1.7	#	126 900	1.6
Total			1 532 000	204.2		1 824 800	263.3		2 031 700	279.5

* Provisional figures for the relevant population group at mid-year as estimated by the Census and Statistics Department.

@ Refers to the subsidy for private doctors participating in the SIVSOP and the VSS. As vaccination services under the GVP are provided free of charge by public hospitals/clinics etc., the related expenses cannot be separately identified.

^ Others include healthcare workers; poultry workers; pig farmers or pig slaughtering industry personnel; persons with intellectual disabilities; Disability Allowance recipients; and pregnant women, etc.

There are no accurate population statistics for this group.

Programme/scheme for provision of Pneumococcal vaccination %	2022/23		2023/24		2024/25 (as at 23 March 2025)	
	No. of Pneumococcal vaccine recipients under each vaccination programme/scheme	Subsidy@ claimed (\$ million)	No. of Pneumococcal vaccine recipients under each vaccination programme/scheme	Subsidy@ claimed (\$ million)	No. of Pneumococcal vaccine recipients under each vaccination programme/scheme	Subsidy@ claimed (\$ million)
GVP	44 100	Not applicable	58 600	Not applicable	46 000	Not applicable
VSS	37 800	20.2	56 700	30.9	62 400	34.0
Total	81 900	20.2	115 300	30.9	108 400	34.0

% Eligible groups: Aged 65 or above

@ Refers to the subsidy for private doctors participating in the VSS. As vaccination services under the GVP are provided free of charge by public hospitals/clinics etc., the related expenses cannot be separately identified.

- End -

CONTROLLING OFFICER'S REPLY

HHB219

(Question Serial No. 2860)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The Department of Health provides preventive healthcare for primary and secondary school students and improves the oral health of primary school children. In this connection, will the Government advise this Committee of:

- (1) the key measures and funding allocated for the provision of promotive and preventive healthcare for primary and secondary school students in the past 3 years;
- (2) the key measures and funding allocated for the improvement of oral health of primary school children in the past 3 years;
- (3) the estimated expenditure on the provision of promotive and preventive healthcare for primary and secondary school students and on improving the oral health of primary school children in 2025-26;
- (4) the actual number of primary and secondary school students participating in the Student Health Service and its percentage in the total number of primary and secondary school students in Hong Kong in the past 3 years;
- (5) the attendance of primary school children at the School Dental Care Service programme and its percentage in the total number of primary school children in Hong Kong in the past 3 years; and
- (6) the measures to increase participation of primary and secondary school students in the Student Health Service?

Asked by: Hon CHAN Wing-kwong (LegCo internal reference no.: 26)

Reply:

(1) to (3)

The Student Health Service Centres (SHSC) of the Department of Health (DH) provides free annual health assessment services for eligible primary and secondary school students with the aim of identifying students with health problems at an early stage for timely advice and intervention. Students are provided with a series of health services designed to cater for their health needs at various stages of their development. Those found to have health problems will be referred to health assessment services under the Student Health Service

(SHS), specialist clinics of the Hospital Authority or other appropriate organisations for further assessment and follow-up.

The actual expenditure of the DH's SHSCs from 2022-23 to 2023-24, its revised estimate for 2024-25 and its estimate for 2025-26 are set out below:

Financial Year	Annual Expenditure (\$ million)
2022-23 (Actual)	254.5
2023-24 (Actual)	266.0
2024-25 (Revised Estimate)	252.2
2025-26 (Estimate)	276.4

Regarding oral health, to safeguard the oral health of the public, the Chief Executive announced in the 2022 Policy Address to conduct a comprehensive review of the dental services provided or subsidised by the Government. The Working Group on Oral Health and Dental Care (Working Group) was subsequently established in end-2022. The Working Group published a final report in end-2024, recommending that the future development of dental services should make reference to the direction of the Primary Healthcare Blueprint emphasising prevention, early identification and timely intervention, with the goal of retention of natural teeth and enhancing the overall level of citizens' oral health.

The Government concurs with the views of the Working Group, asserting that providing or subsidising comprehensive curative dental services from public purse to all Hong Kong citizens regardless of their financial means does not align with the policy objectives of developing a prevention-oriented oral health and dental care system and encouraging citizens to take responsibility for their own oral health. This would exacerbate the current shortcomings of the treatment-oriented system, and would be neither cost-effective nor sustainable in terms of utilisation of public resources. It would be financially untenable for the Government and would strain the resources that could otherwise be used for other healthcare services.

In response to the final report of the Working Group, the Government has formulated an oral health policy that:

- (i) Oral health is an integral component of general health. The Government's oral health policy aims to enable all Hong Kong citizens to improve their oral hygiene and lifestyle conducive to both oral and overall health levels;
- (ii) Through publicity, education, promotion and development of primary oral health and dental care, the Government facilitates citizens to manage their oral health, and put prevention, early identification and timely intervention of dental diseases into action with the objective of tooth retention; and
- (iii) The Government provides appropriate oral health and dental care services targeting underprivileged groups with financial difficulties and special needs, ensuring these groups have access to essential dental care services.

In view of the Working Group's strategic recommendations, the Government has formulated an Oral Health Action Plan, under which the School Dental Care Service (SDCS) and the Primary Dental Co-care Pilot Scheme for Adolescents (PDCC) are rolled out to actively develop prevention-oriented primary oral healthcare according to the strategy of community-wide preventive primary oral health care.

The Government focuses particularly on nurturing good oral hygiene habits from an early age including providing the SDCS to children. Hong Kong primary school students, as well as students aged under 18 with intellectual disability and/or physical disability studying in special schools, can join the SDCS of the DH to receive annual check-ups at designated school dental clinics, which cover oral examination as well as basic treatment and preventive care services. Currently, there are 8 designated school dental clinics, namely Tang Shiu Kin School Dental Clinic, Argyle Street Jockey Club School Dental Clinic (1/F and 3/F), Lam Tin School Dental Clinic, Ha Kwai Chung School Dental Clinic, Pamela Youde School Dental Clinic, Tuen Mun School Dental Clinic and Fanling School Dental Clinic.

The actual expenditure of the SDCS from 2022-23 to 2023-24, its revised estimate for 2024-25 and its estimate for 2025-26 are set out below:

Financial Year	Annual Expenditure (\$ million)
2022-23(Actual)	276.2
2023-24(Actual)	281.6
2024-25 (Revised Estimate)	281.1
2025-26 (Estimate)	287.7

The DH launched the PDCC on 20 March this year as an interface with the SDCS by providing partial subsidies for private dental check-up services for adolescents aged between 13 and 17 on a co-payment basis to foster their partnership with dentists and maintain the good life-long habit of regular oral check-ups for prevention of dental diseases. Adolescents from age 13 to 17 (or will turn 13 in the calendar year when applying to join the PDCC) who hold a valid Hong Kong Identity Card and have registered in the Electronic Health Record Sharing System (eHealth) are eligible to join the PDCC. About 370 000 adolescents are eligible to join each year. While the Government will provide a subsidy of \$200 each time, participants have to pay a co-payment fee as determined by their selected dentists at the time of enrolment. Participants have to pay a co-payment fee as determined by their selected dentists. The co-payment for the subsidised services each time as recommended by the Government is \$200. As at 18 March, there are around 270 registered dentists whose application to participate in the PDCC has been accepted by the DH, providing services at over 370 service locations. Among these dentists, over 67% charge a co-payment amount of \$200 or less while the minimum co-payment amount is \$50. The DH has publicised the PDCC in collaboration with the Education Bureau to all secondary school students and their parents in the territory. The final number of participants will depend on the response from adolescents and their parents.

The Government's financial provision for implementing the PDCC and the Community Dental Support Programme in 2025-26 is \$136.3 million.

(4)

The actual number of primary and secondary school students participating in the SHS and its percentage in the total number of primary and secondary school students in Hong Kong (participation rate) in the past 3 years are as follows:

School Year	Number of Students Participating in SHS and Their Participation Rate					
	Primary School Students		Secondary School Students		Total	
	Number	Participation Rate	Number	Participation Rate	Number	Participation Rate
2021-22 [^]	322 000	92.2%	265 000	81.5%	587 000	87.0%
2022-23 [#]	312 000	93.4%	149 000	46.4%	460 000	70.3%
2023-24	311 000	95.4%	275 000	83.6%	585 000	89.5%

Figures added up may not match the total due to rounding.

[^] The SHS was only able to provide limited services in most of the time of school year 2020/21 to 2021/22 due to the Coronavirus Disease 2019 pandemic. Services gradually resumed as the pandemic eased.

[#] Due to the backlog of cases caused by the epidemic and the ongoing shortage of healthcare staff, annual health assessment services were only provided to Primary 1 to Primary 6 and Secondary 1 to Secondary 3 students in school year 2022/23. In school year 2023/24, annual health assessment services were resumed for students of all grades of primary and secondary schools.

(5)

Over the past 3 service years, the numbers of primary school students participating in the SDCS are as follows:

Service Year [@]	Number of Primary School Students Participating in SDCS	Percentage of the Total Number of Primary School Students in Hong Kong
2022-23	313 500	94%
2023-24	313 700	98%
2024-25	307 600	97%

[@] A service year refers to the period from 1 November of the current year to 31 October of the following year.

(6)

All primary and secondary day school students in the territory are eligible for annual health assessment services by the SHS. To facilitate student participation, the DH will invite all local students to join the SHS programmes through their schools in September each year and will arrange for them to receive annual health assessment at a SHSC according to the district in which their school is located. Alternatively, parents may also directly enrol their children at the SHSCs or through online application. To enhance participation, the DH will provide free school bus services to students to facilitate their visits to the SHSCs, and will send SMS and emails to parents as a reminder for their children to attend annual health assessments. Students who are unable to attend the annual health assessment due to unforeseen circumstances may reschedule their appointment date and time by calling the SHSCs or

through the online platform. To streamline the process, parents may fill in the health questionnaire online in advance to reduce the time spent at the SHSCs during the health assessment. The DH will introduce electronic enrolment for the SHS in 2025-26 to streamline the application procedure and encourage further participation by students.

The SHS monitors the overall health condition and trends of all students in the territory through the data obtained from the annual health assessment service. The SHS will disseminate the information to the public to raise the awareness of society of students' health and to encourage parents to enrol their children in the annual health assessments. Through schools participating in the Whole School Health Programme, the DH encourages students to take part in the annual health assessment service, the results of which will be analysed for compilation of a health report for each participating school. The DH will then recommend targeted school-based health promotion measures to improve students' physical and psychological well-being. The DH will continue to review and implement other measures in a timely manner to enhance the participation of the SHS.

- End -

CONTROLLING OFFICER'S REPLY

HHB220

(Question Serial No. 2225)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (8) Personnel Management of Civil Servants Working in Hospital Authority

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Regarding the personnel management of civil servants working in the Hospital Authority (HA), please advise on the following:

- (a) the reasons for the decline in the number of civil servants working in the HA managed, which saw a decrease from 389 in 2023 to 306 in 2024, and will further drop to 233 in 2025;
- (b) the number of public hospital staff retaining their civil servant status as at 31 December 2024, with a breakdown by post; and
- (c) given the shrinking number of civil servants responsible for the personnel management of civil servants working in the HA, the utilisation of additional operational expenses for 2025-26, which is \$0.1 million (0.9%) higher than the revised estimate for 2024-25 according to the Analysis of Financial and Staffing Provision.

Asked by: Hon CHAN Wing-yan, JoePHY (LegCo internal reference no.: 23)

Reply:

(a) The civil servants working in the Hospital Authority (HA) mainly comprise some healthcare and administrative staff, originally belonged to the civil service establishment prior to the HA's establishment, who chose to retain their civil servant status upon joining the HA. The reduction in the number of these staff is due to natural wastage including retirement.

(b) As at 31 December 2024, the total number of civil servants working in the HA was 241, of whom 175 were working in hospitals and 66 in general out-patient clinics. The number of civil servants working in hospitals under the HA (breakdown by rank) is set out at **Annex**.

(c) The increase in the provision for 2025-26 under this Programme is mainly due to anticipated increase in staff costs and staff-related expenses.

**Number of Civil Servants Working in Hospitals under the Hospital Authority
(breakdown by rank)**

Grade/Rank	Number of Staff (as at 31 December 2024)
MEDICAL & HEALTH OFFICER GRADES	
Consultant (Hospital Services)	1
Sub-total	<u>1</u>
NURSING & ALLIED GRADES	
Senior Nursing Officer	4
Departmental Operations Manager	7
Ward Manager	8
Nursing Officer	40
Registered Nurse	36
Nursing Officer (Psychiatric)	13
Registered Nurse (Psychiatric)	6
Enrolled Nurse	7
Enrolled Nurse (Psychiatric)	3
Sub-total	<u>124</u>
SUPPLEMENTARY MEDICAL GRADES	
Department Manager	1
Chief Dispenser	3
Senior Dispenser	8
Dispenser	10
Medical Technologist	1
Medical Technologist (Hospital Services)	1
Physiotherapist I	1
Senior Radiographer	3
Radiographer I	10
Scientific Officer (Medical)	1
Sub-total	<u>39</u>

Grade/Rank	Number of Staff (as at 31 December 2024)
HOSPITAL ADMINISTRATOR GRADE	
General Manager (Administrative Services)	1
Senior Hospital Administrator	2
Sub-total	<u>3</u>
OTHER DEPARTMENTAL GRADES	
Electrical Technician	4
Hospital Foreman	1
Health Care Assistant	1
Laboratory Attendant	1
Sub-total	<u>7</u>
MODEL SCALE I GRADES	
Workman II	1
Sub-total	<u>1</u>
Total	<u>175</u>

- End -

CONTROLLING OFFICER'S REPLY

HHB221

(Question Serial No. 2233)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

As important providers of primary healthcare services, the Maternal and Child Health Centres (MCHCs) perform key functions in delivering maternal care, monitoring children's healthy development and administering immunisation. However, their service operation in some districts has been impaired by the shortage of healthcare manpower increasingly acute in recent years. In this connection, will the Government please inform this Committee of:

- (a) the estimated and actual expenditure of MCHCs in each of the past 3 years and the factors behind the increase and decrease in expenditure estimates;
- (b) as at the end of 2024, the manpower situation (i.e. the staff establishment, existing strength and number of vacancies) of healthcare staff of each MCHC in tabular form;
- (c) the service utilisation of each MCHC in the past 3 years (i.e. the numbers of service quota, users and attendance) in tabular form; and
- (d) whether the Government has any plans and timetable to resume the services of 3 MCHCs (2 in Kowloon and 1 in the New Territories) temporarily closed due to healthcare manpower arrangements and service utilisation according to the Department of Health's Family Health Service website; if yes, the specific timetable and arrangements; if no, the reasons?

Asked by: Hon CHAN Wing-yan, JoePHY (LegCo internal reference no.: 31)

Reply:

The Government attaches great importance to children's health, and is committed to providing children with quality medical and health services. The 29 Maternal and Child Health Centres (MCHCs) in operation under the Department of Health (DH) are set up in all 18 districts in Hong Kong, providing health promotion and disease prevention services for newborn babies, children up to 5 years old and women of reproductive age, including free vaccination services and continuous monitoring of children's growth and development. Data also shows that the overall coverage for relevant vaccines among locally born pre-school children remains at a remarkably high level of over 98%. The DH is discussing the streamlining of maternal health services with the Primary Healthcare Commission and the Hospital Authority to make better use of resources and enhancing service efficiency.

(a)

The expenditure and estimate of the Family Health Service (excluding Woman Health Centres) in the past 3 years are tabulated as below:

	2022-23 (Actual) \$ million	2023-24 (Actual) \$ million	2024-25 (Revised estimate) \$ million
Expenditure/ Estimate	739.6	754.6	767.6

The increase in expenditure in these 3 years is largely attributed to pay adjustment for staff and the resources required for the North District MCHC which opened in 2024-25.

(b)

The staff establishment, strength and number of vacancies of doctors and nurses at the Head Office of the Family Health Service and each MCHC as at 1 January 2025 are at **Annex 1**.

(c)

The MCHCs provide a wide range of services, including child health, maternal health, cervical screening and family planning services with no fixed service quota. The DH will flexibly allocate resources to ensure that the public have access to the services they need.

The attendance at each MCHC in the past 3 years is tabulated in **Annex 2**. The DH does not maintain statistics on the number of service recipients.

(d)

Among the 18 districts in Hong Kong, the demand for services from the MCHCs is relatively low in Wong Tai Sin District and Kwai Tsing District. For more effective use of resources, the DH has focused its resources on the East Kowloon MCHC and Robert Black MCHC to serve residents in the Wong Tai Sin District, while ensuring that the service needs of local residents remain unaffected. For the Kwai Tsing District, the DH has concentrated its resources on the North Kwai Chung MCHC and Tsing Yi MCHC to ensure that the service needs of residents in the district are met. The DH will continue to monitor the service utilisation of each MCHC and make appropriate adjustments as necessary. At present, there are no plans to resume services at the 3 temporarily closed MCHCs.

Annex 1

The manpower situation of healthcare staff of each MCHC as at 1 January 2025 is tabulated below:

MCHC	Doctors			Nurses ^{Note 1}		
	Establishment	Strength	Vacancy ^{Note 2}	Establishment	Strength	Vacancy ^{Note 2}
Anne Black MCHC	1	1	-	10	7	3
Ap Lei Chau MCHC	2	1	1	14	9	5
Chai Wan MCHC	2	1	1	11	8	3
Sai Wan Ho MCHC	3	1	2	17	11	6
Sai Ying Pun MCHC	3	1	2	17	11	6
Tang Chi Ngong MCHC	2	3	-1	11	11	-
Cheung Chau MCHC ^{Note 3}	-	-	-	-	-	-
Mui Wo MCHC ^{Note 3}	-	-	-	-	-	-
East Kowloon MCHC	2	-	2	4	4	-
Kowloon City MCHC	5	2	3	28	19	9
Kwun Tong MCHC	4	2	2	17	17	-
Lam Tin MCHC	4	1	3	16	15	1
Robert Black MCHC	2	1	1	9	12	-3
Wang Tau Hom MCHC ^{Note 4}	2	-	2	6	-	6
West Kowloon MCHC	6	5	1	27	25	2
Wu York Yu MCHC ^{Note 4}	2	-	2	9	-	9
Yaumatei MCHC	3	1	2	18	17	1
Fanling MCHC	7	4	3	42	16	26
Lek Yuen MCHC	7	4	3	26	28	-2
Ma On Shan MCHC	2	2	-	15	19	-4
North District MCHC ^{Note 5}	3	-	3	13	12	1
Tseung Kwan O Po Ning Road MCHC	4	3	1	24	22	2
Wong Siu Ching MCHC	3	2	1	14	19	-5
Madam Yung Fung Shee MCHC	4	3	1	20	25	-5
North Kwai Chung MCHC	1	1	-	9	7	2
South Kwai Chung MCHC ^{Note 4}	2	-	2	11	-	11
Tin Shui Wai MCHC	3	5	-2	19	21	-2
Tsing Yi MCHC	2	1	1	12	9	3
Tsuen Wan MCHC	5	4	1	26	28	-2
Tuen Mun Wu Hong MCHC	2	2	-	12	19	-7
Yan Oi MCHC	6	5	1	24	15	9
Tung Chung MCHC	1	1	-	4	6	-2
Head Office of the Family Health Service ^{Note 6}	4	8	-4	17	13	4
Total	99	65	34	502	425	77

Note 1: Including registered nurses and enrolled nurses.

Note 2: The Family Health Service will flexibly deploy doctors and nurses based on the service utilisation of each MCHC to ensure provision of appropriate services for the public. As such, the strength figures of healthcare staff of individual MCHCs may be higher than the establishment figures. In such cases, vacancies will be represented as negative figures.

Note 3: The services of the Cheung Chau MCHC and Mui Wo MCHC are provided by staff members of the Anne Black MCHC and Tang Chi Ngong MCHC respectively.

Note 4: In view of the healthcare manpower arrangements and service utilisation of each MCHC, the services of the Wang Tau Hom MCHC and Wu York Yu MCHC have been suspended since 17 February 2020, while the South Kwai Chung MCHC has suspended services since 17 October 2022 for more effective use of resources. Relevant staff have been deployed to other MCHCs.

Note 5: The North District MCHC has been in operation since 27 January 2025.

Note 6: The doctors and nurses at the Head Office of the Family Health Service are responsible for supporting the operation and enhancing the service quality of all MCHCs; providing public health advice on maternal and child health; as well as planning, co-ordinating, monitoring and evaluating health promotion and disease prevention services for women, infants and young children at MCHCs or in the community. Their work includes conducting research, formulating guidelines, arranging training, preparing and disseminating health information, co-ordinating relevant work within and outside the DH.

The attendance at each MCHC in the past 3 years is tabulated as below:

MCHC	Attendance		
	2022	2023	2024
Anne Black MCHC	4 225	4 346	4 501
Ap Lei Chau MCHC	10 935	10 757	11 021
Chai Wan MCHC	8 459	5 583	5 815
Sai Wan Ho MCHC	13 501	16 295	17 810
Sai Ying Pun MCHC	11 839	13 585	14 595
Tang Chi Ngong MCHC	9 572	10 937	12 127
Cheung Chau MCHC	1 018	1 314	1 030
Mui Wo MCHC	684	618	548
East Kowloon MCHC	62	263	130
Kowloon City MCHC	17 597	19 324	20 555
Kwun Tong MCHC	22 449	25 013	27 484
Lam Tin MCHC	12 759	14 352	14 989
Robert Black MCHC	14 087	16 493	18 982
Wang Tau Hom MCHC ^{Note 1}	0	0	0
West Kowloon MCHC	29 097	33 317	34 210
Wu York Yu MCHC ^{Note 1}	0	0	0
Yaumatei MCHC	13 627	15 142	17 730
Fanling MCHC	28 434	31 354	36 515
Lek Yuen MCHC	32 022	33 195	35 498
Ma On Shan MCHC	13 958	14 532	15 618
Tseung Kwan O Po Ning Road MCHC	27 412	31 067	32 570
Wong Siu Ching MCHC	22 930	23 093	24 113
Madam Yung Fung Shee MCHC	31 430	33 589	34 777
North Kwai Chung MCHC	8 294	6 873	7 206
South Kwai Chung MCHC ^{Note 1}	2 727	0	0
Tin Shui Wai MCHC	27 362	28 025	29 608
Tsing Yi MCHC	9 774	11 086	11 338
Tsuen Wan MCHC	34 544	37 738	39 155
Tuen Mun Wu Hong MCHC	17 014	16 641	18 161
Yan Oi MCHC	18 139	20 779	22 010
Tung Chung MCHC	10 011	10 703	11 505
Total	453 962	486 014	519 601

Note 1: In view of the healthcare manpower arrangements and service utilisation of each MCHC, the services of Wang Tau Hom MCHC and Wu York Yu MCHC have been suspended since 17 February 2020, while the South Kwai Chung MCHC has suspended since 17 October 2022 for more effective use of resources. Affected children and women may continue to receive the services at other MCHCs in the district.

- End -

CONTROLLING OFFICER'S REPLY

HHB222

(Question Serial No. 2234)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

With the launch of the Primary Dental Co-care Pilot Scheme for Adolescents (PDCC) on 20 March 2025, eligible adolescents can receive services subsidised by the Government once every calendar year in the amount of \$200 to the dentist per visit. In this connection, will the Government please inform this Committee of:

- (a) the estimated number of adolescents benefiting from the PDCC, the estimated total expenditure involved, the allocation of provisions and the source of funding each year;
- (b) the Government's publicity strategies and ways to promote the PDCC to ensure that the eligible adolescents and their parents are fully aware of the scheme and can participate in it;
- (c) the expenditure on publicity, the specific arrangements for publicity activities (such as social media, co-operation with schools, online promotion), as well as the allocation of provisions concerned; and
- (d) whether the Government will develop assessment indicators (for example, the service utilisation rate, improvement in the oral health of adolescents, parents' satisfaction level) and draw up a timetable with a view to providing more reference data for future enhancement of the PDCC?

Asked by: Hon CHAN Wing-yan, JoePHY (LegCo internal reference no.: 32)

Reply:

(a) to (d)

To safeguard the oral health of the public, the Chief Executive announced in the 2022 Policy Address to conduct a comprehensive review of the dental services provided or subsidised by the Government. The Working Group on Oral Health and Dental Care (Working Group) was subsequently established in end-2022. The Working Group published a final report in end-2024, recommending that the future development of dental services should make reference to the direction of the Primary Healthcare Blueprint emphasising prevention, early identification and timely intervention, with the goal of retention of natural teeth and enhancing the overall level of citizens' oral health.

The Government concurs with the views of the Working Group that providing or subsidising comprehensive curative dental services from public purse to all Hong Kong citizens regardless of their financial means does not align with the policy objectives of developing a prevention-oriented oral health and dental care system and encouraging citizens to take responsibility for their own oral health. This would exacerbate the current shortcomings of the treatment-oriented system, and would be neither cost-effective nor sustainable in terms of utilisation of public resources. It would be financially untenable for the Government and would thin out the resources that could otherwise be used for other healthcare services.

In response to the final report of the Working Group, the Government has adopted the oral health policy that: (1) Oral health is an integral component of general health. The Government's oral health policy aims to enable all Hong Kong citizens to improve their oral hygiene and lifestyle conducive to both oral and overall health levels; (2) Through publicity, education, promotion and development of primary oral health and dental care, the Government facilitates citizens to manage their oral health, and put prevention, early identification and timely intervention of dental diseases into action with the objective of tooth retention; and (3) The Government provides appropriate oral health and dental care services targeting underprivileged groups with financial difficulties and special needs, ensuring these groups have access to essential dental care services.

In view of the Working Group's strategic recommendations, the Government has formulated an Oral Health Action Plan, under which the Primary Dental Co-care Pilot Scheme for Adolescents (PDCC) is rolled out to actively develop prevention-oriented primary oral healthcare according to the strategy of community-wide preventive primary oral health care.

The Department of Health (DH) launched the three-year PDCC on 20 March this year as an interface with the School Dental Care Service by providing partial subsidies for private dental check-up services for adolescents via a co-payment model to foster their establishment of partnership with dentists so as to promote their life-long habit of regular dental check-ups for prevention of dental diseases. Eligible adolescents can receive subsidised services once every calendar year. While the Government will provide a subsidy of \$200 each time, participants have to pay a co-payment fee as determined by their selected dentists. The co-payment for the subsidised services each time recommended by the Government is \$200. As at 18 March, there are around 270 registered dentists whose application to participate in the PDCC has been accepted by the DH, providing services at over 370 service locations. Among these dentists, over 67% charge a co-payment amount of \$200 or less while the minimum co-payment amount is \$50. The scope of subsidised services includes:

- i) Oral check-up;
- ii) Oral health risk assessment;
- iii) Dental scaling;
- iv) Personalised oral care advice;
- v) Fluoride application based on risk assessment; and
- vi) Oral check-up report.

To enhance the transparency of dental service fees other than the co-payment fee, the DH required dentists to disclose the fees for X-ray examinations, tooth fillings and extractions as charged under the PDCC.

The DH held 2 online briefing sessions for registered dentists in February and March to introduce the background, contents and dentist registration procedures of the PDCC. It also introduced the PDCC through a seminar organised by the Hong Kong Dental Association in mid-March.

Adolescents from age 13 to 17 (or will turn 13 in the calendar year when applying to join the PDCC) who hold a valid Hong Kong Identity Card and have registered in the Electronic Health Record Sharing System (eHealth) are eligible to join the PDCC. Eligible adolescents and their parents may, via the eHealth mobile application, access the thematic website and promotional videos launched by the DH in early March to learn about and participate in the PDCC. The DH has also disseminated letters through the Education Bureau to reach out to all secondary school students and their parents in the territory to publicise and promote the PDCC, while also approaching students visiting Student Health Service Centres and School Dental Clinics to publicise the scheme. About 370 000 adolescents are eligible to join each year, though the final number of participants will depend on the response from adolescents and their parents.

Adolescents and their parents who are interested in joining the PDCC can refer to the thematic webpage to view the list of registered dentists participating in the PDCC. After selecting a dentist, they can contact the relevant clinic directly to make an appointment for receiving the subsidised services. Details about the clinic addresses, telephone numbers, professional qualifications and the co-payment amount required from scheme participants are also set out on the list of dentists. All clinics participating in the PDCC will display the signage of the scheme outside their premises or at a prominent place for easy identification.

The DH will continuously monitor the utilisation rates of the service and gather feedback from service users as well as the data on their oral health conditions to review the effectiveness of the PDCC in due course.

The Government's financial provision for implementing the PDCC and the Community Dental Support Programme in 2025-26 is \$136.3 million.

- End -

CONTROLLING OFFICER'S REPLY

HHB223

(Question Serial No. 3229)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Due to the increased provision for operating expenses and the increased provision for personal emoluments as a result of a net increase of 19 posts in 2025–26, the provision for 2025–26 is \$273.3 million (16.0%) higher than the revised estimate for 2024-25. In this connection, will the Government please set out the respective titles of the 19 new posts and the estimates of expenditure incurred?

Asked by: Hon CHOW Ho-ding, Holden (LegCo internal reference no.: 32)

Reply:

There will be a net increase of 19 posts under Programme (1) of the Department of Health in 2025-26 to strengthen manpower for operational needs following the completion of the permanent premises of the Government Chinese Medicines Testing Institute. The work to be undertaken includes advancing research and development of testing methods of Chinese medicines and facilitating technology transfer to the industry. The new posts comprise mainly officers from the Pharmacist, Scientific Officer (Medical), Chemist and Science Laboratory Technician grades, as well as administrative/executive and clerical personnel. The salary expenditure for the net increase of the 19 posts is \$17.42 million in terms of notional annual mid-point salary value.

- End -

CONTROLLING OFFICER'S REPLY**HHB224****(Question Serial No. 1532)**Head: (37) Department of HealthSubhead (No. & title): (-) Not SpecifiedProgramme: (2) Disease PreventionControlling Officer: Director of Health (Dr. Ronald LAM)Director of Bureau: Secretary for HealthQuestion:

Regarding the work to protect and promote health, and prevent and treat illness and disease, against seasonal influenza and Coronavirus Disease 2019 (COVID-19) in particular, will the Government advise this Committee on:

1. the total quantity and expenditure (including transport and storage costs) on procuring vaccines (including seasonal influenza vaccines and various COVID-19 vaccines such as Comirnaty JN.1 and Spikevax JN.1) in 2024-25;
2. whether the Government has assessed the difference in cost between the current COVID-19 vaccines and those procured during the pandemic (2020-2023);
3. the total number of doses of unutilised seasonal influenza and COVID-19 vaccines disposed of (and their percentage in the total number of doses procured) in 2024-25; and
4. the number of people benefiting from various influenza vaccination programmes (including but not limited to the Government Vaccination Programme, the Vaccination Subsidy Scheme, the Seasonal Influenza Vaccination School Outreach (Free of Charge) Programme) and the total amount of subsidies in 2023-24 and 2024-25; and whether the Government has assessed the effectiveness of the above programmes to build a community immune barrier?

Asked by: Hon CHOW Man-kong (LegCo internal reference no.: 16)Reply:

(1)

The quantity and procurement costs (including transport and storage costs) of seasonal influenza (SI) vaccines procured by the Government for the Government Vaccination Programme (GVP) and the Seasonal Vaccination School Outreach (Free of Charge) Programme (SIVSOP) in 2024/25 are as follows:

Type of vaccine	Number of doses	Amount (\$ million)
SI Vaccine	1 280 000 (estimate)	50.5

The quantities of vaccines procured in 2024-25 under the COVID-19 Vaccination Programme (Vaccination Programme) are set out in the table below (as at 28 February 2025):

Type of vaccine	Doses (million)
- Comirnaty XBB.1.5 Vaccine ^{Note 1} (Fosun/BioNTech)	0.03
- Comirnaty JN.1 Vaccine ^{Note 2} (Fosun/BioNTech)	0.115
- Spikevax JN.1 Vaccine ^{Note 3} (Moderna)	0.11
Total	0.255

Note 1: Including the Comirnaty XBB.1.5 adult formulation, the Comirnaty XBB.1.5 paediatric formulation and the Comirnaty XBB.1.5 toddler formulation.

Note 2: Including the Comirnaty JN.1 adult formulation, the Comirnaty JN.1 paediatric formulation and the Comirnaty JN.1 toddler formulation.

Note 3: The Spikevax JN.1 Vaccine (Moderna) is only suitable for people aged 12 or above.

The Government's expenditure on the procurement of vaccines (including transport and storage costs) under the Vaccination Programme this year (as at 28 February 2025) is \$83.4 million.

(2)

The Government has been procuring sufficient quantity of COVID-19 vaccines with reference to vaccination data, recommendations made by the World Health Organization (WHO) and the Scientific Committee on Vaccine Preventable Diseases (SCVPD) and Scientific Committee on Emerging and Zoonotic Diseases (also known as the Joint Scientific Committee) under the Centre for Health Protection (CHP) of the Department of Health (DH), demographic data and the supply terms of vaccine suppliers. Since the commencement of the Vaccination Programme, the vaccines have been distributed from warehouse to various vaccination venues according to the "first-expired, first-out" principle. However, the public demand for vaccines varies with a number of factors, such as the number of persons infected and changes in the epidemic situation.

In view of confidentiality agreements entered into with the drug manufacturers concerned, the Government is not at liberty to disclose the average cost per dose of vaccine and other relevant details. The Government will continue to formulate policies on vaccine supply based on scientific evidence.

(3)

Regarding SI vaccines, as at 23 March 2025, about 1.15 million doses of vaccine have been administered under the GVP and SIVSOP in 2024/25, accounting for about 90% of the amount procured as mentioned above. Given that the SI vaccination programmes are still in progress, the number of unused SI vaccine doses for this season is not yet available.

Regarding COVID-19 vaccines, since the implementation of the Vaccination Programme until now (as at 28 February 2025), about 290 000 doses of the CoronaVac (Sinovac) vaccine (about 3.1% of the procurement total), 1.41 million doses of the Comirnaty (ancestral strain) vaccine (about 11.3% of procurement total), 1.18 million doses of the Comirnaty bivalent vaccine (about 62.1% of the procurement total) and about 900 doses of the Comirnaty

XBB.1.5 vaccine (adult formulation) (about 0.6% of the procurement total) had to be disposed of due to expiration in warehouse. This was attributable to, among other factors, the diminished need for old formulations of vaccines resulting from the use of new vaccine strains as recommended by the WHO and the Joint Scientific Committee in response to virus mutation. Overall, the number of vaccines requiring disposal due to expiration in warehouse only accounted for about 12% of the total vaccines procured, which is in line with the standard stipulated by the COVID-19 vaccine Global Access Facility (COVAX) for the wastage rate of COVID-19 vaccines.

(4)

The SCVPD under the CHP of the DH issues recommendations on the SI vaccines to be used and the priority groups for receiving vaccination in regard to the influenza season in Hong Kong on an annual basis after reviewing scientific evidence, local data, latest recommendations of the WHO and overseas practices.

Based on the recommendations of the SCVPD, the DH has been administering the following vaccination programmes/schemes to provide free/subsidised SI vaccination to eligible persons:

- GVP, which provides free SI vaccination to eligible children, elderly and other target groups at clinics of the DH and the Hospital Authority (HA);
- SIVSOP, which provides free or subsidised SI vaccination to eligible schoolchildren through public-private partnership outreach teams or the DH's outreach team; and
- Vaccination Subsidy Scheme (VSS), which provides subsidised SI vaccination to eligible persons, including persons aged 50 or above, pregnant women and children aged between 6 months and below 18 years of age through private doctors participating in the VSS.

The number of vaccine recipients and the total amount of subsidy for each eligible group under the various vaccination programmes/schemes in 2023/24 and 2024/25 are detailed at **Annex**. As some target group members may have, at their own expense, received SI vaccination at private clinics outside the Government's vaccination programmes/schemes, they are not included in the statistics concerned.

The Government has optimised the SI vaccination arrangements for eligible persons in 2024/25. For example, those with chronic illnesses or pregnant women can receive SI vaccination at public or private clinics where they attend for regular follow-up consultations, while the general public can receive vaccination at their family doctors' clinics. In particular, the Government has introduced several new vaccination venues, including the DH's Maternal and Child Health Centres, where vaccination is available to all children aged between 6 months and under 2, and the 18 District Health Centres (DHCs)/DHC Expresses, so as to provide more vaccination venues for the public.

As at 23 March this year, with the concerted efforts of the Government and all sectors of the community such as the medical sector, schools, parents and residential care homes, a record high number of about 2.07 million doses of SI vaccine have been administered under various

vaccination programmes/schemes in 2024/25, representing an increase of about 12.2% over the same period of the last influenza vaccination season and exceeding the total number of doses (about 1.87 million doses) administered last season. The number of schools participating in the SIVSOP has also increased significantly this year. About 1 020 kindergartens/child care centres (97%), about 640 primary schools (98%) and about 490 secondary schools (98%) have completed or will conduct SIV school outreach activities, which is higher than last year's participation rates (80% of kindergartens/child care centres, 95% of primary schools and 70% of secondary schools).

The winter influenza season, which began in early January and ended on 27 March this year, saw a low incidence of severe cases and deaths (even lower than the situation before the COVID-19 pandemic). Among them, 10 cases regarding severe influenza-associated complications in children were recorded this season without deaths, which was nearly 60% lower than the 24 cases (including 1 death) reported during the 2018/19 influenza season. The CHP believes this is the result of the concerted and comprehensive efforts of various stakeholders in the community and the public to increase the SI vaccination rate.

The Government will continue to take proactive measures to boost the uptake rate, including strengthening collaboration with family doctors, and, through statutory bodies such as the Occupational Safety and Health Council and non-governmental organisations, encourage service recipients, particularly the above priority groups, to receive SI vaccination to safeguard public health.

Programmes/schemes for provision of SI vaccination	2023/24		2024/25 (as at 23 March 2025)	
	No. of SI vaccine recipients	Subsidy [@] claimed (\$ million)	No. of SI vaccine recipients	Subsidy [@] claimed (\$ million)
GVP	653 600	Not applicable	758 900	Not applicable
VSS	849 200	227.2	903 700	238.9
SIVSOP	322 000	36.1	369 100	40.6
Total	1 824 800	263.3	2 031 700	279.5

[@] Refers to the subsidy for private doctors participating in the SIVSOP and the VSS. As vaccination services under the GVP are provided free of charge by public hospitals/clinics etc., the related expenses cannot be separately identified.

- End -

CONTROLLING OFFICER'S REPLY

HHB225

(Question Serial No. 1443)

Head: (37) Department of Health

Subhead (No. & title): (000) Operational expenses

Programme: (1) Statutory Functions

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Regarding the work of the Tobacco and Alcohol Control Office (TACO) of the Department of Health and the Hong Kong Council on Smoking and Health (COSH), will the Government advise this Committee on:

1. the staff establishment and expenditure breakdown of the TACO regarding its enforcement work against smoking offences, commercial sale and supply of alcohol to minors and related offences under the Smoking (Public Health) Ordinance (Cap. 371), the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600) and Part 5 of the Dutiable Commodities (Liquor) Regulations (Cap. 109B) over the past 3 years;
2. the number of enforcements in different premises and statutory no smoking areas and prosecutions instituted by the TACO in the past 3 years in tabular form; and whether prosecutions have been instituted against the operators of the premises suspected of aiding or abetting smoking offences; if yes, a breakdown of the figures;
3. the subsidies to the COSH for taking forward promotional initiatives in support of tobacco control, and to non-governmental organisations (NGOs) for implementing community-based smoking cessation programmes and promoting smoking cessation in the past 3 financial years;
4. in view of the enforcement, publicity and education efforts of the TACO and the COSH, and by the Government in collaboration with the NGOs, the number of smokers along with the change in the smoking prevalence in Hong Kong over the past 3 years, broken down by age and gender; and
5. the data on and the methods employed by the Government in collecting information on the smoking population in Hong Kong; the approaches adopted to reach, including but not limited to, e-cigarette smokers and users of heated tobacco products; if such data is available, the number of these individuals and their percentage in the smoking population in Hong Kong?

Asked by: Hon HO King-hong, Adrian Pedro (LegCo internal reference no.: 2)

Reply:

1.

The Tobacco and Alcohol Control Office (TACO) of the Department of Health (DH) is the principal enforcement agency for the Smoking (Public Health) Ordinance (Cap. 371), the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600) and the Dutiable Commodities (Liquor) Regulations (Cap. 109B). The TACO will conduct inspections and investigation in response to smoking and related complaints. In general, the TACO will issue fixed penalty notices (FPNs) to smoking offenders without warning. Apart from smoking offences, the TACO also issued summonses for offences under Cap. 371 (including aiding and abetting smoking offences, offences relating to smoking product advertisements, the promotion, manufacture, sale, or possession for commercial purposes of alternative smoking products (ASPs), obstruction of inspectors, etc.), and for the offence of importing ASPs under the Import and Export Ordinance (Cap. 60). The expenditure on and provision/revised estimate for tobacco and alcohol control initiatives taken forward by the TACO from 2020-21 to 2024-25, broken down by type of initiatives, and the approved establishment of the TACO from 2022-23 to 2024-25, are at **Annex 1 and Annex 2** respectively. The manpower and resources for the implementation of alcohol and tobacco control initiatives cannot be separately identified.

2.

The number of inspections conducted and FPNs/summonses issued by the TACO from 2022 to 2024 for smoking offences in food premises, shops and shopping malls, public transport facilities, bus interchanges and other statutory no smoking areas is at **Annex 3**. To effectively mitigate the impact of passive smoking on the public and enhance the deterrent effect against illegal smoking, new enforcement strategies were adopted in 2023, including extension of the time of surveillance and inspections in no smoking areas, deploying plain-clothes officers to take proactive enforcement actions, strengthening enforcement action in venues (such as bars and food premises) where waterpipes were offered for smoking, as well as prosecuting people aiding and abetting illegal smoking. From 2023 to 2024, the TACO issued 35 and 61 summonses to persons suspected of aiding and abetting smoking offenders respectively.

3.

The Government announced in June 2024 its plan to introduce 10 tobacco control measures in the short term. Among these initiatives, the Government has proposed to strengthen smoking cessation services as well as publicity and education through measures including increasing the number of smoking cessation service points, enhancing Chinese medicine smoking cessation services, offering smoking cessation services through District Health Centres (DHCs) with a case-management model, enhancing smoking cessation training for primary healthcare practitioners, assisting people in smoking cessation through mobile applications, and incorporating more elements related to the harm of smoking into regular school curriculum.

Over the years, the Government has been actively promoting a tobacco-free environment through publicity for smoking prevention and cessation services. To leverage community effort, the DH collaborates with the Hong Kong Council on Smoking and Health (COSH),

non-governmental organisations (NGOs) and healthcare professionals to promote smoking cessation, provide smoking cessation services and organise publicity programmes on smoking prevention.

At present, the DH is responsible for coordinating the provision of smoking cessation services in Hong Kong. Apart from operating an integrated Smoking Cessation Hotline to handle general enquiries and provide professional counselling on smoking cessation, it also arranges referrals to various smoking cessation services in the territory, including those provided by public clinics under the Hospital Authority (HA) (especially for those with chronic diseases), and community-based cessation programmes operated by NGOs. There are a total of 15 full-time and 55 part-time centres operated by the HA which have been providing smoking cessation services to the general public since 2002, and there are 5 smoking cessation clinics for civil servants operated by the DH. Furthermore, the DH also collaborates with NGOs to provide a range of community-based smoking cessation services including counselling, consultations by doctors (including free postal delivery of smoking cessation drugs) or Chinese medicine practitioners, and designated services for smokers from different ethnicities, immigrant smokers and workplace smokers. For young smokers, the DH collaborates with local universities to operate a hotline to provide them with dedicated counselling services over the phone. Besides, the DH has subvented 2 more service providers (from 2 to 4 in total) since 2023 to operate smoking cessation clinics with a focus on counselling and pharmacotherapy, and 3 more Chinese medicine smoking cessation service providers (from 1 to 4 in total) starting from this year to operate smoking cessation clinics with an emphasis on counselling and acupuncture. It is expected that the number of service users of the former type of clinics will increase by about 40% and the number regarding the latter type will double.

The DH subvents the COSH to organise publicity and education programmes in schools, such as health talks, training programmes and theatre programmes, to raise students' awareness of smoking hazards, including hazards from ASPs. To prevent youngsters from picking up smoking, the DH collaborates with the NGOs to organise health promotional activities at schools. By using interactive teaching materials and setting up mobile classrooms, the programmes enlighten students in respect of the tactics used by the tobacco industry to market tobacco products, and equip them with the skills to resist picking up smoking due to peer pressure. The DH has also launched publicity campaigns through mass media to spread the message that smoking brings risks of serious illnesses. To encourage smokers to try quitting, it distributes free trial packs of smoking cessation drugs (nicotine replacement therapy) for 1 week at community pharmacies, smoking cessation clinics, DHCs and DHC Expresses during the Quit in June annual campaign starting from 2023. During the Quit in June campaign in 2024, the DH implemented the Chinese Medicine Ear Points Patches for Smoking Cessation Trial Programme at designated Chinese medicine smoking cessation clinics. To encourage and help all healthcare professionals to provide support and treatment for smokers who are quitting, the DH organises online and face-to-face training courses, compiles the Practical Handbook for Smoking Cessation Treatments and a clinical guide on smoking cessation with Chinese medicine and acupuncture, and provides related resources, among other initiatives. The expenditure and provision in respect of general health education and promotion of smoking cessation provided by the DH and the expenditure and provision regarding smoking cessation and related services by NGOs are detailed at **Annex 1**.

The Government will continue to step up its work on smoking cessation and explore various tobacco control measures in the medium and long term in order to eliminate the societal harms caused by tobacco products in all aspects and safeguard the health of the community with a progressive and multi-pronged approach.

4. & 5.

Since 1982, the Census and Statistics Department (C&SD) has been conducting regular Thematic Household Surveys (THSs) on the pattern of smoking, with the latest one conducted between May and August in 2023 after the increase in tobacco duty in February. A scientific method is adopted to select a sample of quarters for participating in the THS. About 10 100 households representing the population of Hong Kong were interviewed, with a response rate of 76%. All persons aged 15 and above (excluding foreign domestic helpers) of the households were interviewed in the THS.

The THS concerned revealed that smoking prevalence dropped from 10.2% in 2019 and 9.5% in 2021 to 9.1% in 2023 while the number of cigarettes consumed by smokers per day also dropped from 12.7 sticks in 2019 and 2021 to 12.1 sticks in 2023. The Government further increased the tobacco duty in 2024. In this connection, a THS will be conducted later and it is expected that the survey results will reflect a reduction in the demand for tobacco products. The C&SD conducted and completed 2 rounds of THS on the pattern of smoking in the past 5 years, with a breakdown of the smoking prevalence and the number of cigarettes consumed by smokers daily (by age group and sex) set out at **Annex 4**.

The prevalence of daily smokers of heated tobacco products aged 15 and above in 2023 was 0.1% (around 3 400 smokers) while the corresponding rate in 2021 was also 0.1% (around 8 400 smokers). The prevalence of daily smokers of electronic smoking products aged 15 and above in 2023 was 0.2% (around 11 600 smokers) while the corresponding rate in 2021 was also 0.3% (around 17 500 smokers).

Expenditure on/Provision for
the Department of Health's Tobacco and Alcohol Control Office

	2020-21 (\$ million)	2021-22 (\$ million)	2022-23 (\$ million)	2023-24 (\$ million)	2024-25 Revised Estimate (\$ million)
<u>Enforcement</u>					
Programme 1: Statutory Functions	102.2	101.3	100.4	123.3	167.4
<u>Health Education and Smoking Cessation</u>					
Programme 3: Health Promotion	141.2	138.9	149.0	151.4	170.5
<u>(a) General health education and promotion of smoking cessation</u>					
TACO	64.5	62.8	73.0	83.7	88.2
Subvention to Hong Kong Council on Smoking and Health (COSH)	26.0	26.2	26.8	26.6	27.9
<i>Sub-total</i>	<u>90.5</u>	<u>89.0</u>	<u>99.8</u>	<u>110.3</u>	<u>116.1</u>
<u>(b) Expenditure on/Provision for smoking cessation and related services by Non-Governmental Organisations</u>					
Subvention to Tung Wah Group of Hospitals	30.6	30.8	29.4	10.2	14.0
Subvention to Pok Oi Hospital	7.4	7.5	7.6	14.8	17.9
Subvention to Po Leung Kuk	1.7	0.7	-	-	-
Subvention to Lok Sin Tong	3.0	3.2	3.3	3.6	3.6
Subvention to United Christian	4.4	4.9	5.8	6.1	8.9

<i>Nethersole Community Health Service</i>					
<i>Subvention to Life Education Activity Programme</i>	2.7	2.8	2.8	2.9	3.0
<i>Subvention to Christian Family Service Centre</i>	-	-	-	3.5	7.0
<i>Subvention to The University of Hong Kong</i>	0.9	-	0.3	-	-
<i>Sub-total</i>	<u>50.7</u>	<u>49.9</u>	<u>49.2</u>	<u>41.1</u>	<u>54.4</u>
Total	<u>243.4</u>	<u>240.2</u>	<u>249.4</u>	<u>274.7</u>	<u>337.9</u>

Approved Establishment of
the Department of Health's Tobacco and Alcohol Control Office

Rank	No. of staff from 2022-23 to 2024-25
<u>Head, TACO</u>	
Consultant	1
<u>Enforcement</u>	
Senior Medical & Health Officer	1
Medical & Health Officer	1
Scientific Officer (Medical)	1
Land Surveyor	1
Police Officer	5
Overseer/Senior Foreman/Foreman	125
Senior Executive Officer/Executive Officer	13
<i>Sub-total</i>	<u>147</u>
<u>Health Education and Smoking Cessation</u>	
Senior Medical & Health Officer	1
Medical & Health Officer	1
Scientific Officer (Medical)	2
Nursing Officer/Registered Nurse	3
Hospital Administrator II	4
<i>Sub-total</i>	<u>11</u>
<u>Administrative and General Support</u>	
Senior Executive Officer/Executive Officer	4
Clerical and support staff	19
Motor Driver	1
<i>Sub-total</i>	<u>24</u>
Total	<u>183</u>

Number of inspections conducted and FPNs/summonses issued by TACO from 2022 to 2024 for smoking offences in food premises, shops and shopping malls, public transport facilities, bus interchanges and other statutory no smoking areas under the Smoking (Public Health) Ordinance (Cap. 371) and the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600)

	2022	2023	2024
Inspections conducted ^(Note 1&2)	35 150	27 371	26 031
- Food premises	1 945	1 897	1 921
- Shops and shopping malls	7 757	5 823	4 965
- Public transport facilities	4 560	3 448	3 876
- Bus interchanges	664	309	428
- Other statutory no smoking areas	20 224	15 894	14 841
FPNs issued ^(Note 1)	6 296	10 261	13 488
- Food premises	262	421	630
- Shops and shopping malls	1 841	2 417	3 138
- Public transport facilities	920	2 493	3 130
- Bus interchanges	64	109	226
- Other statutory no smoking areas	3 209	4 821	6 364
Summonses issued ^(Note 1)	35	48	64
- Food premises	2	1	1
- Shops and shopping malls	4	6	14
- Public transport facilities	10	8	14
- Bus interchanges	1	0	3
- Other statutory no smoking areas	18	33	32

Note 1: The TACO does not have separate figures on enforcement at indoor workplace.

Note 2: To effectively mitigate the impact of passive smoking on the public and enhance the deterrent effect against illegal smoking, TACO has flexibly deployed resources and adopted new enforcement strategies since 2023, including extension of the time of surveillance and inspections in no smoking areas, deploying plain-clothes officers to take proactive enforcement actions, strengthening enforcement action in venues (such as bars and food premises) where waterpipes were offered for smoking, as well as prosecuting people inciting, aiding and abetting illegal smoking. The number of prosecutions against illegal smoking has surged due to the new enforcement strategies, reflecting their enhanced effectiveness.

Prevalence of daily cigarette smokers by age group and sex in 2021 and 2023*

Age group	Male		Female		Overall	
	2021	2023	2021	2023	2021	2023
15 - 19	#	#	#	#	#	#
20 - 29	9.6%	9.3%	2.1%	1.7%	5.9%	5.5%
30 - 39	15.3%	16.2%	4.5%	3.6%	9.5%	9.7%
40 - 49	24.6%	21.9%	5.8%	5.0%	14.2%	12.6%
50 - 59	22.0%	23.5%	3.2%	4.1%	11.7%	12.7%
≥ 60	15.7%	15.3%	1.2%	0.9%	8.2%	7.7%
Overall	16.7%	16.4%	3.0%	2.7%	9.5%	9.1%

* As a percentage of all persons in the respective age group. For example, among all males aged 20 to 29, 9.6% were daily cigarette smokers based on the survey conducted in 2021.

The figures are not released due to the large sampling error.

Source: Thematic Household Survey Report Nos. 75 and 79, Census and Statistics Department.

Average Daily Consumption of Cigarettes (number of sticks of cigarettes)
by Age Group and Sex in 2021 and 2023

	2021	2023
Age group		
15 - 19	#	#
20 - 29	11.2	11.2
30 - 39	11.5	11.5
40 - 49	12.7	11.8
50 - 59	13.7	12.6
≥ 60	13.0	12.5
Sex		
Male	13.2	12.6
Female	10.5	9.3
Overall	12.7	12.1

The figures are not released due to the large sampling error.

Source: Thematic Household Survey Report Nos. 75 and 79, Census and Statistics Department.

- End -

CONTROLLING OFFICER'S REPLY

HHB226

(Question Serial No. 1477)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention, (4) Curative Care

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

In recent years, the Government has been actively enhancing the oral health of the community. Initiatives this year include the launch of the Primary Dental Co-care Pilot Scheme for Adolescents (PDCC) as an interface with the School Dental Care Service (SDCS) for primary school students and implementing the Community Dental Support Programme (CDSP). In this connection, will the Government please advise on:

1. the expenditure incurred for the SDCS for primary school students over the past 3 years;
2. the estimated expenditure and target participation rate in respect of the PDCC this year;
3. the estimated expenditure on the CDSP this year; and
4. the future measures to be introduced by the Government to achieve the policy objective of improving the oral hygiene and lifestyle of all Hong Kong people?

Asked by: Hon HO King-hong, Adrian Pedro (LegCo internal reference no.: 36)

Reply:

To safeguard the oral health of the public, the Chief Executive announced in the 2022 Policy Address to conduct a comprehensive review of the dental services provided or subsidised by the Government. The Working Group on Oral Health and Dental Care (Working Group) was subsequently established in end-2022. The Working Group published a final report in end-2024, recommending that the future development of dental services should make reference to the direction of the Primary Healthcare Blueprint emphasising prevention, early identification and timely intervention, with the goal of retention of natural teeth and enhancing the overall level of citizens' oral health.

The Government concurs with the views of the Working Group that providing or subsidising comprehensive curative dental services from public purse to all Hong Kong citizens regardless of their financial means does not align with the policy objectives of developing a prevention-oriented oral health and dental care system and encouraging citizens to take

responsibility for their own oral health. This would exacerbate the current shortcomings of the treatment-oriented system, and would be neither cost-effective nor sustainable in terms of utilisation of public resources. It would be financially untenable for the Government and would thin out the resources that could otherwise be used for other healthcare services.

In response to the final report of the Working Group, the Government has adopted the oral health policy that: (1) Oral health is an integral component of general health. The Government's oral health policy aims to enable all Hong Kong citizens to improve their oral hygiene and lifestyle conducive to both oral and overall health levels; (2) Through publicity, education, promotion and development of primary oral health and dental care, the Government facilitates citizens to manage their oral health, and put prevention, early identification and timely intervention of dental diseases into action with the objective of tooth retention; and (3) The Government provides appropriate oral health and dental care services targeting underprivileged groups with financial difficulties and special needs, ensuring these groups have access to essential dental care services.

In the Oral Health Action Plan formulated based on the Working Group's strategic recommendations, the School Dental Care Service (SDCS) and the Primary Dental Co-care Pilot Scheme for Adolescents (PDCC) are rolled out to actively develop prevention-oriented primary oral healthcare according to the strategy of community-wide preventive primary oral health care. Meanwhile, the Community Dental Support Programme (CDSP) is a service focusing on underprivileged groups who have difficulties in accessing dental under the aforesaid strategy of ensuring these groups have access to essential dental care services.

The services provided by the Department of Health (DH)'s SDCS, PDCC and CDSP and the expenditures involved are set out below:

- (1) The Government focuses particularly on nurturing good oral hygiene habits from an early age including providing the SDCS to children. Primary school students in Hong Kong, as well as students aged under 18 with intellectual disability and/or physical disability studying in special schools, can join the SDCS of the DH to receive annual check-ups at designated school dental clinics, which cover oral examination as well as basic restorative and preventive treatment. The actual expenditures for the SDCS in 2022-23 and 2023-24 and the revised estimate for 2024-25 are as follows:

Financial Year	2022-23 (Actual)	2023-24 (Actual)	2024-25 (Revised Estimate)
Annual Expenditure (\$ million)	276.2	281.6	281.1

- (2) The DH launched the PDCC on 20 March this year as an interface with the SDCS by providing partial subsidies for private dental check-up services for adolescents aged between 13 and 17 on a co-payment basis to foster their partnership with dentists and maintain the good life-long habit of regular oral check-ups for prevention of dental diseases. Adolescents from age 13 to 17 (or will turn 13 in the calendar year when applying to join the PDCC) who hold a valid Hong Kong Identity Card and have registered in the Electronic Health Record Sharing System (eHealth) are eligible to join the PDCC. About 370 000 adolescents are eligible to join each year. While the

Government will provide a subsidy of \$200 each time, participants have to pay a co-payment fee as determined by their selected dentists. The co-payment for the subsidised services each time as recommended by the Government is \$200. As at 18 March, there are around 270 registered dentists whose application to participate in the PDCC has been accepted by the DH, providing services at over 370 service locations. Among these dentists, over 67% charge a co-payment amount of \$200 or less while the minimum co-payment amount is \$50. The DH has publicised the PDCC in collaboration with the Education Bureau to all secondary school students and their parents in the territory. The final number of participants will depend on the response from students and their parents.

- (3) On top of the existing dental grants under the Comprehensive Social Security Assistance Scheme and the emergency dental service provided through General Public Sessions by government dental clinics, the DH will increase the dental services to underprivileged groups with financial difficulties by launching the CDSP in 2025 and enhancing service capacity, increasing service points and expanding service scope, aiming to additionally offer at least twice the current number of quotas provided by the General Public Sessions of government dental clinics (i.e. 40 000 per year). The CDSP leverages the networks of non-governmental organisations and social welfare organisations serving underprivileged groups to provide services to persons with financial difficulties more effectively. In addition to tooth extraction, the CDSP provides dental fillings where dentists consider appropriate to encourage tooth retention.

The Government's financial provision for implementing the PDCC and the CDSP in 2025-26 is \$136.3 million.

- (4) In response to the Working Group's recommendations, the Government will adopt the strategies of developing community-wide preventive primary oral health care on the one hand, and providing essential dental services targeting underprivileged groups on the other for its future development of oral health and dental care system and resource allocation. The strategy of developing community-wide preventive primary oral health care aims to actively develop prevention-oriented primary oral healthcare, through community-wide promotion to support Hong Kong citizens across different age groups to manage their oral health, establish good oral hygiene habits and lifestyles, and seek regular oral check-ups and risk assessment of their own accord. The upcoming measures include:
 - Extend regular oral check-ups and preventive dental services to all minors from infancy to adolescence to establish good habits early;
 - Strengthen oral health publicity, promotion and education, including helping adults and the elderly to correct misconceptions and habits, through the primary healthcare system;
 - Integrate oral health into citizens' life course preventive care plans to encourage citizens to maintain good oral health habits and seek regular oral check-ups;
 - Expand the role of dental care professionals (termed "dental ancillary workers" before the commencement of the relevant amendments to the Dentists Registration Ordinance) in strengthening community-based primary oral healthcare services,

- including oral health education, oral hygiene instructions and risk assessment; and
- Encourage the dental profession to establish essential items for oral checkup services suitable for citizens of different age groups while increasing the transparency of fees for regular oral check-ups, encouraging citizens to seek regular oral check-ups, particularly encouraging elderly to use Elderly Health Care Vouchers for seeking oral check-ups.

- End -

CONTROLLING OFFICER'S REPLY

HHB227

(Question Serial No. 1280)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The Department of Health currently administers multiple subsidised vaccination schemes. In this connection, will the Government advise this Committee on:

- (1) the number of vaccine procurement undertaken by the DH in the past 5 years, the types and quantities of vaccines procured (both injectable and nasal spray vaccines), the number of vaccines disposed of or to be disposed of due to expiry, along with the expenditure involved, with a breakdown by subsidy scheme and year;
- (2) the number of vaccine recipients under each subsidised vaccination scheme, with a breakdown by scheme and year; and
- (3) the personnel deployed to implement the Seasonal Influenza Vaccination School Outreach Programme over the past 5 years, which was launched by the Government to cover all interested secondary schools, primary schools, kindergartens, kindergarten-cum-child care centres and child care centres, in a bid to increase seasonal influenza vaccination uptake rate amongst school students and facilitate schools in arranging outreach vaccination?

Asked by: Hon IP LAU Suk-ye, Regina (LegCo internal reference no.: 4)

Reply:

The Scientific Committee on Vaccine Preventable Diseases (SCVPD) under the Centre for Health Protection (CHP) of the Department of Health (DH) issues recommendations on the seasonal influenza (SI) vaccines to be used and the priority groups for receiving vaccination in regard to the influenza season in Hong Kong on an annual basis after reviewing scientific evidence, local data, latest recommendations of the World Health Organization and overseas practices.

Based on the recommendations of the SCVPD, the DH has been administering the following vaccination programmes/schemes to provide free/subsidised SI vaccination to eligible persons:

- Government Vaccination Programme (GVP), which provides free SI vaccination to eligible children, elderly and other target groups at clinics of the DH and the Hospital Authority (HA);

- Seasonal Influenza Vaccination School Outreach Programme (SIVSOP), which provides free or subsidised SI vaccination to eligible schoolchildren through the public-private partnership outreach teams or the DH's outreach team; and
- Vaccination Subsidy Scheme (VSS), which provides subsidised SI vaccination to eligible persons, including persons aged 50 or above, pregnant women and children aged between 6 months and below 18 years of age through private doctors participating in the VSS.

(1)

Every year, the Government procures SI vaccines (both injectable and nasal spray vaccines) for the implementation of GVP and SIVSOP (free of charge). The quantities of SI vaccines procured by the Government, the procurement cost, along with the number of doses expired, unused, and/or damaged over the past 5 years, are set out below:

Year	Number of SI Vaccines Procured (Inactivated Influenza Vaccines (IIV) (Injectable))	Number of SI Vaccines Procured (Live-attenuated Influenza Vaccines (LAIV) (Nasal))	Procurement Cost (\$ million)	Number of Doses Expired, Unused, and/or Damaged
2020/21	800 000(Actual)	69 000(Actual)	85.0	120 000
2021/22	853 000(Actual)	27 900(Actual)	79.3	120 000
2022/23	1 246 000(Actual)	22 500(Actual)	79.5	382 600
2023/24	1 007 000(Actual)	25 700(Actual)	53.2	34 000
2024/25	1 243 000(Estimated)	37 000(Estimated)	50.5	Not Applicable ^

^ The relevant figures are not available at this stage as the vaccination programmes/schemes for the 2024/25 season have yet to complete. The expenditure incurred by the disposal of vaccines depends on the relevant contract prices for procuring these vaccines.

(2)

The number of vaccine recipients of the eligible groups under each vaccination programme/scheme in the past 5 seasons are detailed at **Annex**. As some target group members may have, at their own expense, received SI vaccination at private clinics outside the Government's vaccination programmes/schemes, they are not included in the statistics concerned.

As at 23 March this year, with the concerted efforts of the Government and all sectors of the community such as the medical sector, schools, parents and residential care homes, a record high number of about 2.07 million doses of SI vaccine have been administered under various vaccination programmes/schemes in 2024/25, representing an increase of about 12.2% over the same period of the last influenza vaccination season and exceeding the total number of doses (about 1.87 million doses) administered last season.

(3)

The DH has been maintaining close liaison with its working partners and stakeholders, including Education Bureau (EDB), school principals, teachers, and residential child care centres, etc., with a view to boosting the uptake rates of SI vaccination among children.

The DH has taken the initiative to encourage and support schools in organising SI vaccination school outreach activities. Upon commencement of the SIVSOP since 2024/25, the DH has reached out to non-participating schools one by one to understand their difficulties, offer necessary assistance (including providing outreach vaccination services to schools in remote area or those that could not identify an appropriate private doctor for the outreach vaccination activity) and facilitate them to participate in the SIVSOP.

To boost the SI vaccination coverage rate among school children and attract schools to participate in the SIVSOP, special arrangements have been made under the SIVSOP this year to offer a more flexible choice of vaccine options. Kindergartens and child care centres can choose both the IIV and the LAIV (i.e. nasal vaccines) for the same or different outreach vaccination activities. As a pilot scheme, the LAIV is also provided to primary and secondary schools that indicated their preference for the LAIV earlier this year.

In addition, to encourage school children to receive SI vaccination, the DH has launched a commendation scheme under the SIVSOP this year. Participating schools with a high uptake rate will be awarded certificates in recognition of their efforts.

The DH has also contacted relevant association of early childhood educators and medical associations, as well as the Federations of Parent-Teacher Associations to appeal for their support for schools to participate in the SIVSOP. The DH has also issued letters to the associations of heads of kindergartens and child care centres through the EDB and contacted school sponsoring bodies to appeal to non-participating schools to arrange for the SI vaccination activities.

As at 23 March 2025, about 1 020 kindergartens/child care centres (97%), about 640 primary schools (98%) and about 490 secondary schools (98%) have completed or will conduct SI vaccination school outreach activities, which is higher than last year's participation rates (80% of kindergartens/child care centres, 95% of primary schools and 70% of secondary schools). This fully reflects the schools' strong support for the SIVSOP.

As at 23 March 2025, the vaccination coverage rate for children aged between 6 months and below 18 years of age is 62.1%, representing an increase of 9.6 percentage points as compared to the coverage rate of the same period last year.

Over the past 5 years, there have been 36 posts in the approved establishment of the SIVSOP's team, including personnel of the Medical and Health Officer, Registered Nurse, Scientific Officer (Medical), Executive Officer, Clerical Officer and Workman II grades.

Programme/scheme for provision of SI vaccination	2020/21	2021/22	2022/23	2023/24	2024/25 (As at 23 March 2025)
	No. of SI vaccine recipients under each vaccination programme/scheme	No. of SI vaccine recipients under each vaccination programme/scheme	No. of SI vaccine recipients under each vaccination programme/scheme	No. of SI vaccine recipients under each vaccination programme/scheme	No. of SI vaccine recipients under each vaccination programme/scheme
Government Vaccination Programme	547 100	474 100	609 900	653 600	758 900
Vaccination Subsidy Scheme	513 000	474 400	662 900	849 200	903 700
Seasonal Influenza Vaccination School Outreach (Free of Charge) Programme	234 600	268 100	259 200	322 000	369 100
Total	1 294 700	1 216 600	1 532 000	1 824 800	2 031 700*

* To ensure adequate immunity against SI, children under 9 years old who have never received SI vaccine are recommended to be given 2 doses of SI vaccine. Consequently, there is a discrepancy between the number of SI vaccine recipients and the number of doses administered.

- End -

CONTROLLING OFFICER'S REPLY

HHB228

(Question Serial No. 1266)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The estimate for this year is about 7.5% higher than the original estimate for the previous year. In this regard, please advise this Committee on:

1. the details of the 19 posts net-increased this year, including their ranks, job descriptions and salary expenditure; and
2. the current staff establishment and related expenses in respect of implementing tobacco control measures and legislation.

Asked by: Hon KONG Yuk-foon, Doreen (LegCo internal reference no.: 28)

Reply:

(1)

There will be a net increase of 19 posts under Programme (1) of the Department of Health in 2025-26 to strengthen manpower for operational needs following the completion of the permanent premises of the Government Chinese Medicines Testing Institute. The work to be undertaken includes advancing research and development of testing methods of Chinese medicines and facilitating technology transfer to the industry. The new posts comprise mainly officers from the Pharmacist, Scientific Officer (Medical), Chemist and Science Laboratory Technician grades, as well as administrative/executive and clerical personnel. The salary expenditure for the net increase of the 19 posts is \$17.42 million in terms of notional annual mid-point salary value.

(2)

The expenditure and provision / revised estimate in respect of the tobacco control initiatives undertaken by the DH's Tobacco and Alcohol Control Office and its approved establishment from 2020-21 to 2024-25 are at **Annex 1** and **Annex 2**.

Expenditure on/Provision for
the Department of Health's Tobacco and Alcohol Control Office

	2020-21 (\$ million)	2021-22 (\$ million)	2022-23 (\$ million)	2023-24 (\$ million)	2024-25 Revised Estimate (\$ million)
<u>Enforcement</u>					
Programme 1: Statutory Functions	102.2	101.3	100.4	123.3	167.4
<u>Health Education and Smoking Cessation</u>					
Programme 3: Health Promotion	141.2	138.9	149.0	151.4	170.5
<u>(a) General Health Education and Promotion of Smoking Cessation</u>					
TACO	64.5	62.8	73.0	83.7	88.2
Subvention to Hong Kong Council on Smoking and Health (COSH)	26.0	26.2	26.8	26.6	27.9
<i>Sub-total</i>	<u>90.5</u>	<u>89.0</u>	<u>99.8</u>	<u>110.3</u>	<u>116.1</u>
<u>(b) Expenditure on/Provision for Smoking Cessation and Related Services by Non-Governmental Organisations</u>					
Subvention to Tung Wah Group of Hospitals	30.6	30.8	29.4	10.2	14.0
Subvention to Pok Oi Hospital	7.4	7.5	7.6	14.8	17.9
Subvention to Po Leung Kuk	1.7	0.7	-	-	-
Subvention to Lok Sin Tong	3.0	3.2	3.3	3.6	3.6
Subvention to United Christian Nethersole Community Health Service	4.4	4.9	5.8	6.1	8.9
Subvention to Life Education Activity Programme	2.7	2.8	2.8	2.9	3.0

<i>Subvention to Christian Family Service Centre</i>	-	-	-	3.5	7.0
<i>Subvention to The University of Hong Kong</i>	0.9	-	0.3	-	-
<i>Sub-total</i>	<u>50.7</u>	<u>49.9</u>	<u>49.2</u>	<u>41.1</u>	<u>54.4</u>
Total	<u>243.4</u>	<u>240.2</u>	<u>249.4</u>	<u>274.7</u>	<u>337.9</u>

Approved Establishment of
the Department of Health's Tobacco and Alcohol Control Office

Rank	Number of Staff from 2020-21 to 2024-25
<u>Head, TACO</u>	
Consultant	1
<u>Enforcement</u>	
Senior Medical & Health Officer	1
Medical & Health Officer	1
Scientific Officer (Medical)	1
Land Surveyor	1
Police Officer	5
Overseer/Senior Foreman/Foreman	125
Senior Executive Officer/Executive Officer	13
<i>Sub-total</i>	<u>147</u>
<u>Health Education and Smoking Cessation</u>	
Senior Medical & Health Officer	1
Medical & Health Officer	1
Scientific Officer (Medical)	2
Nursing Officer/Registered Nurse	3
Hospital Administrator II	4
<i>Sub-total</i>	<u>11</u>
<u>Administrative and General Support</u>	
Senior Executive Officer/Executive Officer	4
Clerical and Support staff	19
Motor Driver	1
<i>Sub-total</i>	<u>24</u>
Total	<u>183</u>

- End -

CONTROLLING OFFICER'S REPLY

HHB229

(Question Serial No. 1651)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Regarding the enforcement of tobacco control legislation, will the Government please advise on:

1. the respective numbers of complaints received, inspections conducted, and warning letters, summonses and fixed penalty notices (FPNs) issued in relation to smoking in the past 3 years;
2. the respective numbers of FPNs issued in restaurants, shops, indoor workplaces, public transport facilities, bus interchanges and on public transport carriers in the past 3 years;
3. the number of people who have quit smoking in the past 3 years; and
4. whether it will consider allocating more resources to achieve the goal of Tobacco-free Hong Kong, such as providing smoking cessation services through District Health Centres and further extending no smoking areas etc.?

Asked by: Hon KOON Ho-ming, Peter Douglas (LegCo internal reference no.: 3)

Reply:

1.

The Tobacco and Alcohol Control Office (TACO) of the Department of Health (DH) is the principal enforcement agency for the Smoking (Public Health) Ordinance (Cap. 371) and the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600). The TACO will conduct inspections and investigation in response to smoking and related complaints. In general, the TACO will issue fixed penalty notices (FPNs) to smoking offenders without warning. Apart from smoking offences, the TACO also issued summonses for offences under Cap. 371 (including aiding and abetting smoking offences, offences relating to smoking product advertisements, the promotion, manufacture, sale, or possession for commercial purposes of alternative smoking products (ASPs), obstruction of inspectors, etc.), and for the offence of importing ASPs under the Import and Export Ordinance (Cap. 60). The numbers of complaints/referrals received, inspections conducted, warning letters issued, and FPNs/summonses issued by TACO for the period from 2020 to 2024 for smoking and other offences are at **Annex 1**.

2.

The number of inspections conducted and FPNs/summonses issued by the TACO from 2022 to 2024 for smoking offences in food premises, shops and shopping malls, public transport facilities, bus interchanges and other statutory no smoking areas is at **Annex 2**.

3. & 4.

The Government announced in June 2024 its plan to introduce 10 tobacco control measures in the short term. Among these initiatives, the Government has proposed to strengthen smoking cessation services as well as publicity and education through measures such as increasing the number of smoking cessation service points, enhancing Chinese medicine smoking cessation services, offering smoking cessation services through District Health Centres (DHCs) with a case-management model, enhancing smoking cessation training for primary healthcare practitioners, assisting people in smoking cessation through mobile applications, and incorporating more elements related to the harm of smoking into regular school curriculum.

Over the years, the Government has been actively promoting a tobacco-free environment through publicity for smoking prevention and cessation services. To leverage community effort, the Department of Health (DH) collaborates with the Hong Kong Council on Smoking and Health (COSH), non-governmental organisations (NGOs) and healthcare professionals to promote smoking cessation, provide smoking cessation services and organise publicity programmes on smoking prevention.

At present, the DH is responsible for coordinating the provision of smoking cessation services in Hong Kong. Apart from operating an integrated Smoking Cessation Hotline to handle general enquiries and provide professional counselling on smoking cessation, the DH arranges referrals to various smoking cessation services in the territory, including those provided by public clinics under the Hospital Authority (HA) (helping patient, especially for those with chronic diseases, to quit smoking), and community-based cessation programmes operated by NGOs. There are a total of 15 full-time and 55 part-time centres operated by the HA which have been providing smoking cessation services to the general public since 2002, and there are 5 smoking cessation clinics for civil servants operated by the DH. Furthermore, the DH also collaborates with NGOs to provide a range of community-based smoking cessation services including counselling, consultations by doctors (including free postal delivery of smoking cessation drugs) or Chinese medicine practitioners, and designated services for smokers from different ethnicities, immigrant smokers and workplace smokers. For young smokers, the DH collaborates with local universities to operate a hotline to provide them with dedicated counselling services over the phone. Besides, the DH has subvented 2 more service providers (from 2 to 4 in total) since 2023 to operate smoking cessation clinics with a focus on counselling and pharmacotherapy, and 3 more Chinese medicine smoking cessation service providers (from 1 to 4 in total) starting from this year to operate smoking cessation clinics with an emphasis on counselling and acupuncture. It is expected that the number of service users of the former type of clinics will increase by about 40% and the number regarding the latter type will double.

Smoking cessation services and counselling for smokers are currently available at all DHCs/DHC Expresses in the 18 districts, which collaborate with smoking cessation service providers in their respective districts to provide information or arrange referrals for smokers in need.

In 2022, 2023 and 2024, the quitlines operated by the DH and local universities handled 9 216, 11 051 and 10 875 enquiries respectively. During these 3 years, there were 20 406, 27 715 and 28 512 smokers receiving smoking cessation services via quitlines, at cessation clinics under the HA and through community-based programmes operated by NGOs.

Smokers who receive smoking cessation treatment receive 52-week follow-up services to assess their quit status. For smokers who receive smoking cessation services via quitlines, at cessation clinics under the HA and through community-based programmes operated by NGOs, their 52-week quit rates, which refer to the percentage of service users self-reporting to have stayed quit in the past 7 days, range from 20% to 60%, which are comparable to those in overseas countries. Discrepancies in the quit rates concerning different smoking cessation programmes are due to differences in terms of their target groups and treatment methods (which include counselling, pharmacotherapy, and Chinese medicine with acupuncture). To become a successful quitter, smokers are encouraged to choose the cessation service that best caters for their personal needs.

The Government will continue to step up its work on smoking cessation and explore various tobacco control measures in the medium and long term in order to eliminate the social hazards posed by tobacco products in all aspects and safeguard the health of the community with a progressive and multi-pronged approach.

Numbers of complaints/referrals received, inspections conducted, warning letters issued, and FPNs/summonses issued by TACO for smoking and other offences under the Smoking (Public Health) Ordinance (Cap. 371), the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600) and the Import and Export Ordinance (Cap. 60)

		2020	2021	2022	2023	2024
Complaints/referrals received		11 568	13 424	14 805	20 116	29 205
Inspections conducted		36 129	41 225	35 281	28 817 ^(Note 4)	30 162
Warning letters issued ^(Note 1 and 2)		16	16	21	10	10
FPNs issued (for smoking offences)		6 587	7 703	6 296	10 261 ^(Note 4)	13 488
Summonses issued	for smoking offences	58	40	35	48	64
	for other offences ^(Note 3)	57	115	130	657	871

Note:

- 1 In general, the TACO will prosecute smoking offenders without prior warning. The TACO will only consider issuing warning letters if the smoking offenders are found to be persons under 15 years old.
- 2 During the 3-month grace period from 30 April to 31 July 2022, warning letters were issued to passengers carrying small quantity of ASPs. After the grace period, any person who imports any quantity of ASPs will be prosecuted when there is sufficient evidence.
- 3 Other offences include willful obstruction, failure to produce identity document, displaying smoking product advertisement, ASP related offences, and aiding and abetting another person committing a smoking offence, etc.
- 4 To effectively mitigate the impact of passive smoking on the public and enhance the deterrent effect against illegal smoking, TACO has flexibly deployed resources and adopted new enforcement strategies since 2023, including extension of the time of surveillance and inspections in no smoking areas, deploying plain-clothes officers to take proactive enforcement actions, strengthening enforcement action in venues (such as bars and food premises) where waterpipes were offered for smoking, as well as prosecuting people inciting, aiding and abetting illegal smoking. The number of prosecutions against illegal smoking has surged due to the new enforcement strategies, reflecting their enhanced effectiveness.

Number of inspections conducted and FPNs/summonses issued by TACO from 2022 to 2024 for smoking offences in food premises, shops and shopping malls, public transport facilities, bus interchanges and other statutory no smoking areas under the Smoking (Public Health) Ordinance (Cap. 371) and the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600)

	2022	2023	2024
Inspections conducted ^(Notes 1 and 2)	35 150	27 371	26 031
- <i>Food premises</i>	1 945	1 897	1 921
- <i>Shops and shopping malls</i>	7 757	5 823	4 965
- <i>Public transport facilities</i>	4 560	3 448	3 876
- <i>Bus interchanges</i>	664	309	428
- <i>Other statutory no smoking areas</i>	20 224	15 894	14 841
FPNs issued ^(Note 1)	6 296	10 261	13 488
- <i>Food premises</i>	262	421	630
- <i>Shops and shopping malls</i>	1 841	2 417	3 138
- <i>Public transport facilities</i>	920	2 493	3 130
- <i>Bus interchanges</i>	64	109	226
- <i>Other statutory no smoking areas</i>	3 209	4 821	6 364
Summonses issued ^(Note 1)	35	48	64
- <i>Food premises</i>	2	1	1
- <i>Shops and shopping malls</i>	4	6	14
- <i>Public transport facilities</i>	10	8	14
- <i>Bus interchanges</i>	1	0	3
- <i>Other statutory no smoking areas</i>	18	33	32

Note 1 : The TACO does not have separate figures on enforcement at indoor workplace and public transport carriers.

Note 2: To effectively mitigate the impact of passive smoking on the public and enhance the deterrent effect against illegal smoking, TACO has flexibly deployed resources and adopted new enforcement strategies since 2023, including extension of the time of surveillance and inspections in no smoking areas, deploying plain-clothes officers to take proactive enforcement actions, strengthening enforcement action in venues (such as bars and food premises) where waterpipes were offered for smoking, as well as prosecuting people inciting, aiding and abetting illegal smoking. The number of prosecutions against illegal smoking has surged due to the new enforcement strategies, reflecting their enhanced effectiveness.

- End -

CONTROLLING OFFICER'S REPLY

HHB230

(Question Serial No. 2306)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions, (3) Health Promotion

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

As the principal agency to enforce laws on tobacco control, the Tobacco and Alcohol Control Office (TACO) of the Department of Health plays an important role in safeguarding public health and reducing tobacco hazards. In this connection, will the Government please advise this Committee on:

- (a) the expenditure of the TACO on tobacco control in each of the past 5 years and the trend of increase or decrease in such expenditure;
- (b) the estimate for 2025-26 and its rates of change;
- (c) the major uses of its earmarked funding (e.g. staff cost, publicity and education, enforcement equipment, etc.); and
- (d) the expenditure, major activities organised and number of people reached in the past 5 years in respect of the publicity and educational initiatives of tobacco control as far as their effectiveness is concerned?

Asked by: Hon KWOK Wai-keung (LegCo internal reference no.: 29)

Reply:

(a) – (c)

The Tobacco and Alcohol Control Office (TACO) of the Department of Health (DH) is the principal enforcement agency for the Smoking (Public Health) Ordinance (Cap. 371) and the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600). The TACO will conduct inspections and investigation in response to smoking and related complaints. In general, the TACO will issue fixed penalty notices (FPNs) to smoking offenders without warning. Apart from smoking offences, the TACO also issued summonses for offences under Cap. 371 (including aiding and abetting smoking offences, offences relating to smoking product advertisements, the promotion, manufacture, sale, or possession for commercial purposes of alternative smoking products (ASPs), obstruction of inspectors, etc.), and for offences of importing ASPs under the Import and Export Ordinance (Cap. 60).

The Government's tobacco control policy seeks to safeguard public health by discouraging smoking, containing the proliferation of tobacco use and minimising the impact of passive

smoking on the public. To this end, the Government adopts a progressive and multi-pronged approach comprising legislation, enforcement, publicity, education, smoking cessation services and taxation.

The Health Bureau (HHB) introduced in June 2024 the new tobacco control strategy, outlining the short, medium and long-term measures to further reduce smoking prevalence incrementally through various measures, with a view to minimising the harmful effects of tobacco products on the community and safeguarding public health through a multi-pronged approach. These measures are formulated around four directions under the tobacco control strategy, namely, reducing the demand for and supply of tobacco products, minimising the attractiveness of tobacco products, protecting the public from the hazard of second-hand smoke and strengthening the provision of smoking cessation services, aiming to take forward the tobacco control process incrementally. The HHB plans to introduce the proposed legislative amendments for the next-phase tobacco control measures to the Legislative Council for scrutiny by the end of this month.

The revised estimate and estimate for tobacco control initiatives taken forward by the TACO by work category from 2020-21 to 2025-26 are at Annex. In the past 5 years, the expenditure on law enforcement and smoking cessation promotion and the subvention on smoking cessation and other related services provided by non-governmental organisations (NGOs) increased gradually. The increase in individual programmes cannot be separately identified.

(d)

Over the years, the Government has been actively promoting a tobacco-free environment through publicity for smoking prevention and cessation services. To leverage community effort, the DH collaborates with the Hong Kong Council on Smoking and Health (COSH), NGOs and healthcare professionals to promote smoking cessation, provide smoking cessation services and organise publicity programmes on smoking prevention.

At present, the DH is responsible for coordinating the provision of smoking cessation services in Hong Kong. Apart from operating an integrated Smoking Cessation Hotline to handle general enquiries and provide professional counselling on smoking cessation, the DH arranges referrals for various smoking cessation services in the territory, including those provided by public clinics under the Hospital Authority (HA) (helping patients, especially for those with chronic diseases), and community-based cessation programmes operated by NGOs. There are a total of 15 full-time and 55 part-time centres operated by the HA which have been providing smoking cessation services to the general public since 2002, and there are 5 smoking cessation clinics for civil servants operated by the DH. Furthermore, the DH also collaborates with NGOs to provide a range of community-based smoking cessation services including counselling, consultations by doctors (including free postal delivery of smoking cessation drugs) or Chinese medicine practitioners, and designated services for smokers from different ethnicities, immigrant smokers and workplace smokers. For young smokers, the DH collaborates with local universities to operate a hotline to provide them with dedicated counselling services over the phone. Besides, the DH has subvented 2 more service providers (from 2 to 4 in total) since 2023 to operate smoking cessation clinics with a focus on counselling and pharmacotherapy, and 3 more Chinese medicine smoking cessation service providers (from 1 to 4 in total) starting from this year to operate smoking cessation clinics with an emphasis on counselling and acupuncture. It is expected that the number of

service users of the former type of clinics will increase by about 40% and the number regarding the latter type will double.

The DH subvents the COSH to organise publicity and education programmes in schools, such as health talks, training programmes and theatre programmes, to raise students' awareness of smoking hazards, including hazards from ASPs. To prevent youngsters from picking up smoking, the DH collaborates with the NGOs to organise health promotional activities at schools. By using interactive teaching materials and setting up mobile classrooms, the programmes enlighten students in respect of the tactics used by the tobacco industry to market tobacco products, and equip them with the skills to resist picking up smoking due to peer pressure. The DH has also launched publicity campaigns through mass media to spread the message that smoking brings risks of serious illnesses. To encourage smokers to try quitting, it distributes free trial packs of smoking cessation drugs (nicotine replacement therapy) for 1 week at community pharmacies, smoking cessation clinics, DHCs and DHC Expresses during the Quit in June annual campaign starting from 2023. During the Quit in June campaign in 2024, the DH implemented the Chinese Medicine Ear Points Patches for Smoking Cessation Trial Programme at designated Chinese medicine smoking cessation clinics. To encourage and help all healthcare professionals to provide support and treatment for smokers who are quitting, the DH organises online and face-to-face training courses, compiles the Practical Handbook for Smoking Cessation Treatments and a clinical guide on smoking cessation with Chinese medicine and acupuncture, and provides related resources, among other initiatives. The expenditure and provision in respect of general health education and promotion of smoking cessation provided by the DH and the expenditure and provision regarding smoking cessation and related services by NGOs are detailed at **Annex**.

During 2022 and 2024, the quitlines operated by the DH and local universities handled 9 216, 11 051 and 10 875 enquiries respectively. During these 3 years, there were 20 406, 27 715 and 28 512 smokers receiving smoking cessation services via quitlines, at smoking cessation clinics under the HA and through community-based programmes operated by NGOs.

The Government will continue to step up its work on smoking cessation and explore various tobacco control measures in the medium and long term in order to eliminate the social hazards posed by tobacco products in all aspects and safeguard the health of the community with a multi-pronged approach.

Expenditure on/provision for
the Department of Health's Tobacco and Alcohol Control Office

	2020-21 (\$ million)	2021-22 (\$ million)	2022-23 (\$ million)	2023-24 (\$ million)	2024-25 Revised Estimate (\$ million)	2025-26 Estimate (\$ million)
<u>Enforcement</u>						
Programme 1: Statutory Functions	<u>102.2</u>	<u>101.3</u>	<u>100.4</u>	<u>123.3</u>	<u>167.4</u>	<u>174.8</u>
<u>Health Education and Smoking Cessation</u>						
Programme 3: Health Promotion	<u>141.2</u>	<u>138.9</u>	<u>149.0</u>	<u>151.4</u>	<u>170.5</u>	<u>180.9</u>
<u>(a) General Health Education and Promotion of Smoking Cessation</u>						
TACO	64.5	62.8	73.0	83.7	88.2	87.0
Subvention to Hong Kong Council on Smoking and Health (COSH)	26.0	26.2	26.8	26.6	27.9	27.3
<i>Sub-total</i>	<u>90.5</u>	<u>89.0</u>	<u>99.8</u>	<u>110.3</u>	<u>116.1</u>	<u>114.3</u>
<u>(b) Provision for Smoking Cessation and Related Services by Non-Governmental Organisations</u>						
Subvention to Tung Wah Group of Hospitals	30.6	30.8	29.4	10.2	14.0	17.8
Subvention to Pok Oi Hospital	7.4	7.5	7.6	14.8	17.9	20.9
Subvention to Po Leung Kuk	1.7	0.7	-	-	-	-
Subvention to Lok Sin Tong	3.0	3.2	3.3	3.6	3.6	3.6
Subvention to United Christian Nethersole Community Health Service	4.4	4.9	5.8	6.1	8.9	13.8
Subvention to Life Education Activity Programme	2.7	2.8	2.8	2.9	3.0	3.0
Subvention to Christian Family Service Centre	-	-	-	3.5	7.0	4.5
Subvention to The University of Hong Kong	0.9	-	0.3	-	-	3.0
<i>Sub-total</i>	<u>50.7</u>	<u>49.9</u>	<u>49.2</u>	<u>41.1</u>	<u>54.4</u>	<u>66.6</u>
Total	<u>243.4</u>	<u>240.2</u>	<u>249.4</u>	<u>274.7</u>	<u>337.9</u>	<u>355.7</u>

- End -

CONTROLLING OFFICER'S REPLY

HHB231

(Question Serial No. 0597)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The Tobacco and Alcohol Control Office (TACO) of the Department of Health (DH) is mainly responsible for matters relating to tobacco control and has been strengthening joint operations since 2023 in order to further curb the situation of illicit cigarette leaflets. In this connection, will the Government inform this Committee of:

- (1) the establishment, strength, salary expenditure and total expenditure of the (i) Overseer; (ii) Foreman; and (iii) Senior Foreman posts responsible for the TACO's work on tobacco control in each of the past 3 years;
- (2) a breakdown of the more than 250 joint operations the TACO conducted in the past 3 years by joint operator (the Police, the Housing Department and the Customs and Excise Department); and
- (3) whether the Government has reviewed why only 17 offenders had been successfully prosecuted for distributing smoking product leaflets despite a total of more than 250 joint operations against illicit cigarette leaflets in the past 3 years; if yes, the improvement plan; if no, the reasons?

Asked by: Hon LAI Tung-kwok (LegCo internal reference no.: 6)

Reply:

(1)

The approved establishment, strength and estimated salary expenditure of the Overseer, Senior Foreman and Foreman posts responsible for the work on tobacco control by the Tobacco and Alcohol Control Office (TACO) of the Department of Health (DH) from 2022-23 to 2024-25 are at **Annex 1**. The expenditure and provision / revised estimate in respect of the tobacco control initiatives undertaken by the TACO (broken down by type of activity) are at **Annex 2**.

(2) & (3)

The TACO is the principal enforcement agency for the Smoking (Public Health) Ordinance (Cap. 371). Part 4 of the Ordinance sets out regulations on the advertising of smoking products, including prohibition on the display or distribution of smoking product advertisements (including leaflets) and the placing of smoking product advertisements on the

Internet. Offenders are liable to a fine of \$50,000. Upon receiving complaints or referrals concerning smoking product advertisements, the TACO will take follow-up action and investigate, prosecuting offenders when there is sufficient evidence. Advertising of smoking products, both duty-paid and duty-not-paid, falls within the ambit of the Ordinance and the TACO's enforcement work. Any case that involves duty-not-paid smoking products will be referred to the Customs and Excise Department (C&ED) for follow-up investigation. The TACO has been proactively conducting market surveillance. In order to further curb the distribution of illicit cigarette leaflets, the TACO has strengthened the joint operations with the Police, the Housing Department (HD) and the C&ED against the sale of illicit cigarettes and related promotional activities in public rental housing (PRH) estates since 2023. Among the more than 250 joint operations in the past 3 years, all were conducted in collaboration with the HD, with the C&ED and the Police participating in over 20% of these operations. The TACO had established a collaboration mechanism with the Police and the HD. When any smoking product leaflet distribution is detected, staff of PRH estates would immediately contact the Police for assistance, and refer the case to the TACO for further investigation. In addition to patrolling PRH estates, officers from the TACO would provide estate security personnel and residents with information on what to do when a suspected violation is found, as well as collaborating with local community members (such as District Council members) to remind residents not to defy the law.

Apart from joint operations with the relevant departments, the TACO also carries out regular online surveillance. Upon identification of the smoking product advertisements on the Internet, the TACO will ask the relevant Internet service providers and social media platforms to remove such contents as soon as possible. From 2022 to 2024, the TACO removed a total of over 3 200 webpages, social media accounts or posts involving smoking product advertisements.

Announced by the Government last June, one of the aims of the "10 measures for tobacco control" is to step up enforcement against illicit cigarettes, which includes introducing a duty stamp system to distinguish duty-paid cigarettes from non-duty-paid cigarettes; increasing the maximum penalty for handling, possessing, selling or buying duty-not-paid cigarettes; and listing the relevant offences under the schedule to the Organized and Serious Crimes Ordinance (Cap. 455) to enable the Government to apply for freezing and forfeiting illicit proceeds and assets associated with illicit cigarette activities by virtue of the Ordinance. The Government expects that the above measures will increase the deterrent effect and enhance the effectiveness of law enforcement departments in combating illicit cigarettes.

Various Government departments concerned including the TACO, the C&ED, the Police and the HD will continue to work closely together to strengthen intelligence exchange and enhance the collaboration mechanism. Enforcement strategies will be adjusted with regard to the actual situation, and we will also take joint enforcement actions and refer suspected illegal cases to the relevant departments, with a view to promoting the work on tobacco control and enforcing the relevant legislation.

Approved Establishment and Estimated Salary Expenditure of the Overseer, Senior Foreman and Foreman Posts of the Department of Health (DH)'s Tobacco and Alcohol Control Office (TACO)

Rank	Approved Establishment from 2022-23 to 2024-25	Estimated Salary Expenditure in 2022-23 (\$ million)	Estimated Salary Expenditure in 2023-24 (\$ million)	Estimated Salary Expenditure in 2024-25 (\$ million)
Overseer	10	4.4	4.5	4.7
Senior Foreman	39	13.5	13.8	14.4
Foreman	76	20.7	21.2	22.2
Total	<u>125</u>	<u>38.6</u>	<u>39.5</u>	<u>41.3</u>

Strength of Overseer, Senior Foreman and Foreman of the DH's TACO

Rank	Strength as at 1 April 2022	Strength as at 1 April 2023	Strength as at 1 April 2024
Overseer	7	9	7
Senior Foreman	27	24	30
Foreman	65	57	63
Total	<u>99</u>	<u>90</u>	<u>100</u>

Expenditure on / Provision for the DH's TACO

	2020-21 (\$ million)	2021-22 (\$ million)	2022-23 (\$ million)	2023-24 (\$ million)	2024-25 Revised Estimate (\$ million)
<u>Enforcement</u>					
Programme 1: Statutory Functions	102.2	101.3	100.4	123.3	167.4
<u>Health Education and Smoking Cessation</u>					
Programme 3: Health Promotion	141.2	138.9	149.0	151.4	170.5
<u>(a) General Health Education and Promotion of Smoking Cessation</u>					
TACO	64.5	62.8	73.0	83.7	88.2
Subvention to Hong Kong Council on Smoking and Health (COSH)	26.0	26.2	26.8	26.6	27.9
<i>Sub-total</i>	<u>90.5</u>	<u>89.0</u>	<u>99.8</u>	<u>110.3</u>	<u>116.1</u>
<u>(b) Expenditure on / Provision for Smoking Cessation and Related Services by Non-Governmental Organisations</u>					
Subvention to Tung Wah Group of Hospitals	30.6	30.8	29.4	10.2	14.0
Subvention to Pok Oi Hospital	7.4	7.5	7.6	14.8	17.9
Subvention to Po Leung Kuk	1.7	0.7	-	-	-
Subvention to Lok Sin Tong	3.0	3.2	3.3	3.6	3.6
Subvention to United Christian Nethersole Community Health Service	4.4	4.9	5.8	6.1	8.9
Subvention to Life Education Activity Programme	2.7	2.8	2.8	2.9	3.0
Subvention to Christian Family Service Centre	-	-	-	3.5	7.0
Subvention to The University of Hong Kong	0.9	-	0.3	-	-
<i>Sub-total</i>	<u>50.7</u>	<u>49.9</u>	<u>49.2</u>	<u>41.1</u>	<u>54.4</u>
Total	<u>243.4</u>	<u>240.2</u>	<u>249.4</u>	<u>274.7</u>	<u>337.9</u>

- End -

CONTROLLING OFFICER'S REPLY**HHB232****(Question Serial No. 0602)**Head: (37) Department of HealthSubhead (No. & title): (-) Not SpecifiedProgramme: (1) Statutory FunctionsControlling Officer: Director of Health (Dr. Ronald LAM)Director of Bureau: Secretary for HealthQuestion:

Regarding the work of the Government Chinese Medicines Testing Institute (GCMTI), will the Government inform this Committee of:

- (1) the financial provision, number of posts in the approved establishment and net recurrent cost of civil service posts of the GCMTI in each of the past 3 financial years;
- (2) the number of various posts (such as Chemists, Scientific Officers and Science Laboratory Technologists in various ranks) in the GCMTI in each of the past 3 financial years;
- (3) the research and thematic projects completed by the GCMTI over the past 3 financial years, along with their commencement and completion dates, findings, as well as details of those underway; and
- (4) the number and names of Chinese Materia Medica (CMM) for which establishment of reference standards was completed under the GCMTI's project on the Hong Kong Chinese Materia Medica Standards (HKCMMS) in each of the past 3 years, and the number and names of such CMM pending publication, along with the actual expenditure involved in the HKCMMS project over the past 3 years?

Asked by: Hon LAI Tung-kwok (LegCo internal reference no.: 11)

Reply:

(1)

The financial provision, establishment and staff cost in respect of the Government Chinese Medicines Testing Institute (GCMTI) in the past 3 years are as follows:

Financial Year	Financial Provision (\$ million)	Number of posts in the approved establishment	Net Recurrent Cost of Civil Service Post (\$ million)
2022-23	around 52.5	29	around 24.6
2023-24	around 63	31	around 26.9
2024-25	around 60.6	31	around 27.7

(2)

The breakdown of the approved establishment of the GCMTI in the past 3 years is as follows –

Rank	Number of post		
	2022-23	2023-24	2024-25
Senior Chemist	1	1	1
Chemist	3	4	4
Pharmacist	1	1	1
Scientific Officer (Medical)	14	14	14
Science Laboratory Technologist	1	1	1
Science Laboratory Technician I	2	3	3
Science Laboratory Technician II	3	3	3
Senior Executive Officer	1	1	1
Executive Officer II	1	1	1
Assistant Clerical Officer	1	1	1
Laboratory Attendant	1	1	1
Total:	29	31	31

(3)

The Department of Health (DH) set up the GCMTI Advisory Committee in 2017 as a platform for stakeholders to advise on the long-term development strategies, measures and specific research proposals of the GCMTI. With the support of the Committee, the GCMTI has completed 10 research and thematic projects in the past 3 years with another 8 projects underway, details of which are set out in the **Annex**.

(4)

The outcomes of the Hong Kong Chinese Materia Medica Standards (HKCMMS) project may not be released every year but announced normally at the end of each research cycle in relation to new references standards for Chinese Materia Medica (CMM) subject to research difficulties and progress. In the past 3 years, the GCMTI has established and released reference standards for 14 CMM in 2024, namely Caryophylli Flos; Changii Radix; Galangae Fructus; Hippophae Fructus; Lycii Fructus; Menthae Haplocalycis Herba; Myrrha; Perillae Folium; Pogostemonis Herba; Poria; Sauropi Folium; Stellariae Radix; Storax and Ziziphi Spinosae Semen. On the other hand, reference standards for the following 13 CMM have been established for release in due course: Agastaches Herba, Ailanthi Cortex, Akebiae Caulis, Angelicae Dahuricae Radix, Armeniacae Semen Amarum, Campsis Flos, Chrysanthemi Flos, Olibanum, Panacis Majoris Rhizoma, Paridis Rhizoma, Sinomenii Caulis, Uncariae Ramulus cum Uncis and Vladimiriae Radix.

The actual expenditures involved in the HKCMMS in the past 3 years are tabulated below:

Financial Year	2022-23	2023-24	2024-25 (Revised Estimate)
Expenditure (\$ million)	6.3	7.9	9.8

Completed and Ongoing Research and Thematic projects of the GCMTI**(i) Projects completed between 2022-23 and 2024-25**

Research/Thematic Projects	Commencement Date	Completion Date	Achievements
DNA method for identification of Bulbus Fritillariae Ussuriensis – a common adulterant found in Bulbus Fritillariae Cirrhosae	October 2019	May 2022	Published the analytical method of the real time polymerase chain reaction (PCR) of Bulbus Fritillariae Ussuriensis
Study on the identification of Ziziphi Spinosae Semen and its commonly confused species	June 2021	November 2022	Published 5 monographs on Ziziphi Spinosae Semen and its commonly confused CMM species
Consolidation of the Preliminary Index of CMM Resources in Hong Kong under the Fourth National Survey of CMM Resources	June 2022	December 2022	A series of tasks including literature reviews, surveys, consultations, fieldwork and the consolidation of the Preliminary Index of CMM Resources in Hong Kong were completed at the request of the National Administration of Traditional Chinese Medicine
Analysis of chemical markers of CMM in Baifeng Wan	December 2021	June 2023	Published a total of 12 analytical methods for the 8 CMM in Baifeng Wan
Building of the Digitalised Chinese Medicines Information Platform (Phase II)	March 2022	December 2023	Built the Digital Herbarium for Chinese Medicines (DHCM) platform and public website featuring 220 commonly used CMM, 3-Dimensional (3D) images, virtual reality tours and special topics on knowledge related to Chinese medicines, etc.

Research/Thematic Projects	Commencement Date	Completion Date	Achievements
Identification of tiny seed and fruit types of CMM	April 2022	May 2024	Published 30 monographs on tiny seed and fruit types of CMM with corresponding identification key
Pilot Study on the Analysis of Chemical Markers in Compound Chinese Medicine Granules	January 2024	September 2024	Provided reliable information in related fields for future research and application, and determined the feasibility of new studies
Analysis of chemical markers in proprietary Chinese medicines (pCms) containing Psoraleae and Ginseng	July 2023	December 2024	Developed a set of highly versatile testing methods for the analysis of chemical markers that can extensively test different formulations and dosage forms of pCms categorised as nourishing and Yang invigorating
Study on the identification of Ziziphi Spinosae Semen and its commonly confused species by DNA method	June 2023	December 2024	Developed a testing method using PCR-restriction fragment length polymorphism (PCR-RFLP) technology for quickly and effectively distinguishing Ziziphi Spinosae Semen from its commonly confused CMM species
Survey of CMM Resources under the Fourth National Survey of CMM Resources (Phase II) – Survey on Hong Kong's CMM market and traditional knowledge	May 2023	March 2025	Conducted literature reviews, online surveys, questionnaires, interviews and on-site surveys to gather information on the CMM (including decoction pieces) available in Hong Kong's CMM market, as well as application knowledge of regional medicines inherited in the local context

(ii) Ongoing projects

- Collection of specimens of Daodi medicinal materials of China and South Eastern Asia herbal medicines for the CMs Herbarium of the GCMTI
- Collection of specimens of Western herbal medicines and Lingnan herbal medicines for the CMs Herbarium of the GCMTI
- Building of 3D CMM Images for the DHCM
- Establishment of reference DNA Sequence Library for CMM (Phase II)
- Survey of CMM Resources under the Fourth National Survey of CMM Resources (Phase II) – Collection of medicinal plant specimens of Hong Kong (Winter and Spring)
- Macroscopic and Microscopic Identification of Cortex type of Decoction Pieces Commonly Found in Hong Kong
- Study on the Identification of Radix or Rhizoma Podophylli emodis and its Confused Species by DNA Method
- Analysis of Chemical Markers in Compound Chinese Medicine Granules

- End -

CONTROLLING OFFICER'S REPLY

HHB233

(Question Serial No. 0609)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (3) Health Promotion

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The Department of Health has launched since last April the two-year Pilot Alcohol Cessation Counselling Service (Pilot Programme) through subvention to the Tung Wah Group of Hospitals to provide free counselling service for people identified to have probable alcohol dependence. In this connection, will the Government please inform this Committee of:

- (1) the number of clients receiving counselling service since the launch of the Pilot Programme;
- (2) the total amount of subsidy for the two-year Pilot Programme; and
- (3) the Government's plan to reduce alcohol-related harm besides the Pilot Programme?

Asked by: Hon LAI Tung-kwok (LegCo internal reference no.: 18)

Reply:

The Government adopts a multi-pronged approach, comprising publicity and education, law enforcement, promotion of alcohol screening, etc., to reduce alcohol-related harm. The relevant initiatives include:

- (i) The Department of Health (DH) has launched a publicity and education campaign named "Understanding Alcohol Harm" since 2022 to enhance the public's understanding of the health risks associated with alcohol consumption through various channels. Through a website, the DH disseminates information on alcohol-related harm to the public, and provides online risk assessment of drinking behaviour, personalised health advice, self-help tools, health education resources, etc. to encourage drinkers to change their drinking behaviour for the sake of their health.
- (ii) District Health Centres (DHCs) and District Health Centre Expresses (DHC Expresses) provide primary healthcare services to citizens, including the Life Course Preventive Care which is an evidence-based and comprehensive health strategy that emphasises prevention and personalised needs. It provides guidance on the health needs of citizens across different life stages and assists citizens in developing a healthy lifestyle, including early identification and intervention of high-risk drinking behaviours through the Health

Risk Factors Assessment and providing alcohol abuse prevention advice, with a view to enhancing the overall health of the Hong Kong citizens.

- (iii) The DH recommends the Alcohol Screening and Brief Intervention (A-SBI) tool to primary healthcare service providers, including organisation of online training for the staff of the DHCs and DHC Expresses to encourage regular use of the A-SBI tool for early identification and management of at-risk drinkers, as well as referral of those with probable alcohol dependence to the relevant services.
- (iv) The DH has also launched the Pilot Alcohol Cessation Counselling Service (Pilot Programme) through subvention to a non-governmental organisation. The Pilot Programme was launched on 8 April 2024 and will last for 2 years to provide free counselling service for Hong Kong residents identified to have probable alcohol dependence. The service comprises 3 components, namely initial assessment, evidence-based individual counselling intervention, and subsequent evaluation follow-up.
- (v) Since 2018, the DH has been enforcing the Dutiable Commodities (Amendment) Regulation 2018 to prevent youth access to alcohol. The sale and supply of intoxicating liquor to minors in the course of business are prohibited under Part 5 of the Dutiable Commodities (Liquor) Regulations (Cap. 109B). It also requires vendors which sell or supply intoxicating liquor in face-to-face distributions to display a prescribed notice in a prominent position at the premises in the course of business. The DH conducts inspections and carries out enforcement actions upon receipt of intelligence or complaints. It may conduct inspections, either randomly or targeted, to check whether vendors have complied with the relevant requirements.

As at the end of December 2024, a total of 124 eligible individuals have enrolled for and started receiving the service provided under the Pilot Programme. Its revised estimate for 2024-25 and estimate for 2025-26 are both \$960,000, totalling \$1.92 million.

The DH will continue to reduce alcohol-related harm through various means and will closely monitor local alcohol consumption through periodic surveys, including the situation following the reduction in the duty for certain types of liquor.

- End -

CONTROLLING OFFICER'S REPLY

HHB234

(Question Serial No. 1746)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention, (3) Health Promotion, (5) Rehabilitation

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Regarding the estimate for Programme (2) Disease Prevention, please inform this Committee of the specific preventive healthcare provided to primary and secondary school students, the respective expenditures incurred, along with the expenses of Child Assessment Centres. Given that healthy eating and weight management are vital for students during their critical period of growth, please advise on the implementation and coverage of initiatives such as “EatSmart School Accreditation Scheme”, “Salt Reduction Scheme for School Lunches” and “Joyful Fruit Month” aimed at enhancing the quality of school meals for students, along with the expenditure of each initiative.

Asked by: Hon LAM Lam, Nixie (LegCo internal reference no.: 5)

Reply:

Under Programme (2) Disease Prevention, the Student Health Service Centre (SHSC) of the Department of Health (DH) provides free annual health assessment for eligible primary and secondary school students with the aim of identifying students with health problems at an early stage for timely advice and intervention. Students are provided with a series of health services designed to cater for their health needs at various stages of their development. Students found to have health problems will be referred to Special Assessment Centres under the Student Health Service, specialist clinics of the Hospital Authority, or other organisations as appropriate for further assessment or management. The revised estimate for the SHSC of the DH in 2024-25 is \$252 million.

Under Programme (3) Health Promotion, the “EatSmart@school.hk” Campaign was launched in the 2006/07 school year with 3 major components: the “EatSmart School Accreditation Scheme” (ESAS), the “Salt Reduction Scheme for School Lunches” and the “Joyful Fruit Month”. The ESAS aims to make the primary school environment favourable and sustainable for the practice of healthy eating, bringing tangible improvements to school lunch and snacks. As at 28 February 2025, over 300 primary schools have enrolled in the ESAS, of which 130 have achieved various levels of accreditation. For the 2023/24 school year, 12 participating school lunch suppliers supplied sodium-reduced lunches to about 500 primary schools in Hong Kong. Held every April, the annual “Joyful Fruit Month” aims to promote

daily fruit eating habit among students. In the 2023/24 school year, over 1 600 pre-primary institutions, as well as primary, secondary and special schools with over 560 000 students participated in the event. The expenditure for implementing the above programmes is absorbed by the DH's overall provision for health promotion and cannot be separately identified. In addition, the DH launched the Health Promoting School Programme as a pilot project in 30 primary and secondary schools from the 2019/20 to 2022/23 school years. Renamed as the Whole School Health Programme, the pilot programme has been regularised since the 2023/24 school year to help participating schools become Health Promoting Schools that are beneficial to living, learning and working. It is announced in the Chief Executive's 2024 Policy Address that the programme will be strengthened and extended to cover all primary and secondary schools in Hong Kong. Health reports will be compiled for each school to recommend targeted school-based health promotion measures for physical activities, meals and other matters, to improve students' physical and psychological well-being. As at 28 February 2025, a total of 762 schools have participated in the programme, covering about 65% of all primary and secondary schools in Hong Kong. The financial provision for implementing the Whole School Health Programme in 2025-26 is about \$31 million.

Under Programme (5) Rehabilitation, the Child Assessment Service (CAS) of the DH provides comprehensive and specialised assessment services for children under 12 years of age who are suspected to have developmental problems. The revised estimate for the CAS in 2024-25 is \$158 million.

- End -

CONTROLLING OFFICER'S REPLY

HHB235

(Question Serial No. 1747)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention, (3) Health Promotion

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

To further promote women's health, it is essential to enhance health promotion and education besides implementing universal screening. Regarding the expenditure under Programme (3) Health Promotion, please advise on the measures included in the Department of Health's publicity and education activities on women's health under a life-course framework along with the expenditure incurred; the respective expenditures on various public gynaecological screening and preventive programmes (including the Cervical Screening Programme, the Breast Cancer Screening Pilot Programme, the human papillomavirus vaccination programme for school girls).

Asked by: Hon LAM Lam, Nixie (LegCo internal reference no.: 6)

Reply:

The Department of Health (DH) adopts a life-course approach to safeguard the health of women. This includes various measures, provision of health information and health promotion activities targeted at women at different stages in life, from birth through schooling, adulthood, employment, pregnancy to advancing into old age.

The DH provides parents of infants and young children with childcare and parenting educational information through child health service of Maternal and Child Health Centres (MCHCs), which includes breastfeeding, nutrition and healthy lifestyles, child care, home safety, immunisation, child development and social emotional development and parent-child bonding and communication, with a view to promoting and safeguarding children's health. Besides clinical service, the DH also disseminates the information through other channels, including websites, printed materials, promotional videos, social media, media interviews, public talks and workshops for parents. For children with early signs of behavioural problems, the MCHCs encourage their parents to attend more in-depth "Positive Parenting Programme" to improve their parenting skills.

To help young children develop healthy lifestyles from an early age, the DH launched the "StartSmart@school.hk" Campaign in 2012 in collaboration with the Education Bureau, the Leisure and Cultural Services Department and key stakeholders concerning pre-primary

education and children's health. The campaign targets kindergartens and child care centres through a school-based setting. With effective health education resources and training, it aims to encourage and support schools, parents and caregivers to create a conducive environment for young children in respect of healthy diets and physical activity in the school and at home. Furthermore, to reduce the sugar intake of preschool students from drinks, the DH has drawn up the Healthy Drinks at School Charter under the said campaign in the 2018/19 school year. Kindergartens and child care centres signing the Charter have committed to encouraging young children to drink water and to providing them with healthy drinks. According to the Charter, they promise not to offer drinks with added sugar or with a relatively high sugar content, nor to reward children with food.

To help children develop a healthy lifestyle at an early age when they start school, the DH has launched the Whole School Health Programme (WSHP), making reference to the "Health Promoting School (HPS) Framework" advocated by the World Health Organization (WHO). Through guidelines and checklist, as well as health reports compiled for each participating school providing recommendations on targeted school-based measures, the DH assists schools in reviewing and formulating measures to promote physical activity, healthy eating, mental health and social well-being, and gradually becoming Health Promoting Schools that are beneficial to living, learning and working. The DH provides health promotion activities for students such as outreach health talks at schools, covering healthy lifestyle, mental health and social well-being, with topics related to sex education such as changes during puberty and safer sex.

With a view to lowering children's risk of diseases associated with eating habits, the DH, the Education Bureau and stakeholders from various sectors jointly launched the "EatSmart@school.hk" Campaign (ESS Campaign) in primary schools over the territory in the 2006/07 school year. The ESS Campaign consists of 3 major components: EatSmart School Accreditation Scheme (ESAS), Salt Reduction Scheme for School Lunches and Joyful Fruit Month (JFM). Through accreditation, the ESAS provides guidance and assistance for schools to develop a sustainable healthy eating environment on campus. The Salt Reduction Scheme for School Lunches aims to enhance the collaboration with lunch suppliers to reduce the sodium content in school lunches, whereas the JFM promotes an atmosphere that encourages fruit consumption to cultivate the daily habit of eating fruit among students. These initiatives are well received by schools, and are enthusiastically supported by various sectors.

For women of childbearing age, the DH disseminates health messages according to their needs through antenatal, postnatal, family planning and cervical screening services provided by the MCHCs. The health messages cover common diseases affecting women and related examinations, healthy lifestyles, family planning and preparation for pregnancy, healthy diets during pregnancy and lactation, breastfeeding, antenatal and postnatal care, mental health and bone health, with a view to enhancing women's health awareness and promoting healthy habits, as well as reducing disease risks. Apart from services provided by the clinics, the DH also disseminates the relevant information through various channels, including websites, printed materials, promotional videos, social media and public talks.

As far as the workplace is concerned, the DH, in conjunction with the Labour Department and the Occupational Safety and Health Council, launched the "Joyful@Healthy Workplace" programme in 2016, followed by the "Mental Health Workplace Charter" in 2019 to create a

healthy and pleasant working environment by encouraging collaboration between employers and employees. In addition to promoting healthy eating and physical activities, it also emphasises mental health in the workplace, encourages active listening and communication to facilitate early identification and management of mental distress.

Given that cancer prevention and control remain an important aspect of women's health, the DH has been promoting healthy lifestyles (including avoidance of smoking and alcohol, maintaining a healthy diet, regular physical activities and achieving a healthy weight and waist circumference) as the primary strategy for cancer prevention. The DH places significant emphasis on public education about cancers in women (including breast and cervical cancers) to promote public awareness and prevention of these cancers. Information is disseminated through websites, printed materials, articles, social media, online publicity, education hotlines, media interviews, and so on.

In respect of elderly women, the 18 Visiting Health Teams under the DH's Elderly Health Service (EHS) reach out to the community in collaboration with other elderly service providers to organise health promotion activities for elderly persons and their carers, aiming to promote healthy ageing, enhance elderly self-care and reduce their disease risks. The training topics cover a wide array of areas, including healthy diets, physical activities, reduction of alcohol-related harm, mental health promotion, injury prevention and sexual health. In addition, the EHS also compiles health education materials and supports non-governmental organisations in organising health education activities so as to promote healthy lifestyles, improve self-care capabilities of elderly persons and help them prevent diseases.

The expenditure associated with the above measures and activities is absorbed within the overall provision for the DH and cannot be separately identified.

The information on the Cervical Screening Programme (CSP), Breast Cancer Screening Pilot Programme (BCSPP) and human papillomavirus (HPV) vaccination programme is set out below:

- (a) The expenditure involved in the CSP is absorbed within the overall provision for the DH's Family Health Service (FHS) and cannot be separately identified.
- (b) The expenditure involved in Phase I of the BCSPP is absorbed within the overall provision for the DH's WHCs and EHCs and cannot be separately identified. Acting on the recommendations of the Expert Working Group, the Government is now preparing for Phase II of the BCSPP, which is expected to be launched around the second quarter of 2025. Details will be announced in due course.
- (c) The DH has launched a programme to administer HPV vaccines to Primary 5 and Primary 6 school girls as part of the Hong Kong Childhood Immunisation Programme (HKCIP) since the 2019/20 school year. The number of Primary 5 and Primary 6 girls receiving HPV vaccines and the expenditure on the vaccine procurement in each school year since the launch of the vaccination programme are tabulated as follows:

School Year	2019/20	2020/21	2021/22	2022/23	2023/24

Number of Vaccine Recipients	22 200#	46 300	48 400	53 600	51 600
Expenditure on vaccine procurement (\$ million) ^	19.0	37.4	45.8	55.6	56.5

Only Primary 5 female students received HPV vaccines in the 2019/20 school year.

^ HPV vaccination usually begins in the second term of a school year, and the vaccine procurement expenses are calculated from December each year to November of the following year.

In 2022, the WHO further recommended the provision of catch-up vaccinations to girls aged between 9 and 18. The Scientific Committee on Vaccine Preventable Diseases under the Centre for Health Protection also agreed earlier to expand the target group of HPV vaccination to older girls aged 18 or below. Taking into account the scientific evidence, the Government has decided to launch a one-off HPV Vaccination Catch-up Programme (the Catch-up Programme) in phases starting from December 2024, for female Hong Kong residents who were born between 2004 and 2008, and have not been covered by the HKCIP (i.e. girls aged 18 or below as in 2022, and not being covered by the existing programme) to receive free HPV vaccination, over a period of about 2 years. The total time-limited provision for the Catch-up Programme is \$242.8 million (comprising \$16.2 million for 2024-25, \$121.3 million for 2025-26 and \$105.3 million for 2026-27).

- End -

CONTROLLING OFFICER'S REPLY

HHB236

(Question Serial No. 1749)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The Government will revamp maternal and child health and family-planning services to strengthen pre-pregnancy counselling and parental education and promote healthy fertility. In this connection, please advise on the operating expenses of Maternal and Child Health Centres responsible for promoting the health of pregnant women, infants and children. With the official launch of the Primary Dental Co-care Pilot Scheme for Adolescents this March, where adolescents will be subsidised for dental check-ups at private dental clinics and helped to form a habit of regular oral check-ups, please also advise on the expenditure on and the number of participants of the Scheme.

Asked by: Hon LAM Lam, Nixie (LegCo internal reference no.: 8)

Reply:

The Maternal and Child Health Centres (MCHC) under the Department of Health (DH) provide a range of health promotion and disease prevention services for all children from birth to 5 years of age and women of reproductive age. Services for children include immunisation, monitoring of children's health and development and parenting education, whereas those for women include antenatal and postnatal services as well as family planning and cervical screening services. In addition, the DH has been offering service on fertility preparation to those planning to start a family. For example, the MCHCs provide family planning services for women of reproductive age, as well as counselling and referrals for women with subfertility problems.

It is set out in The Chief Executive's 2024 Policy Address that the DH will strengthen pre-pregnancy counselling and parental education and promote healthy fertility. In view of this, the DH will introduce new pre-pregnancy health services at MCHCs in phases for women of reproductive age, providing medical checkups, blood tests and other investigations, as well as nutritional dietary and lifestyle advice with a view to aligning with the Government's policy of encouraging and promoting healthy fertility and further protecting and advancing maternal and child health. It is also set out in The Chief Executive's 2024 Policy Address that the DH will also review and adjust the scope of family planning service currently subsidised by

the Government under the Family Planning Association of Hong Kong to tie in with the Government's policy of encouraging and promoting healthy fertility.

The provision for the above services is absorbed within the overall provision for the DH's Family Health Service and hence cannot be separately identified.

The DH launched the Primary Dental Co-care Pilot Scheme for Adolescents (PDCC) on 20 March this year as an interface with the School Dental Care Service by providing partial subsidies for private dental check-up services for adolescents aged between 13 and 17 on a co-payment basis to foster their partnership with dentists and maintain the good life-long habit of regular oral check-ups for prevention of dental diseases. Adolescents from age 13 to 17 (or will turn 13 in the calendar year when applying to join the PDCC) who hold a valid Hong Kong Identity Card and have registered in the Electronic Health Record Sharing System (eHealth) are eligible to join the PDCC. About 370 000 adolescents are eligible to join each year. While the Government will provide a subsidy of \$200 each time, participants have to pay a co-payment fee as determined by their selected dentists. The co-payment for the subsidised services each time as recommended by the Government is \$200. As at 18 March, there are around 270 registered dentists whose application to participate in the PDCC has been accepted by the DH, providing services at over 370 service locations. Among these dentists, over 67% charge a co-payment amount of \$200 or less while the minimum co-payment amount is \$50. The DH has publicised the PDCC in collaboration with the Education Bureau to all secondary school students and their parents in the territory. The final number of participants will depend on the response from students and their parents.

The Government's financial provision for implementing the PDCC and the Community Dental Support Programme in 2025-26 is \$136.3 million.

- End -

CONTROLLING OFFICER'S REPLY

HHB237

(Question Serial No. 3223)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions, (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Currently, over 400 outsourced health surveillance staff are deployed daily at various boundary control points, which has driven the relevant expenditure up to \$400 million last year, representing a 90% surge compared to pre-pandemic levels. However, a total number of more than 5 500 travellers (with 1 at the private car kiosks) only were identified with fever from 2023 to May 2024 with no cases requiring compulsory hospital admission. In this connection, will the Government please inform this Committee of the cost-benefit assessment results concerning the expenditure incurred, and whether the Government has any plans to introduce a smart body temperature monitoring system to reduce manpower costs; if yes, the detailed timeline, expenditure estimate for its technical testing and the anticipated reduction in the number of outsourced staff and estimated annual savings after full implementation of the system?

Asked by: Hon LAM Lam, Nixie (LegCo internal reference no.: 39)

Reply:

In accordance with the power conferred by the Prevention and Control of Disease Ordinance of Hong Kong and with regard to the guidelines of the International Health Regulations, the Department of Health (DH) enforces various preventive measures at boundary control points (BCPs) to prevent the introduction or spreading of infectious diseases into or out of Hong Kong. The Port Health Division under the DH carries out health screening work at each BCP (including conducting regular body temperature screening for arrivals and setting up health stations). Taking into account the design of each BCP and its traveller and vehicle flow, the DH deploys manpower as appropriate to conduct body temperature screening for all arrivals; and performs, in accordance with the mechanism, further health assessments for travellers with fever or in need (such as travellers who self-reported being unwell) to understand their symptoms, travel history, contact history, etc., in order to make appropriate referrals and follow-up, including compulsory referral of persons with suspected infection of major infectious diseases to Hong Kong public hospitals for checking, advising other travellers with fever or in need to seek medical treatment at medical institutions with issuance of referral letters, and assisting persons in need to call for ambulance service for further treatment at Accident and Emergency Department.

The Hong Kong Special Administrative Region (HKSAR) Government has been maintaining close co-operation with entry-exit health inspection and quarantine authorities of the Mainland to safeguard the well-being and safety of residents and travellers of the 2 places. The Health Bureau and the General Administration of Customs of the People's Republic of China (GACC) signed the Co-operation Arrangement for Entry-exit Health Inspection and Quarantine between the GACC and the Health Bureau of the HKSAR Government in 2023. Under the normalisation arrangements for epidemic prevention and control, the 2 parties agreed to focus on the health inspection and quarantine of their respective inbound personnel travelling between the HKSAR and the Mainland BCPs.

The HKSAR Government will maintain close liaison with the relevant Mainland authorities and, taking into account factors such as cost-effectiveness and appropriateness, actively review the entry health inspection and quarantine arrangements (including temperature screening) from the public health perspective.

From 2020 to 2024, the average number of health screening shifts of the DH per day at various BCPs (some health screening posts involve more than 1 shift according to the operation of BCPs) is as follows:

	2022	2023	2024
Total Number of Health Screening Posts	880	751	722

Note:

The DH redeploys health screening posts in view of the actual circumstances. Some of the posts at BCPs where operation has been suspended would be redeployed to other BCPs. Health screening service of Kai Tak Cruise Terminal and Ocean Terminal was not included as it was only provided during stopover of cruises.

The expenditure incurred by health screening shifts listed in the table above is set out below:

	Financial Year		
	2022-23	2023-24	2024-25
Total Expenditure (\$ million)	239	240	205

From 2022 to 2024, the number of inbound travellers confirmed with fever during temperature screening at BCPs, along with the number of those compulsorily referred to public hospitals upon fulfilling the reporting criteria of any major infectious disease are set out below:

	2022	2023	2024
Total Number of Inbound Travellers with Fever	135	4 759	4 214
Number of Inbound Travellers Compulsorily Referred to Public Hospitals upon Fulfilling Reporting Criteria of Any Major Infectious Disease	250	61	6

Note:

The compulsory isolation arrangement imposed on persons infected with Coronavirus Disease 2019 (COVID-19) has been rescinded with effect from 30 January 2023.

Ongoing health screening, which facilitates early identification of potential infectious diseases imported into Hong Kong, is vital to safeguarding public health. Currently, health screening measures are in place for inbound travellers at all BCPs between Hong Kong and the Mainland.

The DH mainly employs an Infrared Thermal Imaging System at various BCPs to detect the body temperatures of multiple travellers simultaneously to reduce the manpower required for such work. However, drivers and all passengers in a cross-boundary private car are allowed to remain in their vehicle while passing through the kiosks of the Immigration Department, the Customs and Excise Department and the DH without the need to get off from the vehicle or go to the traveller's clearance hall. Due to site constraints, the Infrared Thermal Imaging System cannot be used to measure the forehead temperature of drivers and passengers passing through the vehicle lanes. As a result, hand-held infrared thermometers are used to measure the body temperature of inbound passengers on board the vehicles at the DH vehicle kiosks.

The DH reviews the health screening arrangements from time to time and deploys manpower as appropriate at various BCPs according to the actual circumstances to provide appropriate services for inbound travellers. For instance, the additional personnel deployed during the COVID-19 epidemic in the light of the actual needs have been reduced after the epidemic, and the manpower at relevant BCPs has basically returned to the pre-epidemic level. Meanwhile, the DH also keeps a close eye on technological development and actively explores the adoption of innovative technology in collaboration with other departments at BCPs to reduce the manpower need for health screening and optimise the use of human resources.

- End -

CONTROLLING OFFICER'S REPLY

HHB238

(Question Serial No. 0326)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

It is learned that the Drug Office (DO), short of frontline pharmacists, needs longer processing time for drug approval and registration. The “1+” mechanism, in place for the approval of drugs with a new chemical entity (NCE drugs), will not enhance the registration efficiency for generic drugs (i.e. interchangeable drugs launched after the patent expiry of the innovator product). Normally far lower in price than their innovator counterparts, generic drugs can promote market competition and help slash drug prices. In this connection, will the Government please inform this Committee of:

- 1) the respective number of generic drugs and NCE drugs pending approval and registration by the DO;
- 2) the average and longest time taken from submission of application to completion of approval of generic drugs and NCE drugs in each of the past 3 years;
- 3) the staff establishment (including pharmacists and other staff members) of the DO for approving drugs and the number of vacancies; and
- 4) the frontline staff establishment for approving drugs of the Hong Kong Centre for Medical Products Regulation planned for development?

Asked by: Hon LAM Tzit-yuen (LegCo internal reference no.: 5)

Reply:

As mentioned in the Chief Executive's Policy Address in 2023 and 2024, the HKSAR Government will enhance the current evaluation and registration mechanism for drugs, and establish an internationally renowned regulatory authority of drugs and medical devices. To this end, the HKSAR Government set up a Preparatory Office for the Hong Kong Centre for Medical Products Regulation (CMPR) in the Department of Health (DH) in June 2024. The Preparatory Office is proactively reviewing the regulatory functions of the DH, including the regulation of Chinese and Western medicines and medical devices; studying the potential restructuring and strengthening of the regulatory and approval regime for medicines, medical devices and medical technology; and putting forward proposals and steps for the establishment of the CMPR which will be a step towards the transition to the “primary evaluation” approach in approving applications for registration of new medical products.

This will help accelerate the clinical application of new drugs and medical devices, and foster the development of emerging industries related to the research and development (R&D) as well as testing of medical products. The Preparatory Office is drawing up the timetable for establishing the CMPR and the roadmap towards adoption of “primary evaluation”, and will announce them in the first half of 2025 as scheduled.

(1) and (2)

According to the Pharmacy and Poisons Ordinance (Cap. 138), pharmaceutical products must satisfy the criteria of safety, efficacy and quality for registration with the Pharmacy and Poisons Board of Hong Kong (the Board) before they can be sold or supplied in the Hong Kong Special Administrative Region (HKSAR). To facilitate proper execution of the approval of pharmaceutical products, the Drug Office (DO) of the Department of Health (DH) is responsible for providing professional and executive support for the Board and its Pharmacy and Poisons (Registration of Pharmaceutical Products and Substances) Committee (Registration Committee).

Applications for pharmaceutical products registration in Hong Kong are classified into two main categories, namely pharmaceutical products with new chemical or biological entities (containing active ingredients which have not been registered in Hong Kong, i.e. new drugs) and those without new chemical or biological entities (i.e. generic drugs).

In general, applicants for new drug registration are required to, in accordance with the Guidance Notes on Registration of Pharmaceutical Products Containing a New Chemical or Biological Entity as promulgated by the Board, provide documentary proof for registration issued by at least 2 drug regulatory authorities of specified reference places in order to provide supporting evidence that relevant products have been rigorously evaluated before being placed on the market (i.e. the “secondary evaluation” approach). To enhance the drug regulatory regime and implement the “primary evaluation” approach in the long run, the Board has launched on 1 November 2023 the “1+” mechanism for approval of new drugs and widened its applicability to all new drugs on 1 November 2024. For pharmaceutical products containing new chemical or biological entities that are supported with local clinical data and scope of application recognised by local relevant expert, applicants concerned are only required to submit approval from 1 reference drug regulatory authority (instead of the 2 or more) to apply for registration in Hong Kong. On the other hand, applications for new drugs should be submitted to the Registration Committee under the Board for approval. In such cases, legislative amendments and gazettals are required in order to incorporate the new chemical entities into the relevant schedules to the ordinance. To expedite the registration of new drugs, the Government has made amendments to the Pharmacy and Poisons Ordinance (Cap. 138) in 2015, enabling legislative amendments relating to the incorporation of new drugs be made via negative vetting procedures.

For generic drugs, applicants are only required to submit, apart from general documents and reports (such as labelling and stability reports), evidence demonstrating that the specifications of such products have complied with the requirements of relevant pharmacopoeia or quality standards. For generic drugs manufactured or registered outside Hong Kong, a free sale certificate/approval issued by the drug regulatory authority of the country of origin, as well as the evidence showing the manufacturer’s compliance with the Pharmaceutical Inspection Co-operation Scheme (PIC/S) Good Manufacturing Practice are required. As generic drugs have already been supported by comparable data and literature in respect of safety and

efficacy, the Registration Committee has streamlined the approval procedures and empowered the DO to expedite the processing of applications in accordance with the approval criteria as promulgated by the Board.

In addition to the Board’s website, the DO has, with a view to helping the pharmaceutical industry better understand the registration requirements of pharmaceutical products, uploaded to its website detailed guidance notes and a short introductory video on application for pharmaceutical products registration. A hotline is set up to answer industry enquiries, and regular meetings with industry representatives are held to explain the relevant registration requirements.

The DH has pledged to process at least 90% of applications for pharmaceutical products registration in support of the Board within 5 months upon submission of all required documents by the applicants. From 2022 to 2024, all applications have been processed within 5 months upon submission of the required documents by the applicants. The number of approved pharmaceutical products is set out in detail as follows:

	Year		
	2022	2023	2024
Number of Approved Pharmaceutical Products			
Generic Drugs	282	291	341
New Drugs	92	98	102
All Pharmaceutical Products	374	389	443

The Board and the DH do not maintain statistics on the average and longest time taken for the approval of new drugs registration.

(3)

The Drug Registration Units of the DO are responsible for the work on drug approval, such as handling new applications for pharmaceutical products registration, their renewal applications, and the change of registered particulars. As at 1 February 2025, the staff establishment and vacancies of the units are set out as follows:

Rank	Number of Posts	Vacancies
Senior Pharmacist	3	0
Pharmacist	20	0
Scientific Officer (Medical)	2	0
Other Staff (including Executive Officer II, Clerical Officer, Assistant Clerical Officer, Clerical Assistant and Office Assistant)	10	1
Total	35	1

In response to the evolving landscape of drug regulation, the DO has stepped up its work on drug registration by internal redeployment of resources and employment of 6 additional non-civil service contract staff (Registered Pharmacist). Starting from April this year, 4 Pharmacists will be seconded from the Hospital Authority to the DO in phases to support, among others, drug approval work under the “1+” mechanism.

(4)

The Legislative Council has approved the creation by the DH of 4 permanent directorate posts/non-civil service positions (including 1 Controller, 1 Deputy Controller and 2 Assistant Controller positions) in 2025-26 to provide dedicated support for the CMPR to launch various initiatives, as well as to formulate and introduce more stringent regulatory and approval regimes for medicines and medical devices in accordance with the “primary evaluation” approach. The creation of the above positions will be accompanied by the deletion of 4 existing permanent Consultant posts.

In addition, the DH will consolidate and re-organise the existing functions in relation to the regulation of Chinese and Western medicines and medical devices, and then put them under the purview of the CMPR to be established. This can make fuller use of the existing highly efficient regulatory regime to bring about greater benefits and synergies. In this way, the CMPR can also centralise relevant expertise and optimise resource allocation, with the aim of supporting the approval of innovative medical products, promoting the scientific advancement of medicines, medical devices and medical technology, and expediting their clinical application, thereby driving the development of industries relating to the R&D as well as testing of medical products. The said reorganisation involves the redeployment of 7 existing permanent directorate posts (including 2 Assistant Directors, 3 Chief Pharmacists and 2 Principal Medical and Health Officers) and about 420 non-directorate posts.

The DH will continue to review the integration of various functions of the CMPR, as well as the manpower and resources required.

- End -

CONTROLLING OFFICER'S REPLY

HHB239

(Question Serial No. 0329)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

October to November each year is noted to be the peak season for the public to seek influenza vaccination from private doctors, who are unable to gauge in advance people's demand for such vaccination. As each batch of vaccines expires by the end of a particular year, doctors procure as their first batch only a limited quantity of influenza vaccines, which may turn out to be too few to meet public demand. When doctors proceed with procuring the second batch, which often takes more than a month, few are in line for vaccination by the time the replenishment arrives as in doctors' experience public enthusiasm for vaccination declines over time. In this connection, will the Government advise this Committee on whether it will consider adopting a practice as in the COVID-19 pandemic to conduct centralised procurement of influenza vaccines for distribution to private doctors; if yes, the details; if no, the reasons?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 8)

Reply:

The Department of Health (DH) has been vigilant in tracking the overall market supply of seasonal influenza (SI) vaccines, maintaining contact with vaccine suppliers to ensure a steady supply for the Government's vaccination programmes/schemes. In the primary interest of public health, the DH ought to ensure that SI vaccines are reserved for priority vaccination of high-risk groups. Under the current established arrangement, private doctors enrolling in the Vaccination Subsidy Scheme (VSS) are required to procure their own SI vaccines. The DH has consistently reminded them to monitor and assess the supply of and demand for SI vaccines to ensure early procurement. Based on past experience, the overall supply of SI vaccines in the private market has remained stable.

Regarding the seasonal influenza vaccination programme in 2025-26, the Government is exploring the feasibility of procuring a portion of the SI vaccines for private doctors enrolled in the VSS, and has been liaising with vaccine suppliers to gain a better understanding of the market supply. Details will be announced in due course.

- End -

CONTROLLING OFFICER'S REPLY

HHB240

(Question Serial No. 0330)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

In 2023, the Department of Health launched the three-year Elderly Health Care Voucher Pilot Reward Scheme, under which an elderly person who has an accumulated use of vouchers of \$1,000 or more for designated primary healthcare purposes such as disease prevention and health management in a year will be allotted \$500 reward automatically to his or her voucher account by the eHealth System. In this connection, will the Government please inform this Committee of the total number of people allotted the reward since the implementation of the Scheme and the total value of the rewards in money terms?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 9)

Reply:

In accordance with the Primary Healthcare Blueprint (Blueprint) launched in December 2022, the Government will strive to direct resources towards primary healthcare services with an emphasis on strengthening chronic disease management and reinforcing the different levels of prevention. To tie in with the directions set out in the Blueprint, the Government launched the three-year Elderly Health Care Voucher Pilot Reward Scheme (Pilot Reward Scheme) in November 2023 to further incentivise elderly persons by offering rewards to them to make better use of Elderly Health Care Vouchers (EHCVs) for continuous preventive healthcare and chronic disease management services, etc. It is hoped that the policy objective of the EHVS can be achieved through such optimised use of resources to promote primary healthcare and support the healthcare needs of elderly persons.

Under the Pilot Reward Scheme, elderly persons only need to accumulate the use of EHCVs of \$1,000 or more for designated primary healthcare purposes such as disease prevention and health management services within the same year (from January to December), and they will be automatically allotted a \$500 reward to their voucher accounts by the eHealth System (Subsidies), which can be used for the same designated primary healthcare purposes. No further registration is needed. In other words, for elderly persons who meet the above criterion and are allotted the reward, the amount of EHCVs they receive in that year is increased from \$2,000 to \$2,500.

Since the launch of the Pilot Reward Scheme on 13 November 2023 up until 31 December 2024, a total of 788 975 elderly persons have received the reward, involving a sum of about \$390 million in total. The number of voucher claim transactions used on the designated primary healthcare services was 3 507 731, accounting for 60% of the total voucher claim transactions during the same period, whereas that for the period between January 2023 and mid-November 2023, i.e. prior to the launch of the Pilot Reward Scheme, was 48%. This shows that the Pilot Reward Scheme has the effect of encouraging elderly persons to use the designated primary healthcare services. The Government will keep closely monitoring the implementation of the Pilot Reward Scheme and evaluate its effectiveness in promoting the receipt of health assessment, disease screening and chronic disease management services by elderly persons.

- End -

CONTROLLING OFFICER'S REPLY

HHB241

(Question Serial No. 0332)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Regarding the admission of non-locally trained medical practitioners to Hong Kong, will the Government please advise this Committee on:

- 1) the number of non-locally trained medical practitioners admitted to practise in Hong Kong through the special registration scheme along with where they acquired their medical qualifications, broken down by specialty; and
- 2) whether the Government has any plan in 2025-26 to continue expanding the "List of Recognized Medical Qualifications" in Schedule 1A to the Medical Registration Ordinance; if yes, the details; if no, the reasons?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 11)

Reply:

- 1) According to the information provided by the Medical Council of Hong Kong (MCHK), since the passage of the Medical Registration (Amendment) Bill 2021 up to 31 December 2024, a total of 119 medical practitioners (including 106 applicants holding recognized medical qualifications and 13 applicants transferred from limited registration to special registration) have been granted special registration to practise in Hong Kong. As at 31 December 2024, the special registration of 106 of them has taken effect / was still valid. Among the 106 medical practitioners, 23 have had their names included in the Specialist Register of the MCHK. Their respective specialties are tabulated as follows:

Specialty	Number of medical practitioners
Anaesthesiology	4
Radiology	4
Gastroenterology & Hepatology	3
Public Health Medicine	2
Clinical Oncology	1
Emergency Medicine	1
Family Medicine	1
Geriatric Medicine	1
Medical Oncology	1
Neurosurgery	1
Ophthalmology	1
Otorhinolaryngology	1
Paediatrics	1
Urology	1
Total:	23

The countries/places where the 106 medical practitioners obtained their medical qualifications are tabulated as follows:

Country/Place	Number of medical practitioners
China (except Hong Kong) ^{Note (1)}	10
United Kingdom	69
Australia	15
Canada	4
United States of America	4
South Africa	3
Others	1 ^{Note (2)}
Total:	106

Note:

(1) Including Mainland China, Macao Special Administrative Region and Taiwan.

(2) The medical practitioner under special registration obtained the medical qualification from the Czech Republic.

- 2) In November 2021, the Special Registration Committee (SRC) was established under the MCHK in accordance with the amended Medical Registration Ordinance (MRO) (Cap. 161) to draw up the list of recognized medical qualifications upon review of non-local medical programmes of quality comparable to those run by the 2 medical schools in Hong Kong. The list will be submitted to the Registrar of Medical Practitioners for promulgation as a Legal Notice. To date, a total of 128 non-local medical qualifications have been promulgated as recognized medical qualifications in Hong Kong. The SRC is pressing ahead with assessment of other non-local medical programmes fulfilling the stipulated criteria in order to include suitable programmes in the “List of Recognized Medical Qualifications” in Schedule 1A to the MRO.

- End -

CONTROLLING OFFICER'S REPLY

HHB242

(Question Serial No. 0333)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Regarding the Breast Cancer Screening Pilot Programme, will the Government inform this Committee of:

- 1) the number of participants and effectiveness of the programme so far; and
- 2) whether it has considered expanding the programme or introducing new cancer screening programmes; if yes, the work plan and estimated expenditure?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 12)

Reply:

The Cancer Expert Working Group on Cancer Prevention and Screening (CEWG) under the Cancer Coordinating Committee chaired by the Secretary for Health regularly reviews local and international scientific evidence, with a view to making recommendations to the Government on suitable evidence-based measures for cancer prevention and screening for the local population. Based on the CEWG's recommendations on cancer screening, the Government has rolled out the Cervical Screening Programme, the Colorectal Cancer Screening Programme and the Breast Cancer Screening Pilot Programme (BCSPP).

When considering recommendations for any disease screening, the Government will refer to the evidence-based risk assessment and views of relevant experts from the perspective of public health. A number of factors will be carefully assessed, such as local prevalence of the cancer, accuracy and safety of the screening tests, effectiveness in reducing incidence and mortality rates as well as feasibility of implementation of a screening programme. The perspective of good utilisation of medical resources will be taken into account to determine the priority. Excessive screening under public health programmes not only wastes resources for the overall public health, but also runs out of resources that can be invested on other projects in greater need, and may pose unnecessary health risks to individuals, often causing more harm than good.

Primary prevention (i.e. reducing exposure to cancer risk factors) is the most important strategy for reducing the risk of developing cancer. The Department of Health (DH) has all

along been encouraging members of the public to adopt a healthy lifestyle, including avoidance of smoking and alcohol, healthy diet, regular physical activity and maintenance of a healthy body weight and waist circumference, in order to reduce the risk of non-communicable diseases including cancer.

(1)

Based on the recommendations of the CEWG, the Government adopts a risk-based approach for breast cancer screening and launched Phase I of the BCSPP in 2021. Women aged between 44 and 69 with certain combinations of personalised risk factors (including presence of history of breast cancer among first-degree relatives, a prior diagnosis of benign breast disease, nulliparity or late age of first live birth, early age of menarche, high body mass index and physical inactivity) putting them at increased risk of breast cancer are recommended to consider mammography (MMG) screening every 2 years.

In the two-year Phase I of the BCSPP (which ran from September 2021 to December 2023), a total of 27 807 women aged between 44 and 69 have received breast cancer risk assessment in Woman Health Centres, 4 Maternal and Child Health Centres and 18 Elderly Health Centres. 7 785 (about 28%) of them underwent the MMG screening on referral based on the risk assessment. Among the women with abnormal MMG results who had been referred to specialists for treatment, 409 cases were followed up in public hospitals, among which 68 were confirmed to have breast cancer. The breast cancer detection rate per 1 000 MMG screenings was 8.7, which was comparable to the international standard of about 5 cases per 1 000 MMG screenings. Of the 68 breast cancer cases identified through the MMG screening, 97% were at stage II or below. Following the review of Phase I of the BCSPP, the breast cancer risk assessment and screening have been included as part of the regular services provided by the Woman Health Service and the Elderly Health Service.

The Woman Health Service under the DH will be integrated into the district health network of the Health Bureau Primary Healthcare Commission within 2025. The service points, to be named Women Wellness Satellites, will form a network with District Health Centres (DHCs)/DHC Expresses in all 18 districts across Hong Kong to provide eligible women with prevention-based and more personalised primary healthcare services, including breast cancer screening. In parallel, the DHCs/DHC Expresses actively promote the “Life Course Preventive Care Plan”. In line with the core principles of prevention-oriented and whole-person care, a personalised preventive care plan will be formulated based on the most updated evidence and the health needs of citizens across different life stages. Family doctors and primary healthcare professionals will collaborate to promote healthy lifestyles and disease prevention, including providing education and vaccination for cancer prevention, and advising on cancer screening services according to personal risk factors.

(2)

Based on the recommendations of the CEWG, the Government is now preparing for Phase II of the BCSPP to provide subsidised breast cancer screening services for women at high risk of developing breast cancer (i.e. carriers of certain gene mutations and/or with strong family history of breast cancer or ovarian cancer) through Public-Private Partnership programmes in collaboration with non-governmental organisations. Phase II of the BCSPP, of which details

will be announced in due course, is expected to be launched around the second quarter of 2025.

- End -

CONTROLLING OFFICER'S REPLY

HHB243

(Question Serial No. 0337)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention, (4) Curative Care

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Regarding public dental services in Hong Kong, will the Government inform this Committee of the expenditure on various public dental care services, broken down by type of service, in each of the past 5 financial years, and its proportion to the public healthcare expenditure in that year?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 16)

Reply:

To safeguard the oral health of the public, the Chief Executive announced in the 2022 Policy Address to conduct a comprehensive review of the dental services provided or subsidised by the Government. The Working Group on Oral Health and Dental Care (Working Group) was subsequently established in end-2022. The Working Group published a final report in end-2024, recommending that the future development of dental services should make reference to the direction of the Primary Healthcare Blueprint emphasising prevention, early identification and timely intervention, with the goal of retention of natural teeth and enhancing the overall level of citizens' oral health.

The Government concurs with the views of the Working Group that providing or subsidising comprehensive curative dental services from public purse to all Hong Kong citizens regardless of their financial means does not align with the policy objectives of developing a prevention-oriented oral health and dental care system and encouraging citizens to take responsibility for their own oral health. This would exacerbate the current shortcomings of the treatment-oriented system, and would be neither cost-effective nor sustainable in terms of utilisation of public resources. It would be financially untenable for the Government and would thin out the resources that could otherwise be used for other healthcare services.

In response to the final report of the Working Group, the Government has adopted the oral health policy that: (1) Oral health is an integral component of general health. The Government's oral health policy aims to enable all Hong Kong citizens to improve their oral hygiene and lifestyle conducive to both oral and overall health levels; (2) Through publicity,

education, promotion and development of primary oral health and dental care, the Government facilitates citizens to manage their oral health, and put prevention, early identification and timely intervention of dental diseases into action with the objective of tooth retention; and (3) The Government provides appropriate oral health and dental care services targeting underprivileged groups with financial difficulties and special needs, ensuring these groups have access to essential dental care services.

In the Oral Health Action Plan formulated based on the Working Group's strategic recommendations, the School Dental Care Service (SDCS), the Primary Dental Co-care Pilot Scheme for Adolescents (PDCC), and the dental services provided under the Elderly Health Care Voucher Scheme (EHVS) are rolled out to actively develop prevention-oriented primary oral healthcare according to the strategy of community-wide preventive primary oral health care, while the Hospital Dental Service, the Emergency Dental Service, the Special Oral Care Service (SOCS), the Healthy Teeth Collaboration (HTC), the Outreach Dental Care Programme for the Elderly (ODCP) and the Community Dental Support Programme (CDSP) are services focusing on underprivileged who have difficulties in accessing dental care under the aforesaid strategy of ensuring these groups have access to essential dental care services.

The public dental services provided by the Department of Health (DH) and the expenditures involved are set out below:

(A) The SDCS

The Government focuses particularly on nurturing good oral hygiene habits from an early age including providing the SDCS to children. Primary school students in Hong Kong, as well as students aged under 18 with intellectual disability and/or physical disability studying in special schools, can join the SDCS of the DH to receive annual check-ups at designated school dental clinics, which cover oral examination as well as basic restorative and preventive treatment. The actual expenditures for the SDCS in 2020-21, 2021-22, 2022-23 and 2023-24 and the revised estimate for 2024-25 are as follows:

SDCS	2020-21 (Actual)	2021-22 (Actual)	2022-23 (Actual)	2023-24 (Actual)	2024-25 (Revised estimate)
Annual expenditure (\$ million)	283.8	270.8	276.2	281.6	281.1

(B) Hospital Dental Service, Emergency Dental Service and the SOCS

The DH provides free emergency dental service (generally referred to as General Public (GP) Sessions) to the public through designated sessions each week at 11 government dental clinics. Such services cover treatment of acute dental problems, prescriptions for pain relief, treatment of oral abscess and tooth extraction. The dentists will also provide professional advice based on individual needs of patients. Under the civil service terms of appointment, the Government is obliged to provide dental benefits for civil servants/pensioners and their eligible dependents. Dental clinics under the DH are established primarily for fulfilling this obligation. That said, the Government uses only a small fraction of the service capacity of the dental clinics to provide supplementary emergency dental service to the general public.

In addition, oral maxillofacial surgery and specialist dental treatment are provided by the DH's Oral Maxillofacial Surgery and Dental Clinics in 7 public hospitals for hospital in-patients, and patients with special oral health care needs and dental emergency needs. To improve the oral health of children with intellectual disability, the DH also provides the SOCS for pre-school children under 6 years old with intellectual disability for early intervention and prevention of common oral diseases in collaboration with the Hospital Authority since September 2019.

The expenditures for Hospital Dental Service, Emergency Dental Service and the SOCS in 2020-21 to 2023-24 are absorbed within the DH's overall provision for dental services under Programme (4) and Programme (7) and there is no breakdown available. The revised estimates for Hospital Dental Service, Emergency Dental Service and the SOCS for 2024-25 are \$80.41 million, \$9.60 million and \$4.80 million respectively.

(C) Dental Care Support for Adult Persons with Intellectual Disability

The Government launched a three-year programme named the HTC in July 2018 to provide free oral check-ups, dental treatments and oral health education for adult persons aged 18 or above with intellectual disability. The HTC was further extended from 16 July 2024 to March 2027 with 900 additional quotas for new cases every year and its scope extended to cover persons aged 18 or above with autistic spectrum disorder. The actual expenditures for implementing the HTC in 2020-21, 2021-22, 2022-23 and 2023-24 and the revised estimate for 2024-25 are as follows:

HTC	2020-21 (Actual)	2021-22 (Actual)	2022-23 (Actual)	2023-24 (Actual)	2024-25 (Revised estimate)
Annual expenditure (\$ million)	6.8	11.1	22.8	33.4	46.4

(D) Dental Care Support for Elderly Persons in Residential Care Homes for the Elderly (RCHEs) and Day Care Centres for the Elderly (DEs)

The ODCP has been implemented since October 2014 to provide free on-site oral check-ups for elderly persons and oral care training to caregivers of RCHEs, DEs and similar facilities in the 18 districts of Hong Kong through outreach dental teams set up by non-governmental organisations (NGOs). Free dental treatment will be provided on-site or at a dental clinic if the elderly person is considered suitable for further curative treatments. The outreach dental teams will also design personalised oral care plans for the elderly persons to suit their oral care needs and self-care abilities. The actual expenditures for implementing the ODCP in 2020-21, 2021-22, 2022-23 and 2023-24 and the revised estimate for 2024-25 are as follows:

ODCP	2020-21 (Actual)	2021-22 (Actual)	2022-23 (Actual)	2023-24 (Actual)	2024-25 (Revised estimate)

Annual expenditure (\$ million)	37.8	41.6	48.6	55.8	63.7

(E) Dental Care Support for Financially Disadvantaged Underprivileged Groups

On top of the existing dental grants under the Comprehensive Social Security Assistance (CSSA) Scheme and the emergency dental service provided through the GP Sessions by government dental clinics, the DH will increase the dental services to underprivileged groups with financial difficulties by launching the CDSP in 2025 and enhancing service capacity, increasing service points and expanding service scope, aiming to additionally offer at least twice the current number of quotas provided by the GP Sessions of government dental clinics (i.e. 40 000 per year). The CDSP leverages the networks of NGOs and social welfare organisations serving underprivileged groups to provide services to persons with financial difficulties more effectively. In addition to tooth extraction, the CDSP provides dental fillings where dentists consider appropriate to encourage tooth retention.

(F) Dental Care Support for Adolescents

The DH launched the PDCC on 20 March this year as an interface with the SDCS by providing partial subsidies for private dental check-up services for adolescents aged between 13 and 17 on a co-payment basis to foster their partnership with dentists and maintain the good life-long habit of regular oral check-ups for prevention of dental diseases. Adolescents from age 13 to 17 (or will turn 13 in the calendar year when applying to join the PDCC) who hold a valid Hong Kong Identity Card and have registered in the Electronic Health Record Sharing System (eHealth) are eligible to join the PDCC. About 370 000 adolescents are eligible to join each year. While the Government will provide a subsidy of \$200 each time, participants have to pay a co-payment fee as determined by their selected dentists. The co-payment for the subsidised services each time as recommended by the Government is \$200. As at 18 March, there are around 270 registered dentists whose application to participate in the PDCC has been accepted by the DH, providing services at over 370 service locations. Among these dentists, over 67% charge a co-payment amount of \$200 or less while the minimum co-payment amount is \$50. The DH has publicised the PDCC in collaboration with the Education Bureau to all secondary school students and their parents in the territory. The final number of participants will depend on the response from adolescents and their parents.

The total revised estimate for implementing the PDCC and the CDSP for 2024-25 is \$38.4 million.

Apart from the above public dental services provided by the DH, the EHVS provides eligible Hong Kong elderly persons aged 65 or above with an annual voucher amount of \$2,000 (with an accumulation limit of \$8,000) to subsidise their use of private primary healthcare services, including dental services. The amount of vouchers claimed by dentists/for dental (stomatology) services under the EHVS in the past 5 years are as follows:

Amount of vouchers claimed (\$'000)					
	2020	2021	2022	2023	2024
Dentists in Hong Kong	276,556	355,444	343,327	413,222	402,347
Dental/Stomatology Department of the medical institutions in the Greater Bay Area (GBA) ^{Note}	316	302	170	462	17,408

Note : The medical institutions in the GBA cover two service points operated by the University of Hong Kong-Shenzhen Hospital and 7 pilot medical institutions under the Elderly Health Care Voucher GBA Pilot Scheme. The Department of Stomatology at the Nansha Division of the First Affiliated Hospital, Sun Yat-sen University is pending service launch.

The recurrent public/government expenditures on healthcare in the past 5 financial years are as follows:

Policy area group	2020-21 (Actual)	2021-22 (Actual)	2022-23 (Actual)	2023-24 (Actual)	2024-25 (Revised estimate)
Expenditure on health (\$ billion)	87.598	98.329	127.002	103.918	109.211

As mentioned above, since there is no breakdown of expenditures for some of the services, the proportion of the annual expenditure on public dental care services to the public healthcare expenditure for the respective year is not available. As for 2024-25, the total revised estimate for the public dental services provided by the DH mentioned above is about \$944 million, which represents about 0.86% of the recurrent public/government expenditure on healthcare.

Based on the actual expenditures provided above, as well as the expenditure separately under the “Elderly Dental Assistance Programme” funded by the Community Care Fund and the dental grants under the CSSA Scheme of the Social Welfare Department, the expenditures on dental services provided or subsidised by the Government was close to \$1.3 billion in 2023-24.

- End -

CONTROLLING OFFICER'S REPLY

HHB244

(Question Serial No. 0338)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (-) Not Specified

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

In respect of the manpower change of Dental Officers of the Department of Health (DH), please set out in detail:

the number of new recruits (and their percentage in the total number of the DH's Dental Officers) and attrition figures broken down by retirement and resignation in the past 3 years.

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 17)

Reply:

A Dental Officer is mainly deployed to provide dental care and perform administrative duties at dental clinics or other specified institutions under the Department of Health (DH). As at 1 February 2025, the strength of the DH's Dental Officers stands at 290.

A breakdown of the establishment, strength, vacancies, wastage rates, number of new recruits and attrition figures in respect of the DH's Dental Officer Grade is set out below:

Financial year	Establishment	Strength	Vacancy	Wastage rate ^{Note 1} (Percentage)	Number of new recruits (Percentage in the total strength of Dental Officers in the DH)	Attrition figure	
						Number of resignees (Percentage in the total attrition figure)	Number of retirees (Percentage in the total attrition figure)
2022-23 (as at 31 March 2023)	370	294	76	12.9%	11 (3.7%)	32 (84.2%)	6 (15.8%)
2023-24 (as at 31 March 2024)	370	268	102	13.1%	9 (3.4%)	20 (57.1%)	15 (42.9%)
2024-25 (as at 1 February 2025)	372	290	82	8.3%	46 (15.9%)	6 (25%)	18 (75%)

Note 1 The wastage rates are calculated by dividing the total attrition figures during the financial year by the strength as at the end of that financial year or on 1 February 2025.

- End -

CONTROLLING OFFICER'S REPLY

HHB245

(Question Serial No. 0342)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Totalling more than 130 000, healthcare professionals shall, in general, comply with the continuing professional development (CPD) requirements when applying for practising certificates. Given the heavy workload involved in vetting and approving the CPD programmes for more than 10 professions, verifying the attendance records of such programmes, as well as calculating and validating the CPD credits for each practitioner, a large number of civilian staff of the Department of Health have to spend hours to work on such matter. Regarding the Government's general direction of promoting digital services, will the Government please advise this Committee on whether there are any plans to launch a multi-disciplinary CPD digital platform for shared use by different healthcare professions; if yes, the details; if no, the reasons?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 21)

Reply:

At present, 13 healthcare professions in Hong Kong are regulated by their respective statutory authorities. Among these professions, specialist doctors, specialist dentists and registered Chinese medicine practitioners, are required by the law to fulfill the requirements on continuing professional education (CPE) ^{Note}. The CPE credits they acquired shall be recorded and consolidated by recognised professional bodies or organisations, and only those who comply with the requirements can maintain their specialist registration or qualification to practise. In July 2024, the Legislative Council passed the relevant legislations to make continuing professional development a mandatory requirement for dentists and nurses for renewal of their practising certificates. In addition, it is the Government's plan to further extend the mandatory CPE requirements to supplementary medical professionals regulated by the Supplementary Medical Professions Ordinance through legislative amendment, with a view to upholding and enhancing the standards of the healthcare profession.

To support the healthcare sector in handling CPE-related matters, the Department of Health will streamline the administrative procedures, assist professional bodies or organisations recognised by respective boards and councils in managing data in a more effective manner

through utilisation of information technology, reduce clerical workload and enhance efficiency, thereby facilitating the renewal of practising certificates for healthcare professionals. Furthermore, we are also exploring the development of a digital database which sets out the details of all accredited courses and qualified course providers, making it easier for different healthcare professionals to obtain the most updated and comprehensive information. We will maintain liaison with the sector on the implementation of relevant work to ensure that the measures to be introduced will be able to meet the operational needs of various professions.

Note: The CPE requirements for specialist doctors and specialist dentists are determined by the Hong Kong Academy of Medicine, while that for registered Chinese medicine practitioners are determined by the Chinese Medicine Practitioners Board under the Chinese Medicine Council of Hong Kong.

- End -

CONTROLLING OFFICER'S REPLY

HHB246

(Question Serial No. 0351)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Regarding the Elderly Health Care Voucher Greater Bay Area Pilot Scheme (Pilot Scheme), will the Government please inform this Committee of:

- 1) the number of Elderly Health Care Voucher claim transactions and the total amount claimed so far, broken down by medical service provider, at the 7 medical institutions included in the Pilot Scheme; and
- 2) the percentage of elderly persons residing in the Greater Bay Area with respect to the above transactions?

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 30)

Reply:

1)

The Government launched the Elderly Health Care Voucher Greater Bay Area Pilot Scheme (Pilot Scheme) in 2024 to extend the coverage of Elderly Health Care Vouchers (EHCVs) to suitable medical institutions in the Guangdong-Hong Kong-Macao Greater Bay Area (GBA). As at September 2024, the coverage of the EHCVs has been extended to 7 integrated medical/dental institutions in the GBA. Together with the 2 existing service points operated by the University of Hong Kong – Shenzhen Hospital, eligible elderly persons can use EHCVs to pay for outpatient healthcare services provided by the designated departments at 9 service points in the GBA, located at Guangzhou, Zhongshan, Dongguan and Shenzhen, offering more convenience and flexibility for eligible Hong Kong elderly persons residing in Mainland cities in the GBA by providing more service points for them to better use their EHCVs on primary healthcare services for improving their health.

As at 31 December 2024, there were a total of 15 468 EHCV claim transactions at the 7 medical institutions under the Pilot Scheme, with the amount claimed totalling about \$19.78 million. The number of voucher claim transactions and the amount of vouchers claimed at each of the pilot medical institutions, broken down by service type, are tabulated below:

Pilot Medical Institutions	Preventive Care		Follow-up/Monitoring of Long Term Conditions		Management of Acute Episodic Conditions		Rehabilitative Care		Total	
	Number of Voucher Claims	Amount of Vouchers Claimed (\$'000)	Number of Voucher Claims	Amount of Vouchers Claimed (\$'000)	Number of Voucher Claims	Amount of Vouchers Claimed (\$'000)	Number of Voucher Claims	Amount of Vouchers Claimed (\$'000)	Number of Voucher Claims	Amount of Vouchers Claimed (\$'000)
The First Affiliated Hospital, Sun Yat-sen University (since 28 June 2024)	158	191	1 254	103	305	500	148	137	1 865	931
Zhongshan Chen Xinghai Hospital of Integrated Traditional Chinese and Western Medicine (since 18 July 2024)	289	305	969	125	505	450	289	115	2 052	995
Shenzhen New Frontier United Family Hospital (since 14 August 2024)	572	762	599	269	229	562	2	1	1 402	1,594
Nansha Division of The First Affiliated Hospital, Sun Yat-sen University (since 6 September 2024) Note: The Department of Stomatology pending commencement	17	24	188	13	33	56	8	2	246	95
Dongguan Tungwah Hospital (since 6 September 2024)	313	221	335	45	125	174	17	11	790	451
Shenzhen C.K.J Stomatological Hospital (since 14 August 2024)	2 266	362	4 180	200	87	7,082	2 370	7,620	8 903	15,264
Dental Bauhinia Specialty Service Center (Shenzhen)/ Dental Bauhinia General Care Center (Shenzhen) (since 14 August 2024)	69	65	93	56	17	199	31	132	210	452

2)

As at 31 December 2024, the number of eligible elderly persons using EHCVs at the 7 medical institutions under the Pilot Scheme was 9 064, involving a total of 15 468 EHCV claim transactions. According to the statistics on the city of usual residence reported by elderly persons when using EHCVs in the GBA, in respect of the above voucher claim transactions, about 19% (1 681 persons) of elderly persons usually resided in Mainland cities in the GBA, with a breakdown of their distribution by city below:

City	Number of Elderly Persons (Percentage of elderly persons who usually resided in Mainland cities in the GBA)
Guangzhou	593 (6.54%)
Shenzhen	130 (1.43%)
Zhuhai	20 (0.22%)
Foshan	47 (0.52%)
Huizhou	18 (0.20%)
Dongguan	289 (3.19%)
Zhongshan	567 (6.26%)
Jiangmen	15 (0.17%)
Zhaoqing	2 (0.02%)
Total:	1 681

- End -

CONTROLLING OFFICER'S REPLY

HHB247

(Question Serial No. 1395)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

It is mentioned in the Matters Requiring Special Attention in 2025-26 under this Programme that the Government will continue to enhance the seasonal influenza vaccination (SIV) arrangements for better protection of high risk groups. In this connection, will the Government inform this Committee of:

- 1) the number of SIV recipients and the uptake rate in the past 3 years, with a breakdown by age group: i) 6 months to 2; ii) 3 to 18; iii) 19 to 49; iv) 50 to 64; and v) 65 or above;
- 2) the number of severe cases and deaths associated with seasonal influenza in the past 3 years, with a breakdown by age group: i) 6 months to 2; ii) 3 to 11; iii) 12 to 18; iv) 19 to 49; v) 50 to 64; and vi) 65 or above;
- 3) among the deaths associated with seasonal influenza in the past 3 years, the percentage of those who did not receive influenza vaccination; and
- 4) the ways to increase SIV uptake rate among elderly aged 65 or above and children aged between 6 months and 2?

Asked by: Hon LAU Ip-keung, Kenneth (LegCo internal reference no.: 31)

Reply:

(1)

The Scientific Committee on Vaccine Preventable Diseases (SCVPD) under the Centre for Health Protection (CHP) of the Department of Health (DH) issues recommendations on the seasonal influenza (SI) vaccines to be used and the priority groups for receiving vaccination in regard to the influenza season in Hong Kong on an annual basis after reviewing scientific evidence, local data, latest recommendations of the World Health Organization and overseas practices.

Based on the recommendations of the SCVPD, the DH has been administering the following vaccination programmes/schemes to provide free/subsidised SI vaccination to eligible persons:

- Government Vaccination Programme, which provides free SI vaccination to eligible children, elderly and other target groups at clinics of the DH and the Hospital Authority (HA);
- Seasonal Influenza Vaccination School Outreach Programme, which provides free or subsidised SI vaccination to eligible schoolchildren through the public-private partnership outreach teams or the DH's outreach team; and
- Vaccination Subsidy Scheme (VSS), which provides subsidised SI vaccination to eligible persons, including persons aged 50 or above, pregnant women and children aged between 6 months and below 18 years of age through private doctors participating in the VSS.

The number of vaccine recipients and the uptake rate of the eligible groups under each vaccination programme/scheme in the past 3 seasons, broken down by age group, are detailed at **Annex 1**. As some target group members may have, at their own expense, received SI vaccination at private clinics outside the Government's vaccination programmes/schemes, they are not included in the statistics concerned.

As at 23 March this year, with the concerted efforts of the Government and all sectors of the community such as the medical sector, schools, parents and residential care homes, a record high number of about 2.07 million doses of SI vaccine have been administered under various vaccination programmes/schemes in 2024/25, representing an increase of about 12.2% over the same period of the last influenza vaccination season and exceeding the total number of doses (about 1.87 million doses) administered last season.

(2) & (3)

The number of severe cases and deaths associated with seasonal influenza in each of the past 3 years and, among them, the number of persons who did not receive SI vaccination during the influenza season, as well as the percentage of deaths where influenza vaccination was not received, broken down by age group, are detailed at **Annex 2**.

(4)

To improve the accessibility to the public, the Government has optimised the SI vaccination arrangements for eligible persons in 2024/25. For example, those with chronic illnesses or pregnant women can receive SI vaccination at public or private clinics where they attend for regular follow-up consultations, while the general public can receive vaccination at their family doctors' clinics. In particular, the Government has introduced several new vaccination venues, including the DH's Maternal and Child Health Centres, where vaccination is available to all children aged between 6 months and under 2, and the 18 District Health Centres (DHCs)/DHC Expresses, so as to provide more vaccination venues for the public.

The DH has been maintaining close liaison with its working partners and stakeholders, including the HA, Social Welfare Department, Education Bureau, school principals, teachers, residential care homes for the elderly, residential child care centres and the healthcare sector, with a view to boosting the uptake rates of SI vaccination among the elderly and children.

The DH encourages and supports the elderly in the community, in particular elderly singletons, via district networks to receive necessary vaccination (including SI vaccination), so as to reduce the risk of complications and death due to infection. The DH also disseminates information on SI vaccination to the elderly through the district services and Community Care Teams, and provides them with relevant infographics to encourage them to receive vaccination as early as possible.

Adopting a multi-pronged approach, the DH promotes vaccination through a variety of publicity and promotional channels, both online and offline. These promotional efforts include broadcasting Announcements in the Public Interest on SI vaccination on television and radio, as well as publicity through social media, newspapers, parent-child magazines and means of transport, etc. At the same time, the importance of vaccination and the related arrangements are relayed to the elderly through elderly service organisations and websites. Regarding vaccination for children, local paediatric experts are invited to conduct media interviews and film short videos to answer questions on SI vaccination frequently asked by parents, so as to bring out the importance of SI vaccination from a professional perspective in simple terms.

The winter influenza season, which began in early January and ended on 27 March this year, saw a low incidence of severe cases and deaths (even lower than the situation before the COVID-19 pandemic). Among them, 10 cases regarding severe influenza-associated complications in children were recorded this season without deaths, which was nearly 60% lower than the 24 cases (including 1 death) reported during the 2018/19 influenza season. The CHP believes this is the result of the concerted and comprehensive efforts of various stakeholders in the community and the public to increase the SI vaccination rate.

Yet, the uptake rate of SI vaccination, currently at around 25% for children aged 6 months to less than 2 years and people aged 50 to 64, is still relatively low. The Government will continue to take proactive measures to boost the uptake rate, including strengthening collaboration with family doctors, and, through statutory bodies such as the Occupational Safety and Health Council and non-governmental organisations, encourage service recipients, particularly the above priority groups, to receive SI vaccination to safeguard public health.

Annex 1

Target group	2022/23		2023/24		2024/25 (as at 23 March 2025)	
	No. of SI vaccine recipients	The uptake rate within the age group	No. of SI vaccine recipients	The uptake rate within the age group	No. of SI vaccine recipients	The uptake rate within the age group
Children aged between 6 months and under 2	5 000	9.1%	11 500	22.1%	13 500	26.8%
Children aged between 2 and under 18	360 300	41.7%	480 800	54.8%	552 400	64.2%
Persons aged between 50 and 64	320 200	17.8%	349 500	19.2%	459 000	25.3%
Persons aged 65 or above	734 200	48.3%	842 800	51.5%	879 900	51.3%
Others [^]	112 300	Not applicable	140 200	Not applicable	126 900	Not applicable
Total	1 532 000	Not applicable	1 824 800	Not applicable	2 031 700	Not applicable

[^] Others include healthcare workers; poultry workers; pig farmers or pig slaughtering industry personnel; persons with intellectual disabilities; Disability Allowance recipients; and pregnant women, etc.

Annex 2

Age group	2023			2024			2025 (as at 16 March 2025)		
	Number of severe cases (cases in which vaccination was not received during the influenza season)*	Number of deaths (cases in which vaccination was not received during the influenza season)	Percentage of deaths among people who did not receive influenza vaccination	Number of severe cases (cases in which vaccination was not received during the influenza season)*	Number of deaths (cases in which vaccination was not received during the influenza season)	Percentage of deaths among people who did not receive influenza vaccination	Number of severe cases (cases in which vaccination was not received during the influenza season)*	Number of deaths (cases in which vaccination was not received during the influenza season)	Percentage of deaths among people who did not receive influenza vaccination
Between 6 months and under 2	5 (5)	0 (0)	/	3 (3 [#])	0 (0)	/	2 (2)	0 (0)	/
Between 2 and 11	9 (6)	3 (3)	100%	21 (16)	6 (3)	50%	5 (3)	0 (0)	/
Between 12 and under 18	9 (7)	2 (2)	100%	4 (3)	0 (0)	/	3 (2)	0 (0)	/
Between 18 and 49	76 (73)	12 (10)	83%	102 (96)	18 (15)	83%	41 (38)	7 (6)	86%
Between 50 and 64	86 (74)	59 (38)	64%	168 (148)	89 (70)	79%	61 (55)	27 (20)	74%
Aged 65 or above	173 (116)	515 (293)	57%	185 (139)	820 (413)	50%	58 (38)	297 (169)	57%

*Cases of deaths not included

Including 1 case in which the child was under 6 months old

- End -

CONTROLLING OFFICER'S REPLY

HHB248

(Question Serial No. 2427)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions, (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The Department of Health (DH) has been conducting temperature checks for people arriving in Hong Kong at all Immigration Control Points. In this connection, will the Government please advise this Committee on:

1. the expenditure on and establishment for temperature screening measures in the past 5 years;
2. the respective numbers of travellers crossing the boundary whose body temperature was detected to be abnormal during temperature screening in each of the past 5 years, and the Government's procedures for handling such cases; and
3. whether the DH has assessed the effectiveness of the screening measures; if yes, the details; if no, the reasons?

Asked by: Hon LEE Chun-keung (LegCo internal reference no.: 15)

Reply:

In accordance with the power conferred by the Prevention and Control of Disease Ordinance of Hong Kong and with regard to the guidelines of the International Health Regulations, the Department of Health (DH) enforces various preventive measures at boundary control points (BCPs) to prevent the introduction or spreading of infectious diseases into or out of Hong Kong. The Port Health Division under the DH carries out health screening work at each BCP (including conducting regular body temperature screening for arrivals and setting up health stations). Taking into account the design of each BCP and its traveller and vehicle flow, the DH deploys manpower as appropriate to conduct body temperature screening for all arrivals; and performs, in accordance with the mechanism, further health assessments for travellers with fever or in need (such as travellers who self-reported being unwell) to understand their symptoms, travel history, contact history, etc., in order to make appropriate referrals and follow-ups.

The Hong Kong Special Administrative Region (HKSAR) Government has been maintaining close co-operation with entry-exit health inspection and quarantine authorities of the Mainland to safeguard the well-being and safety of residents and travellers of the 2 places. The Health Bureau and the General Administration of Customs of the People's Republic of

China (GACC) signed the Co-operation Arrangement for Entry-exit Health Inspection and Quarantine between the GACC and the Health Bureau of the HKSAR Government in 2023. Under the normalisation arrangements for epidemic prevention and control, the 2 parties agreed to focus on the health inspection and quarantine of their respective inbound personnel travelling between the HKSAR and the Mainland BCPs.

The HKSAR Government will maintain close liaison with the relevant Mainland authorities and, taking into account factors such as cost-effectiveness and appropriateness, actively review the entry health inspection and quarantine arrangements (including temperature screening) from the public health perspective.

(1)

From 2020 to 2024, the average number of health screening shifts of the DH per day at various BCPs (some health screening posts involve more than 1 shift according to the operation of BCPs) is as follows:

	2020	2021	2022	2023	2024
Airport	270	244	226	125	122
Lo Wu	40	0	0	40	40
Lok Ma Chau Spur Line	30	0	0	30	30
Lok Ma Chau	90	90	111	94	94
Man Kam To	27	27	41	36	36
Sha Tau Kok	37	37	20	8	0
Shenzhen Bay	137	171	182	116	94
Hong Kong-Zhuhai-Macao Bridge	141	178	178	116	130
Heung Yuen Wai	28	28	28	68	58
Express Rail Link West Kowloon	6	6	31	51	51
Hung Hom	18	18	18	0	0
Macau Ferry Terminal	42	42	45	45	45
China Ferry Terminal	22	22	0	22	22
Total	888	863	880	751	722

Note:

The DH redeploys health screening posts in view of the actual circumstances. Some of the posts at BCPs where operation has been suspended would be redeployed to other BCPs. Health screening service of Kai Tak Cruise Terminal and Ocean Terminal was not included as it was only provided during stopover of cruises.

The expenditure incurred by health screening shifts listed in the table above is set out below:

	Financial Year				
	2020-21	2021-22	2022-23	2023-24	2024-25
Expenditure (\$ million)	215	205	239	240	205

(2)

From 2020 to 2024, the number of inbound travellers confirmed with fever during temperature screening at BCPs, along with the number of those compulsorily referred to public hospitals upon fulfilling the reporting criteria of any major infectious disease are set out below:

	2020	2021	2022	2023	2024

Total Number of Inbound Travellers with Fever	1 003	30	135	4 759	4 214
Number of Inbound Travellers Compulsorily Referred to Public Hospitals upon Fulfilling Individual Reporting Criteria of Any Major Infectious Disease	1 547	205	250	61	6

Note:

The compulsory isolation arrangement imposed on persons infected with Coronavirus Disease 2019 (COVID-19) has been rescinded with effect from 30 January 2023.

In addition to compulsory referral of persons with suspected infection of major infectious diseases to Hong Kong public hospitals for checking, the DH also, subject to the results of health assessments, offered health advice and issue referral letters to persons having fever but without suspected infection of such diseases, advised them to seek treatment from medical institutions on their own, and assisted persons in need to call for ambulance service for further treatment at Accident and Emergency Department.

(3)

Ongoing health screening, which facilitates early identification of potential infectious diseases imported into Hong Kong, is vital to safeguarding public health. Currently, health screening measures are in place for inbound travellers at all BCPs between Hong Kong and the Mainland.

The DH mainly employs an Infrared Thermal Imaging System at various BCPs to detect the body temperatures of multiple travellers simultaneously to reduce the manpower required for such work. However, drivers and all passengers in a cross-boundary private car are allowed to remain in their vehicle while passing through the kiosks of the Immigration Department, the Customs and Excise Department and the DH without the need to get off from the vehicle or go to the traveller's clearance hall. Due to site constraints, the Infrared Thermal Imaging System cannot be used to measure the forehead temperature of drivers and passengers passing through the vehicle lanes. As a result, hand-held infrared thermometers are used to measure the body temperature of inbound passengers on board the vehicles at the DH vehicle kiosks.

The DH reviews the health screening arrangements from time to time and deploys manpower as appropriate at various BCPs according to the actual circumstances to provide appropriate services for inbound travellers. For instance, the additional personnel deployed during the COVID-19 epidemic in the light of the actual needs have been reduced after the epidemic, and the manpower at relevant BCPs has basically returned to the pre-epidemic level. Meanwhile, the DH also keeps a close eye on technological development and actively explores the adoption of innovative technology in collaboration with other departments at BCPs to reduce the manpower need for health screening and optimise the use of human resources.

- End -

CONTROLLING OFFICER'S REPLY

HHB249

(Question Serial No. 2449)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (-) Not Specified

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

It has been reported that there are only 3.7 dentists approximately on average for every 10 000 in Hong Kong people, a ratio that is lower than that in many developed countries and the Mainland. In this connection, will the Government please inform this Committee of:

- 1) the establishment, actual strength, vacancies and wastage rates of the Dental Officer grade and other dental care services personnel in the Government for the past 5 years;
- 2) further to the above question, whether the Government has identified the reasons for the staff wastage; if yes, the details; if no, the reasons; and
- 3) the measures taken by the Government to ensure that manpower for public dental services is sufficient to meet the service demand of the public?

Asked by: Hon LEE Hoey Simon (LegCo internal reference no.: 13)

Reply:

- 1) The establishment, actual strength, vacancies and wastage rates of the Dental Officer (DO) grade and other dental care services personnel in the Department of Health (DH) are set out in the **Annex**.
- 2) In the past 5 years, a total of 151 DOs have left service, 47 of whom have reached retirement age at the time of departure. Wastage of other DOs might be related to their career paths and aspirations.
- 3) To safeguard the oral health of the public, the Chief Executive announced in the 2022 Policy Address to conduct a comprehensive review of the dental services provided or subsidised by the Government. The Working Group on Oral Health and Dental Care (Working Group) was subsequently established in end-2022. The Working Group published a final report in end-2024, recommending that the future development of dental services should make reference to the direction of the Primary Healthcare Blueprint

emphasising prevention, early identification and timely intervention, with the goal of retention of natural teeth and enhancing the overall level of citizens' oral health.

The Government concurs with the views of the Working Group that providing or subsidising comprehensive curative dental services from public purse to all Hong Kong citizens regardless of their financial means does not align with the policy objectives of developing a prevention-oriented oral health and dental care system and encouraging citizens to take responsibility for their own oral health. This would exacerbate the current shortcomings of the treatment-oriented system, and would be neither cost-effective nor sustainable in terms of utilisation of public resources. It would be financially untenable for the Government and would thin out the resources that could otherwise be used for other healthcare services.

In response to the final report of the Working Group, the Government has adopted the oral health policy that: (1) Oral health is an integral component of general health. The Government's oral health policy aims to enable all Hong Kong citizens to improve their oral hygiene and lifestyle conducive to both oral and overall health levels; (2) Through publicity, education, promotion and development of primary oral health and dental care, the Government facilitate citizens to manage their oral health, and put prevention, early identification and timely intervention of dental diseases into action with the objective of tooth retention; and (3) The Government provides appropriate oral health and dental care services targeting underprivileged groups with financial difficulties and special needs, ensuring these groups have access to essential dental care services.

The Government has adopted a multi-pronged approach to ensure sufficient manpower to meet the demand for public dental services. Regarding the training of talents, the Government has increased the number of first-year-first-degree training places of the University Grants Committee-funded bachelor programme in dentistry on 4 occasions. The number increased from 50 per year in the 2009/10 academic year to 90 in the 2024/25 academic year, representing an increase of 80%. Meanwhile, under the premise that professional standards and patients' wellbeing are maintained, the Government provides different pathways for admitting qualified non-locally trained dentists. Apart from the Licensing Examination (LE) organised all along by the Dental Council of Hong Kong (DCHK), new pathways of limited registration and special registration have also been introduced.

As for public dental services, the DH has all along been taking various measures to encourage dentists to join the Government by, for example, providing more opportunities for continuing education, specialist training and promotion, besides retaining talents who wish to continue to serve the public through the Post-retirement Service Contract Scheme. The DH regularly organises talks and briefing sessions for graduating students of the Faculty of Dentistry of the University of Hong Kong (HKU) to introduce training and career opportunities of the post of DO to attract more fresh graduates to apply for the post. In 2024, there were a total of 50 new recruits, 80% of whom were fresh graduates. To attract more prospective candidates to apply for DOs, the DH has been launching year-round recruitment from 2021, granting incremental credits based on the work experience of candidates and exercising flexibility in the language proficiency requirement for appointment. Apart from civil service recruitment, the DH accepts applications for non-

civil service contract positions throughout the year from persons with relevant professional qualifications, with a view to attracting a wider pool of suitable talents.

The DH launched a recruitment exercise for full-time Contract Dentist (General Dentistry) in July 2024 and accepted applications from both locally and non-locally trained dentists. In addition to disseminating information on its websites for access from around the world, the DH conducted promotion in different regions through offices outside Hong Kong. At the same time, the relevant information was disseminated to dental training institutions and dentists organisations. Online briefing sessions were held to introduce the job opportunities offered by the DH to interested parties in the Mainland and overseas. By the deadline for application, the DH has received over 90 applications from non-locally trained dentists. As at 28 February 2025, the DH has issued conditional offers to 11 non-locally trained dentists assessed to be suitable for recruitment. These recruited applicants, who are non-locally trained dentists, may join the DH upon completion of their applications to the DCHK and issuance of limited registration or special registration. 3 of these recruited non-locally trained dentists reported to duty on 10 March.

The Government concurred with the Working Group's views on ancillary dental workers, (to be retitled as dental care professionals (DenCPs) upon commencement of relevant provisions of the Dentists Registration (Amendment) Ordinance (DRO)), which comprised of dental hygienists and dental therapists, could play a significant role in primary oral healthcare. Based on the risk-based principle and after consultation with the profession and relevant stakeholders, the DRO will suitably adjust the scope of practice of dental hygienists and dental therapists to enable them, upon training, to carry out certain lower-risk preventive dental care (e.g. oral examination, education, teeth cleaning and polishing, fluoride application) without the presence of a dentist, and perform scaling in accordance with the directions of a dentist who is present in the same premises. Dental therapists may also perform basic curative dental care (e.g. filling, extraction) in accordance with the directions of a dentist who is present in the same premises, enabling dentists to focus on more complex dental treatments. To strengthen the training for local DenCPs, the Government announced in the 2023 Policy Address that it would gradually increase the training places of DenCPs. In the 2025/26 academic year, the total number of training places (including places offered by the Prince Philip Dental Hospital's programmes for dental hygienists and dental therapists, and 60 places offered by the Vocational Training Council's new programme for Professional Diploma in Dental Hygiene) will rise to 220, representing an increase of nearly 20% compared to the 2024/25 academic year. The increase rate will reach 57% in the 2028/29 academic year.

**Establishment, actual strength, vacancies and wastage rates of Dental Officer grade
and other dental care services personnel in the DH**

Grade	2020-21				2021-22			
	Establishment	Actual strength	Vacancies	Wastage rate Note 1 (%)	Establishment	Actual strength	Vacancies	Wastage rate Note 1 (%)
Dental Officer	372	349	23	4.3%	371	321	50	12.1%
Dental Hygienist	14	11	3	36.4%	14	9	5	22.2%
Dental Surgery Assistant	365	362	3	6.4%	365	354	11	7.9%
Dental Technician	47	47	0	0%	47	49	-2 Note 2	8.2%
Dental Therapist	298	266	32	3.8%	298	251	47	9.2%

Grade	2022-23				2023-24				2024-25			
									(As at 1 February 2025)			
	Establishment	Actual strength	Vacancies	Wastage rate Note 1 (%)	Establishment	Actual strength	Vacancies	Wastage rate Note 1 (%)	Establishment	Actual strength	Vacancies	Wastage rate Note 1 (%)
Dental Officer	370	294	76	12.9%	370	268	102	13.1%	372	290	82	8.3%
Dental Hygienist	14	9	5	11.1%	14	8	6	12.5%	24	12	12	0%
Dental Surgery Assistant	366	343	23	7.3%	366	342	24	7.3%	397	337	60	4.5%
Dental Technician	47	47	0	6.4%	47	45	2	4.4%	47	42	5	7.1%
Dental Therapist	298	240	58	9.2%	298	236	62	5.9%	298	235	63	6.8%

Note 1 The wastage rate is calculated by dividing the number of wastage by the actual strength on the end date of the financial year or as at 1 February 2025.

Note 2 Including 2 staff on pre-retirement leave.

- End -

CONTROLLING OFFICER'S REPLY

HHB250

(Question Serial No. 2094)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

During the Coronavirus Disease 2019 (COVID-19) pandemic, some unscrupulous individuals feigned the illness to coax doctors time and again into prescribing oral drugs for COVID-19 during medical consultations, potentially with the intent to resell them for profit. Media reports surfaced from time to time, indicating that some patients had resold surplus drugs from public hospitals or the Department of Health (DH) either offline or online. Sellers even explicitly stated that the prescription drugs came from public hospitals or the DH, hammering home the point about improper use of public healthcare resources. In this connection, will the Government inform this Committee of:

1. the expenditure of the Hospital Authority (HA) and DH on procuring drugs for each of the past 5 years;
2. the number of convictions for the sale or possession of unregistered drugs recorded by the DH in each of the past 5 years, and of which, the number involving the resale of drugs from public hospitals or the DH;
3. the number of intelligence-led enforcement actions conducted for the resale of drugs from public hospitals or the DH in each of the past 5 years;
4. whether the Government has conducted any review and taken any action to curb the resale of drugs from public hospitals or the DH over the past 5 years; if not, whether the Government will review the current procedures for prescribing drugs, such as labelling the drugs prescribed by public hospitals or the DH distinctly, or removing their original packaging to prevent resale?

Asked by: Hon LEUNG Hei, Edward (LegCo internal reference no.: 17)

Reply:

(1)

In line with the Government's public healthcare policy to ensure that no one is denied adequate medical treatment due to lack of means, the Hospital Authority (HA) provides medical services and drugs or medical items to patients at highly subsidised rates based on their clinical needs and in accordance with the HA's treatment guidelines. The expenditures

of the HA and the Department of Health (DH) on procuring drugs in each of the past 5 years are as follows:

	2020-21	2021-22	2022-23	2023-24	2024-25 (Estimate)
HA Expenditure on Procuring Drugs* (\$ million)	8,685	9,642	12,451	13,127	12,951
DH Expenditure on Procuring Drugs (\$ million)	678.0	612.0	681.1	648.9	623.5

* Including drugs charged on standard fees and those self-financed by patients. Other expenses such as storage and repackaging were not included.

(2) & (3)

Under the Pharmacy and Poisons Ordinance (Cap. 138) (the Ordinance), pharmaceutical products (PPs) must meet the standards of safety, efficacy and quality, as well as have been approved for registration with the Pharmacy and Poisons Board of Hong Kong (the Board) before such products may be sold or distributed in the Hong Kong Special Administrative Region (HKSAR). In addition, if the medicine concerned is included in Part 1 of the Poisons List of the Ordinance, the PP concerned can only be sold on the registered premises at Authorized Sellers of Poisons (ASPs, commonly known as “pharmacies”) under the supervision of a registered pharmacist, and prescription drugs can only be sold at registered pharmacies under the supervision of a registered pharmacist and in accordance with the prescription of a medical practitioner. The Code of Practice for Authorized Sellers of Poisons issued by the Board under the Ordinance mandates pharmacies to obtain PPs through lawful channels, such as licensed pharmaceutical wholesale dealers or licensed pharmaceutical manufacturers for sale.

The Ordinance and the Pharmacy and Poisons Regulations (Cap. 138A) stipulate that it is an offence for any person to sell (by any means, including online) or possess unregistered PPs or Part 1 poisons unlawfully, or to sell or supply PPs for resale without authorisation or the relevant licence. Upon conviction, the maximum penalty for each charge is a fine of \$100,000 and imprisonment for 2 years. In addition, if a licensed medicine trader is found to have breached the code of practice, the case may be referred to the Board for disciplinary proceedings.

The DH adopts a risk-based approach and conducts blitz inspections of licensed medicine traders (including pharmacies) from time to time to monitor their compliance with the legislation and the relevant codes of practice. In accordance with the established mechanism, the DH monitors the sale of PPs in the market and follows up on the relevant complaints received. When suspected breaches of drug-related legislation are identified, the DH will immediately initiate investigation and, where necessary, refer the case to the relevant law-enforcement departments for follow-up actions or carry out joint operations with the departments. Any irregularities detected will be dealt with according to the law. Upon completion of investigation, the DH will consult the Department of Justice (DoJ) for prosecution advice.

In addition, when the DH learns of the potential irregularities in the market, it will proactively remind medicine traders of the relevant statutory requirements through various channels (such as issuing letters) and encourage them to inform the DH of such to combat crime.

Over the past 5 years, the DH has handled 121 conviction cases involving illegal sale and/or possession of unregistered PPs. During the course of the DH's investigation, no evidence was found to suggest that the cases involved supply (or sale) of medicines from public hospitals or the DH. A breakdown by year of the relevant convictions over the past 5 years is set out below:

Year	Number of Conviction Cases Involving Illegal Sale and/or Possession of Unregistered PP
2020	18
2021	26
2022	18
2023	30
2024	29
Total	121

The DH has been following up on intelligence (including complaints) involving suspected supply (or sale) of medicines from public hospitals or the DH. Over the past 5 years, the DH proactively took enforcement actions and carried out investigations into 3 cases involving intelligence related to suspected supply (or sale) of medicines from public hospitals or the DH. After investigation or consultation with the DoJ, no sufficient evidence was found to initiate prosecution regarding these cases. A breakdown by year of the relevant cases in the past 5 years is set out below:

Year	Number of Cases Involving Intelligence Related to Suspected Supply (or Sale) of Medicines from Public Hospitals or the DH
2020	0
2021	1
2022	1
2023	0
2024	1
Total	3

Apart from strengthening control through enforcement, the DH has been reminding medicine traders of the regulatory requirements for the sale of medicines through various channels, including letters, newsletters for medicine traders and online information. The DH has also compiled safety information for consumers regarding the selection and use of medicines, including the "General Knowledge on the Use of Medicines".

To protect public health, the DH has been issuing press releases to alert members of the public on incidents such as illegal sale and/or possession of unregistered medicines. To this end, the DH has all along strongly urged members of the public not to buy products of unknown or doubtful composition, or to consume products from unknown sources, as the safety, efficacy and quality of these products are not guaranteed.

As mentioned in the Chief Executive's Policy Address in 2023 and 2024, the HKSAR Government will enhance the current evaluation and registration mechanism for drugs, and establish an internationally renowned regulatory authority of drugs and medical devices. To this end, the HKSAR Government set up a Preparatory Office for the Hong Kong Centre for Medical Products Regulation (CMPR) in the DH in June 2024. The Preparatory Office is proactively reviewing the regulatory functions of the DH, including the regulation of Chinese and Western medicines and medical devices; studying the potential restructuring and strengthening of the regulatory and approval regime for medicines, medical devices and medical technology; and putting forward proposals and steps for the establishment of the CMPR which will be a step towards the transition to the "primary evaluation" approach in approving applications for registration of new medical products. This will help accelerate the clinical application of new drugs and medical devices, and foster the development of emerging industries related to the research and development as well as testing of medical products. The Preparatory Office is drawing up the timetable for establishing the CMPR and the roadmap towards adoption of "primary evaluation", and will announce them in the first half of 2025 as scheduled. The Preparatory Office will also conduct a review of the need for amending existing legislation related to drugs (in respect of, for example, the requirement for an electronic record of drug supply, prohibition to adopt names or descriptions alluding to "pharmacies", etc.) to step up the overall regulation of drugs.

(4)

Members of the public should not supply (or sell) medicines prescribed by doctors to others. To enhance public awareness, the DH has also posted notices at the dispensaries of its clinics to provide the public with relevant information. The DH continuously emphasises that patients should take prescribed medications on time and follow the instructions of doctors or pharmacists. They should not arbitrarily stop taking medications or reduce the dosages. At the same time, the DH has been providing the public with information on health education and drug knowledge through various channels, such as its Drug Office website, which provides information on the use of drugs and the stipulations of the drug-related legislation.

On the other hand, the HA has in place a mechanism to monitor the utilisation and expenditures of drugs to ensure prudent use of limited public healthcare resources. The HA will optimise the existing drug dispensing mechanism in public hospitals, with new arrangements introduced on 24 March 2025, under which all discharged patients, as well as patients attending Specialist and General Outpatient Clinics of the HA will be dispensed medications with a maximum of 24 weeks. If a patient is prescribed with medications for more than 24 weeks, arrangement will be made for the patient to collect the medications through medication refills, so as to prevent patients from accumulating excess medications at home, thereby reducing medication wastage and profit-making resale. If anyone is found to be deliberately reselling medications for profit, the HA will contact relevant law enforcement and regulatory authorities for appropriate follow-up actions.

In addition, the Government and the HA will endeavour to implement the fees and charges reform for public healthcare announced recently. By reforming the subsidisation structure, reducing waste and abuse, and enhancing healthcare protection, the initiative aims at guiding the public to make optimal use of healthcare resources, as well as enhancing healthcare protection for "poor, acute, serious, critical" patients on all fronts, with a view to ensuring that limited healthcare resources can be directed in a targeted manner to help those patients

most in need. The ultimate goal is to enhance the sustainability of the healthcare system to cope with the challenges posed by an ageing population, inflation of healthcare costs, etc., thereby serving as a safety net for all.

- End -

CONTROLLING OFFICER'S REPLY

HHB251

(Question Serial No. 2111)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Regarding the implementation of the COVID-19 Vaccination Programme, will the Government advise this Committee on:

1. the quantity of vaccines administered each month in the past 3 years, broken down by age group and type of vaccine;
2. the quantity of expired vaccines in each of the past 3 years and whether the Government has taken any measures to mitigate waste; if yes, the details; if no, the reasons;
3. the utilisation of the latest JN.1 vaccine and whether the Government will replace older vaccines with it entirely;
4. the quantity of vaccines to be procured for implementing the Programme this year, as well as the total amount of such procurement and the personnel involved.

Asked by: Hon LEUNG Hei, Edward (LegCo internal reference no.: 105)

Reply:

The Government has been procuring sufficient quantity of COVID-19 vaccines with reference to vaccination data, recommendations made by the World Health Organization (WHO) and the Scientific Committee on Vaccine Preventable Diseases and Scientific Committee on Emerging and Zoonotic Diseases (also known as the Joint Scientific Committee) under the Centre for Health Protection (CHP) of the Department of Health (DH), demographic data and the supply terms of vaccine suppliers. Since the commencement of the COVID-19 Vaccination Programme (the Vaccination Programme), the vaccines have been distributed from warehouse to various vaccination venues according to the “first-expired, first-out” principle. However, the public demand for vaccines varies with a number of factors, such as the number of persons infected and changes in the epidemic situation. The Government will continue to formulate policies on vaccine supply based on scientific evidence.

1.

Over the past 3 years to date, the monthly number of various types of vaccines administered under the Vaccination Programme with a breakdown by age is set out below:

Number of vaccine doses administered	Type of vaccine					
2022-23	Inactivated vaccine			Messenger ribonucleic acid (mRNA) vaccine		
	Aged between 6 months and 11	Aged between 12 and 49	Aged 50 or above	Aged between 6 months and 11	Aged between 12 and 49	Aged 50 or above
April 2022	110 051	90 190	222 321	28 637	297 456	165 435
May 2022	33 788	118 296	258 583	39 436	413 784	176 219
June 2022	29 691	80 335	228 125	12 504	185 667	94 498
July 2022	39 147	47 647	134 691	5 048	76 310	61 550
August 2022	72 130	74 522	194 414	6 760	122 712	111 484
September 2022	109 758	114 325	234 439	11 037	190 256	130 742
October 2022	47 671	53 013	104 583	6 112	99 498	57 776
November 2022	20 427	22 356	52 735	6 003	38 468	23 601
December 2022	18 316	21 426	63 109	5 310	99 250	148 667
January 2023	6 563	9 703	40 441	3 239	85 405	141 389
February 2023	2 123	3 356	19 051	1 277	16019	32 077
March 2023	1 353	2 465	11 088	930	8 529	15 836
Total	491 018	637 634	1 563 580	126 293	1 633 354	1 159 274
	2 692 232			2 918 921		

Number of vaccine doses administered	Type of vaccine					
2023-24	Inactivated vaccine			mRNA vaccine		
	Aged between 6 months and 11	Aged between 12 and 49	Aged 50 or above	Aged between 6 months and 11	Aged between 12 and 49	Aged 50 or above
April 2023	821	1 903	11 269	671	7 652	17 701
May 2023	668	442	9 908	523	1 293	15 407
June 2023	478	251	6 250	379	689	8 919
July 2023	329	168	4 818	271	368	6 466
August 2023	274	257	4 184	194	292	4 682
September 2023	131	103	3 262	111	212	4 002
October 2023	198	212	10 355	166	287	8 574
November 2023	211	120	8 014	142	197	8 160
December 2023	188	189	9 484	141	288	22 840
January 2024	170	523	14 619	173	1 442	63 037
February 2024	87	210	4 879	91	1 297	30 941
March 2024	97	210	3 470	118	709	15 835
Total	3 652	4 588	90 512	2 980	14 726	206 564
	98 752			224 270		

Number of vaccine doses administered	Type of vaccine					
	Inactivated vaccine			mRNA vaccine		
2024-25 (as at 28 February 2025)	Aged between 6 months and 11	Aged between 12 and 49	Aged 50 or above	Aged between 6 months and 11	Aged between 12 and 49	Aged 50 or above
April 2024	58	130	2 047	88	335	6 449
May 2024	90	117	2 014	96	256	5 822
June 2024	67	127	1 466	92	188	3 601
July 2024	52	114	1 517	91	212	3 348
August 2024	44	134	2 805	69	266	5 577
September 2024	24	274	4 310	53	369	6 063
October 2024	7	63	924	70	404	12 347
November 2024	0	0	0	99	342	9 431
December 2024	0	0	0	73	373	11 983
January 2025	0	0	0	71	442	8 193
February 2025	0	0	0	55	310	5 465
Total	342	959	15 083	857	3 497	78 279
	16 384			82 633		

Note: The inactivated COVID-19 vaccines in the territory have expired and ceased supply on 3 October 2024.

2.

Since the implementation of the Vaccination Programme until now (as at 28 February 2025), about 290 000 doses of the CoronaVac (Sinovac) vaccine (about 3.1% of the procurement total), 1.41 million doses of the Comirnaty (ancestral strain) vaccine (about 11.3% of procurement total), 1.18 million doses of the Comirnaty bivalent vaccine (about 62.1% of the procurement total) and about 900 doses of the Comirnaty XBB.1.5 vaccine (adult formulation) (about 0.6% of the procurement total) had to be disposed of due to expiration in warehouse. This was attributable to, among other factors, the diminished need for old formulations of vaccines resulting from the use of new vaccine strains as recommended by the WHO and the Joint Scientific Committee in response to virus mutation. Overall, the number of vaccines requiring disposal due to expiration in warehouse only accounted for about 12% of the total vaccines procured, which is in line with the standard stipulated by COVAX for the wastage rate of COVID-19 vaccines.

The Government will continue to review the local arrangements of vaccine procurement and make reference to overseas experiences to adopt various feasible measures to make the best use of the procured vaccines.

3.

Acting on the recommendations from the WHO and the Joint Scientific Committee, the Government has been providing JN.1 lineage COVID-19 vaccines (JN.1 vaccines) to eligible persons aged 12 and above under the Vaccination Programme in place of the XBB vaccines since 19 November 2024. In addition, the JN.1 vaccines (toddler and paediatric formulations) have also been provided by the Government to eligible children aged between 6 months and 11 years old since 25 February 2025 to replace the XBB vaccines. As at 28

February 2025, about 30 000 doses of JN.1 vaccines have been administered under the Vaccination Programme. The Government will continue to closely monitor the mutation of the coronavirus and assess the risks with an emphasis on safeguarding high-risk groups, and will keep in view the WHO's latest assessment of the pandemic as well as the latest recommendations from the Joint Scientific Committee.

4.

Regarding the procurement of COVID-19 vaccines, as at 28 February 2025, the Government has procured about 30 000 doses of Comirnaty XBB.1.5 vaccine, around 115 000 doses of Comirnaty JN.1 vaccine and approximately 110 000 doses of Spikevax JN.1 vaccine. The expenditure incurred (including transport and storage costs) is about \$83.4 million. As the procurement of COVID-19 vaccines is undertaken by the staff responsible for the procurement and management of other vaccination programmes under the DH, the manpower involved in the Vaccination Programme cannot be separately identified.

- End -

CONTROLLING OFFICER'S REPLY

HHB252

(Question Serial No. 2112)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Regarding the Elderly Health Care Voucher Greater Bay Area Pilot Scheme (Pilot Scheme), will the Government advise this Committee on:

1. the details of the number of attendances, the amount of vouchers claimed and the types of healthcare services in respect of the 7 participating medical institutions since the launch of the Pilot Scheme;
2. whether the Government has received any complaints from patients since the Pilot Scheme was launched; and their follow-up;
3. in view of society's concern on and monitoring of the Elderly Health Care Voucher Scheme (EHVS), whether the Government has conducted any spot checks on the Pilot Scheme; the situation concerned; and whether the percentage of these checks is consistent with that on local EHVS; if yes, the details, if no, the reasons; and
4. whether the Government has any plans or timetable to further extend the Pilot Scheme to the remaining cities in the Greater Bay Area, if yes, the details, if no, the reasons?

Asked by: Hon LEUNG Hei, Edward (LegCo internal reference no.: 106)

Reply:

1.

The Government launched the Elderly Health Care Voucher Greater Bay Area Pilot Scheme (Pilot Scheme) in 2024 to extend the coverage of Elderly Health Care Vouchers (EHCVs) to 7 medical institutions in the Guangdong-Hong Kong-Macao Greater Bay Area (GBA). As at end-2024, there were a total of 15 468 voucher claim transactions at the 7 medical institutions under the Pilot Scheme, with the amount claimed totalling about \$19.78 million. The number of voucher claim transactions and the amount of vouchers claimed at each of the pilot medical institutions, broken down by service type, are tabulated below:

Pilot Medical Institutions	Preventive Care		Follow-up / Monitoring of Long Term Conditions		Management of Acute Episodic Conditions		Rehabilitative Care		Total	
	Number of Voucher Claims	Amount of Vouchers Claimed (\$'000)	Number of Voucher Claims	Amount of Vouchers Claimed (\$'000)	Number of Voucher Claims	Amount of Vouchers Claimed (\$'000)	Number of Voucher Claims	Amount of Vouchers Claimed (\$'000)	Number of Voucher Claims	Amount of Vouchers Claimed (\$'000)
The First Affiliated Hospital, Sun Yat-sen University (since 28 June 2024)	158	191	1 254	103	305	500	148	137	1 865	931
Zhongshan Chen Xinghai Hospital of Integrated Traditional Chinese and Western Medicine (since 18 July 2024)	289	305	969	125	505	450	289	115	2 052	995
Shenzhen New Frontier United Family Hospital (since 14 August 2024)	572	762	599	269	229	562	2	1	1 402	1,594
Nansha Division of The First Affiliated Hospital, Sun Yat-sen University (since 6 September 2024) Note: The Department of Stomatology pending commencement	17	24	188	13	33	56	8	2	246	95
Dongguan Tungwah Hospital (since 6 September 2024)	313	221	335	45	125	174	17	11	790	451
Shenzhen C.K.J Stomatological Hospital (since 14 August 2024)	2 266	362	4 180	200	87	7,082	2 370	7,620	8 903	15,264
Dental Bauhinia Specialty Service Center (Shenzhen)/ Dental Bauhinia General Care Center (Shenzhen) (since 14 August 2024)	69	65	93	56	17	199	31	132	210	452

2. As at 31 December 2024, the Department of Health (DH) received 3 complaints against medical institutions under the Pilot Scheme in relation to operational procedures and service charges. Upon completion of the follow-up investigations, the DH has found no non-compliance with the terms and conditions of the Elderly Health Care Voucher Scheme (EHVS) Agreement or voucher claims showing aberrant patterns by the pilot medical institutions concerned.

3. The DH adopts a robust monitoring mechanism for checking and auditing voucher claims under the EHVS to ensure proper disbursement of public monies in the handling of reimbursement to healthcare service providers. The relevant measures and procedures include routine checking, monitoring and investigating in respect of aberrant transactions, and investigations into complaints. The DH adopts a risk-based approach to check voucher claims, targeting healthcare service providers who have records of non-compliance with the terms and conditions of the EHVS Agreement and those whose voucher claims show aberrant patterns. The above measures will also be applicable to the University of Hong Kong-Shenzhen Hospital and the medical institutions participating in the Pilot Scheme.

In addition to enforcing the above checking and auditing strategies concerning the medical institutions under the Pilot Scheme, the DH has further obtained consent from the health authorities of the Mainland to provide assistance to facilitate the DH's monitoring and investigation in respect of the Pilot Scheme when necessary, enhancing its monitoring capabilities and ensuring the proper reimbursement of voucher claims to the participating medical institutions.

As at end-December 2024, the DH conducted inspections of all participating pilot medical institutions with related monitoring measures well in place. No aberrant voucher claims were found.

4. The Chief Executive's 2024 Policy Address announced the extension of the Pilot Scheme to cover 9 Mainland cities in the GBA. The Health Bureau and the DH are actively taking forward the related work. The initial plan is to commence the relevant arrangements by the 4th quarter of 2025.

- End -

CONTROLLING OFFICER'S REPLY

HHB253

(Question Serial No. 3196)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The Department of Health has stated in the Matters Requiring Special Attention in 2025-26 under this Programme that it will continue to enhance the seasonal influenza vaccination arrangements for better protection of high risk groups. In this connection, will the Government inform this Committee of:

1. the number of persons in target groups vaccinated under the Government's influenza vaccination programmes and their respective uptake rates in the past 3 years;
2. the expenditure of the Government's influenza vaccination programmes in the past 3 years and the estimated expenditure for 2025-26; and
3. the number of severe cases and deaths involving children and elderly persons associated with influenza as well as the death rates in the past 3 years, and whether those children and elderly persons had received influenza vaccine?

Asked by: Hon LEUNG Hei, Edward (LegCo internal reference no.: 152)

Reply:

(1) & (2)

The Scientific Committee on Vaccine Preventable Diseases (SCVPD) under the Centre for Health Protection (CHP) of the Department of Health (DH) issues recommendations on the seasonal influenza (SI) vaccines to be used and the priority groups for receiving vaccination in regard to the influenza season in Hong Kong on an annual basis after reviewing scientific evidence, local data, latest recommendations of the World Health Organization and overseas practices.

Based on the recommendations of the SCVPD, the DH has been administering the following vaccination programmes/schemes to provide free/subsidised seasonal influenza (SI) vaccination to eligible persons:

- Government Vaccination Programme (GVP), which provides free SI vaccination to eligible children, elderly and other target groups at clinics of the DH and the Hospital Authority (HA);

- Seasonal Influenza Vaccination School Outreach Programme (SIVSOP), which provides free or subsidised SI vaccination to eligible schoolchildren through the public-private partnership outreach teams or the DH's outreach team; and
- Vaccination Subsidy Scheme (VSS), which provides subsidised SI vaccination to eligible persons, including persons aged 50 or above, pregnant women and children aged between 6 months and below 18 years of age through private doctors participating in the VSS.

The target population, the number of vaccine recipients, the uptake rate and the expenditure on subsidy for the eligible groups under each vaccination programme/scheme in the past 3 seasons are detailed at **Annex 1**. As some target group members may have, at their own expense, received SI vaccination at private clinics outside the Government's vaccination programmes/schemes, they are not included in the statistics concerned.

As at 23 March this year, with the concerted efforts of the Government and all sectors of the community such as the medical sector, schools, parents and residential care homes, a record high number of about 2.07 million doses of SI vaccine have been administered under various vaccination programmes/schemes in 2024/25, representing an increase of about 12.2% over the same period of the last influenza vaccination season and exceeding the total number of doses (about 1.87 million doses) administered last season.

Regarding the seasonal influenza vaccination schemes in 2025/26, the Government will continue to step up efforts to assist high-risk groups (especially young children, schoolchildren, and the elderly) in receiving influenza vaccination, and is exploring the feasibility of procuring a portion of the SI vaccines for private doctors enrolled in the VSS, and has been liaising with vaccine suppliers to gain a better understanding of the market supply. Details will be announced in due course. The estimated expenditure for 2025/26 (i.e. the subsidies for private doctors under the SIVSOP and the VSS) is about \$279 million. As vaccination services under the GVP are provided free of charge by public hospitals/clinics etc., the related expenses cannot be separately identified.

(3)

The numbers of severe cases and deaths involving children and elderly persons associated with seasonal influenza and the death rates in each of the past 3 years, as well as whether those children and elderly persons had received influenza vaccinations, broken down by age group, are detailed at **Annex 2**.

The winter influenza season, which began in early January and ended on 27 March this year, saw a low incidence of severe cases and deaths (even lower than the situation before the COVID-19 pandemic). Among them, 10 cases regarding severe influenza-associated complications in children were recorded this season without deaths, which was nearly 60% lower than the 24 cases (including 1 death) reported during the 2018/19 influenza season. The CHP believes this is the result of the concerted and comprehensive efforts of various stakeholders in the community and the public to increase the SI vaccination rate.

Annex 1

Target group	Programmes /schemes for provision of SI vaccination	2022/23				2023/24				2024/25 (as at 23 March 2025)			
		Target Population *	No. of SI vaccine recipients under each vaccination programme/ scheme	The uptake rate within the age group	Subsidy@ (\$ million)	Target Population *	No. of SI vaccine recipients under each vaccination programme/ scheme	The uptake rate within the age group	Subsidy@ (\$ million)	Target Population*	No. of SI vaccine recipients under each vaccination programme/ scheme	The uptake rate within the age group	Subsidy@ claimed (\$ million)
Elderly aged 65 or above	GVP	1 520 100	452 900	48.3%	Not applicable	1 637 600	513 100	51.5%	Not applicable	1 715 400	515 500	51.3%	Not applicable
	VSS		281 300		73.1		329 700		85.7		364 400		94.7
Persons aged between 50 and 64	GVP	1 796 700	49 200	17.8%	Not applicable	1 824 900	6 100	19.2%	Not applicable	1 815 300	115 700	25.3%	Not applicable
	VSS		271 000		70.5		343 400		89.3		343 300		89.3
Children aged between 6 months and under 18	GVP	917 900	1 400	39.8%	Not applicable	929 600	800	53.0%	Not applicable	911 400	6 900	62.1 %	Not applicable
	VSS		104 700		30.3		169 500		50.5		189 900		53.3
	SIVSOP		259 200		28.8		322 000		36.1		369 100		40.6
Others ^	GVP/VSS	#	112 300	#	1.5	#	140 200	#	1.7	#	126 900	#	1.6
Total			1 532 000		204.2		1 824 800		263.3		2 031 700		279.5

* Provisional figures for the relevant population group at mid-year as estimated by the Census and Statistics Department.

@ Refers to the subsidy for private doctors participating in the SIVSOP and the VSS. As vaccination services under the GVP are provided free of charge by public hospitals/clinics etc., the related expenses cannot be separately identified.

^ Others include healthcare workers; poultry workers; pig farmers or pig slaughtering industry personnel; persons with intellectual disabilities; Disability Allowance recipients; and pregnant women, etc.

There are no accurate population statistics for this group.

Annex 2

Age Group	2023			2024			2025 (as at 16 March 2025)		
	Number of severe cases (cases in which vaccination was not received during the influenza season)*	Number of deaths (cases in which vaccination was not received during the influenza season)	Death rate (per 100 000 population) ^	Number of severe cases (cases in which vaccination was not received during the influenza season)*	Number of deaths (cases in which vaccination was not received during the influenza season)	Death rate (per 100 000 population) ^	Number of severe cases (cases in which vaccination was not received during the influenza season)*	Number of deaths (cases in which vaccination was not received during the influenza season)	Death rate (per 100 000 population) ^
Between 0 and 5	7 (7)	3 (3)	1.19	14 (13 [#])	2 (1)	0.84	4 (4)	0 (0)	0
Between 6 and 11	7 (4)	0 (0)	0	11 (7)	4 (2)	1.22	3 (1)	0 (0)	0
Between 12 and 17	9 (7)	2 (2)	0.56	4 (3)	0 (0)	0	3 (2)	0 (0)	0
Total number of children	23 (18)	5 (5)	0.52	29 (23 [#])	6 (3)	0.65	10 (7)	0 (0)	0
Elderly persons (aged 65 or above)	173 (116)	515 (293)	31.37	185 (139)	820 (413)	47.70	58 (38)	297 (169)	16.91

* Cases of deaths not included

Including 1 case in which the child was under 6 months old

^ Estimates for 2023 to 2024 are based on the mid-year population figures for the respective year, while estimates for 2025 are based on the end-of-year population figures for 2024.

- End -

CONTROLLING OFFICER'S REPLY

HHB254

(Question Serial No. 2150)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

In the light of the rapidly ageing population, the Government mentioned in the Matters Requiring Special Attention in 2025-26 that it would continue to oversee the Outreach Dental Care Programme for the Elderly (ODCP) to address the growing demand for dental services among the elderly. In this connection, will the Government please inform this Committee of:

- (a) the numbers of residential care homes for the elderly (RCHEs) participating in the ODCP and the elderly service recipients in the past 5 years;
- (b) the estimated expenditure and staffing arrangements in respect of the ODCP in the past 5 years;
- (c) regarding the future direction of the ODCP, whether regular reviews will be conducted by the Government to assess if the geographical coverage of the ODCP is sufficient; and
- (d) upon delivery of ODCP services, whether the Government has conducted surveys among the elderly and RCHEs to gauge service satisfaction?

Asked by: Hon NG Chau-pei, Stanley (LegCo internal reference no.: 28)

Reply:

To safeguard the oral health of the public, the Chief Executive announced in the 2022 Policy Address to conduct a comprehensive review of the dental services provided or subsidised by the Government. The Working Group on Oral Health and Dental Care (Working Group) was subsequently established in end-2022. The Working Group published a final report in end-2024, recommending that the future development of dental services should make reference to the direction of the Primary Healthcare Blueprint emphasising prevention, early identification and timely intervention, with the goal of retention of natural teeth and enhancing the overall level of citizens' oral health.

The Government concurs with the views of the Working Group that providing or subsidising comprehensive curative dental services from public purse to all Hong Kong citizens regardless of their financial means does not align with the policy objectives of developing a prevention-oriented oral health and dental care system and encouraging citizens to take responsibility for their own oral health. This would exacerbate the current shortcomings of the treatment-oriented system, and would be neither cost-effective nor sustainable in terms of utilisation of public resources. It would be financially untenable for the Government and would thin out the resources that could otherwise be used for other healthcare services.

In response to the final report of the Working Group, the Government has adopted the oral health policy that: (1) Oral health is an integral component of general health. The Government's oral health policy aims to enable all Hong Kong citizens to improve their oral hygiene and lifestyle conducive to both oral and overall health levels; (2) Through publicity, education, promotion and development of primary oral health and dental care, the Government facilitates citizens to manage their oral health, and put prevention, early identification and timely intervention of dental diseases into action with the objective of tooth retention; and (3) The Government provides appropriate oral health and dental care services targeting underprivileged groups with financial difficulties and special needs, ensuring these groups have access to essential dental care services.

In the Oral Health Action Plan formulated based on the Working Group's strategic recommendations, the Outreach Dental Care Programme for the Elderly (ODCP) is a service focusing on underprivileged groups who have difficulties in accessing dental care under the aforesaid strategy of ensuring these groups have access to essential dental care services.

The ODCP has been implemented since October 2014 to provide free on-site oral check-up for elderly persons and oral care training to caregivers of residential care homes (RCHes), day care centres (DEs) and similar facilities in the 18 districts of Hong Kong through outreach dental teams set up by non-governmental organisations (NGOs). The timing for provision of the service is arranged between the NGOs and RCHes/DEs; basically, elderly persons in RCHes/DEs participating in the ODCP receive the service once a year. Free dental treatments will be provided on-site or at a dental clinic if the elderly person is considered suitable for further curative treatments. The outreach dental teams will also design personalised oral care plans for elderly persons to suit their oral care needs and self-care abilities. A total of 25 outreach dental teams from 11 NGOs have currently been set up under the ODCP. Each outreach dental team comprises at least 1 dentist and 1 dental surgery assistant. Six civil service posts in DH are responsible for implementing the ODCP.

Since implementation of the ODCP in October 2014 and up to end-January 2025, the number of attendances was about 428 000.

As at January 2025, around 80% of the RCHes/DEs have participated in the ODCP. To encourage elderly persons' participation, the NGOs will meet with their assigned RCHes/DEs to discuss further promotion efforts. The DH regularly reviews the implementation and effectiveness of the ODCP through questionnaire surveys, the results of which indicated that the RCHes/DEs interviewed are satisfied with the ODCP. The Government also takes the initiative to learn about the situations faced by the RCHes/DEs that have not participated in the ODCP, such as the floor area and manpower of the RCHes, the health conditions of their residents, as well as the requests of the residents and/or their families, etc. Some

RCHEs/DEs, on the other hand, have arranged dental services on their own for their residents. The Government will continue to promote the programme and encourage participation.

The Government's actual expenditure in respect of the implementation of the ODCP in 2020-21, 2021-22, 2022-23, 2023-24 and its revised estimate in 2024-25, as well as the number of RCHEs/DEs participating in the ODCP and the number of attendances for the ODCP in 2020-21, 2021-22, 2022-23, 2023-24 and 2024-25 (up to January 2025) are set out below:

Year	2020-21	2021-22	2022-23	2023-24	2024-25 (up to January 2025)
Annual expenditure (\$ million)	37.8 (Actual)	41.6 (Actual)	48.6 (Actual)	55.8 (Actual)	63.7 (Revised Estimate)
Number of RCHEs/DEs participating in the ODCP	630	690	706	830	823
Number of attendances	25 011	37 245	39 146	47 931	45 334

- End -

CONTROLLING OFFICER'S REPLY

HHB255

(Question Serial No. 0927)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Enforcing laws on tobacco control is one of the work of the Department of Health (DH) under this Programme. According to the Matters Requiring Special Attention in 2025-26, DH will take forward the next phase of tobacco control measures and strengthen the enforcement of the Smoking (Public Health) Ordinance (Cap. 371) and the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600). Please advise this Committee on the Government's expenditure and manpower involved in enforcing laws on tobacco control in 2024-25, the effectiveness of its work (in terms of, for example, enforcement action taken and the number of prosecutions instigated), and the estimated manpower and expenditure devoted to the enforcement work in 2025-26?

Asked by: Hon NG Kit-chong, Johnny (LegCo internal reference no.: 25)

Reply:

The Health Bureau (HHB) introduced in June 2024 the new tobacco control strategy, outlining the short, medium and long-term measures to further reduce smoking prevalence incrementally through various measures, with a view to minimising the harmful effects of tobacco products on the community and safeguarding public health through a multi-pronged approach. These measures are formulated around four directions under the tobacco control strategy, namely, reducing the demand for and supply of tobacco products, minimising the attractiveness of tobacco products, protecting the public from the hazard of second-hand smoke and strengthening the provision of smoking cessation services, aiming to take forward the tobacco control process incrementally. The HHB plans to introduce the proposed legislative amendments for the next-phase tobacco control measures to the Legislative Council for scrutiny by the end of this month.

The Tobacco and Alcohol Control Office (TACO) of the Department of Health (DH) is the principal enforcement agency for the Smoking (Public Health) Ordinance (Cap. 371) and the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600). The TACO will conduct inspections and investigation in response to smoking and related complaints. In general, the TACO will issue fixed penalty notices (FPNs) to smoking offenders without warning. Apart from smoking offences, the TACO also issued summonses for offences under Cap. 371

(including aiding and abetting smoking offences, offences relating to smoking product advertisements, the promotion, manufacture, sale, or possession for commercial purposes of alternative smoking products (ASPs), obstruction of inspectors, etc.), and for the offence of importing ASPs under the Import and Export Ordinance (Cap. 60). The numbers of complaints/referrals received, inspections conducted, warning letters issued, and FPNs/ summonses issued by the TACO in 2024 for smoking and other offences are at **Annex 1**.

The TACO will continue to closely monitor the market situation and take stringent enforcement actions against violation of the Smoking (Public Health) Ordinance. The revised estimate, estimate and approved establishment for the period from 2024-25 to 2025-26 in relation to the tobacco control work carried out by the TACO are set out in **Annex 2** and **Annex 3** respectively.

Annex 1

Numbers of complaints/referrals received, inspections conducted, warning letters issued, and FPNs/summonses issued by TACO for smoking and other offences under the Smoking (Public Health) Ordinance (Cap. 371), the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600) and the Import and Export Ordinance (Cap. 60)

		2024
Complaints/referrals received		29 205
Inspections conducted		30 162 ^(Note 3)
Warning letters issued ^(Note 1)		10
FPNs issued (for smoking offences)		13 488 ^(Note 3)
Summonses issued	for smoking offences	64
	for other offences ^(Note 2)	871

Note:

- 1 In general, the TACO will prosecute smoking offenders without prior warning. The TACO will only consider issuing warning letters if the smoking offenders are found to be persons under 15 years old.
- 2 Other offences include willful obstruction, failure to produce identity document, displaying smoking product advertisement, ASP related offences, and aiding and abetting another person committing a smoking offence, etc.
- 3 To effectively mitigate the impact of passive smoking on the public and enhance the deterrent effect against illegal smoking, TACO has flexibly deployed resources and adopted new enforcement strategies since 2023, including extension of the time of surveillance and inspections in no smoking areas, deploying plain-clothes officers to take proactive enforcement actions, strengthening enforcement action in venues (such as bars and food premises) where waterpipes were offered for smoking, as well as prosecuting people inciting, aiding and abetting illegal smoking. The number of prosecutions against illegal smoking has surged due to the new enforcement strategies, reflecting their enhanced effectiveness.

Revised Estimate/Estimate for
the Department of Health's Tobacco and Alcohol Control Office

	2024-25 Revised Estimate (\$ million)	2025-26 Estimate (\$ million)
<u>Enforcement</u>		
Programme 1: Statutory Functions	<u>167.4</u>	<u>174.8</u>
<u>Health Education and Smoking Cessation</u>		
Programme 3: Health Promotion	<u>170.5</u>	<u>180.9</u>
<u>(a) General health education and promotion of smoking cessation</u>		
TACO	88.2	87.0
Subvention to Hong Kong Council on Smoking and Health	27.9	27.3
<i>Sub-total</i>	<u>116.1</u>	<u>114.3</u>
<u>(b) Revised estimate/estimate for smoking cessation and related services by Non-Governmental Organisations</u>		
Subvention to Tung Wah Group of Hospitals	14.0	17.8
Subvention to Pok Oi Hospital	17.9	20.9
Subvention to Lok Sin Tong	3.6	3.6
Subvention to United Christian Nethersole Community Health Service	8.9	13.8
Subvention to Life Education Activity Programme	3.0	3.0
Subvention to Christian Family Service Centre	7.0	4.5
Subvention to the University of Hong Kong	-	3.0
<i>Sub-total</i>	<u>54.4</u>	<u>66.6</u>
Total	<u>337.9</u>	<u>355.7</u>

Approved Establishment of
the Department of Health's Tobacco and Alcohol Control Office

Rank	Number of staff in 2024-25 and 2025-26
<u>Head, TACO</u>	
Consultant	1
<u>Enforcement</u>	
Senior Medical & Health Officer	1
Medical & Health Officer	1
Scientific Officer (Medical)	1
Land Surveyor	1
Police Officer	5
Overseer/ Senior Foreman/ Foreman	125
Senior Executive Officer/ Executive Officer	13
<i>Sub-total</i>	<u>147</u>
<u>Health Education and Smoking Cessation</u>	
Senior Medical & Health Officer	1
Medical & Health Officer	1
Scientific Officer (Medical)	2
Nursing Officer/ Registered Nurse	3
Hospital Administrator II	4
<i>Sub-total</i>	<u>11</u>
<u>Administrative and General Support</u>	
Senior Executive Officer/ Executive Officer	4
Clerical and support staff	19
Motor Driver	1
<i>Sub-total</i>	<u>24</u>
Total	<u>183</u>

- End -

CONTROLLING OFFICER'S REPLY

HHB256

(Question Serial No. 0943)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

It is mentioned in the 2024 Policy Address that the Government plans to formulate risk-based screening programmes for prevalent cancers on a gradual basis, including breast cancer screening, exploring the use of artificial intelligence (AI) to assist lung cancer screening, and implementing hepatitis B screening to prevent liver cancer. It is mentioned in the Controlling Officer's Report that the Department of Health (DH) will formulate risk-based screening programmes for prevalent cancers in 2025-26. In this connection, will the Government inform this Committee of the following:

1. the respective amount of funding earmarked by the Government for breast cancer screening, AI-assisted lung cancer screening and the implementation of hepatitis B screening, and whether additional medical funding will be earmarked for treating new cases of cancer following the above screening; if yes, the details; if no, the reasons;
2. regarding the 3 screening programmes mentioned above, how the Government will deploy staff for their implementation and whether additional manpower is required; if additional manpower is needed, the relevant staff establishment; if existing manpower is to be deployed to take forward the above screening programmes, from which departments the Government will deploy staff, the respective number of staff to be deployed, and how the Government will ensure that existing health services remain unaffected; and
3. regarding the 3 screening programmes mentioned above, the estimated time for the DH to announce their details and whether the Government has formulated a timetable for their implementation; if yes, the details; if no, the reasons?

Asked by: Hon NGAN Man-yu (LegCo internal reference no.: 1)

Reply:

The Cancer Expert Working Group on Cancer Prevention and Screening (CEWG) under the Cancer Coordinating Committee chaired by the Secretary for Health regularly reviews local and international scientific evidence, with a view to making recommendations to the

Government on suitable evidence-based measures for cancer prevention and screening for the local population. Based on the CEWG's recommendations on cancer screening, the Government has rolled out the Cervical Screening Programme, the Colorectal Cancer Screening Programme and the Breast Cancer Screening Pilot Programme (BCSPP).

When considering recommendations for any disease screening, the Government will refer to the evidence-based risk assessment and views of relevant experts from the perspective of public health. A number of factors will be carefully assessed, such as local prevalence of the cancer, accuracy and safety of the screening tests, effectiveness in reducing incidence and mortality rates as well as feasibility of implementation of a screening programme. The perspective of good utilisation of medical resources will be taken into account to determine the priority. Excessive screening under public health programmes not only wastes resources for the overall public health, but also runs out of resources that can be invested on other projects in greater need, and may pose unnecessary health risks to individuals, often causing more harm than good.

Primary prevention (i.e. reducing exposure to cancer risk factors) is the most important strategy for reducing the risk of developing cancer. The Department of Health (DH) has all along been encouraging members of the public to adopt a healthy lifestyle, including avoidance of smoking and alcohol, healthy diet, regular physical activity and maintenance of a healthy body weight and waist circumference, in order to reduce the risk of non-communicable diseases including cancer.

(1) to (3)

Breast cancer screening

Based on the recommendations of the CEWG, the Government adopts a risk-based approach for breast cancer screening and launched Phase I of the BCSPP in 2021. Women aged between 44 and 69 with certain combinations of personalised risk factors (including presence of history of breast cancer among first-degree relatives, a prior diagnosis of benign breast disease, nulliparity or late age of first live birth, early age of menarche, high body mass index and physical inactivity) putting them at increased risk of breast cancer are recommended to consider mammography (MMG) screening every 2 years.

In the two-year Phase I of the BCSPP (which ran from September 2021 to December 2023), a total of 27 807 women aged between 44 and 69 have received breast cancer risk assessment in Woman Health Centres, 4 Maternal and Child Health Centres and 18 Elderly Health Centres. 7 785 (about 28%) of them underwent the MMG screening on referral based on the risk assessment. Among the women with abnormal MMG results who had been referred to specialists for treatment, 409 cases were followed up in public hospitals, among which 68 were confirmed to have breast cancer. The breast cancer detection rate per 1 000 MMG screenings was 8.7, which was comparable to the international standard of about 5 cases per 1 000 MMG screenings. Of the 68 breast cancer cases identified through the MMG screening, 97% were at stage II or below. Following the review of Phase I of the BCSPP, the breast cancer risk assessment and screening have been included as part of the regular services provided by the Woman Health Service and the Elderly Health Service.

The Woman Health Service under the DH will be integrated into the district health network of the Health Bureau Primary Healthcare Commission within 2025. The service points, to be named Women Wellness Satellites, will form a network with District Health Centres (DHCs)/DHC Expresses in all 18 districts across Hong Kong to provide eligible women with prevention-based and more personalised primary healthcare services, including breast cancer screening. In parallel, the DHCs/DHC Expresses actively promote the “Life Course Preventive Care Plan”. In line with the core principles of prevention-oriented and whole-person care, a personalised preventive care plan will be formulated based on the most updated evidence and the health needs of citizens across different life stages. Family doctors and primary healthcare professionals will collaborate to promote healthy lifestyles and disease prevention, including providing education and vaccination for cancer prevention, and advising on cancer screening services according to personal risk factors.

Based on the recommendations of the CEWG, the Government is now preparing for Phase II of the BCSPP to provide subsidised breast cancer screening services for women at high risk of developing breast cancer (i.e. carriers of certain gene mutations and/or with strong family history of breast cancer or ovarian cancer) through Public-Private Partnership programmes in collaboration with non-governmental organisations. Phase II of the BCSPP, of which details will be announced in due course, is expected to be launched around the second quarter of 2025.

Lung cancer screening

Regarding lung cancer screening, the CEWG considers that there is insufficient evidence to recommend population-based screening in asymptomatic persons at average risk. As for asymptomatic persons at higher risk, the CEWG is of the view that based on overseas literature, individuals with heavy smoking history may benefit from lung cancer screening with low-dose computed tomography (LDCT), yet there is currently insufficient data to assess the lung cancer screening strategies in the local setting, such as target groups and the most cost-effective screening protocol.

Given the above scientific evidence, the Government will not implement any lung cancer screening programme at this stage. As proposed in the Chief Executive’s 2024 Policy Address, the Government will explore the lung cancer screening strategies in the local setting and consider conducting research in collaboration with universities to provide the scientific basis for the development of local screening strategies and to assess the feasibility of lung cancer screening by the LDCT with artificial intelligence technology for asymptomatic persons at higher risk in Hong Kong. The DH is proactively undertaking the follow-up work in this regard.

Hepatitis B screening

As for liver cancer, the CEWG currently does not recommend routine screening for liver cancer for asymptomatic persons at average risk.

The major risk factor leading to liver cancer is chronic hepatitis B (CHB) infection. As stated in the Chief Executive’s 2024 Policy Address, the Government will implement a hepatitis B screening programme this year for early identification and continuous management and treatment of individuals with CHB infection. This will help reduce the risk

of developing serious liver diseases such as cirrhosis and liver cancer associated with CHB infection, thereby minimising the incidence and mortality of liver cancer cases. At the helm of the Primary Healthcare Commission and through strategic purchasing, persons at higher risk will be subsidised under the new programme for hepatitis B screening and continuous management to be provided by the DHCs and family doctors in the community. The Government has earmarked relevant resources, with details to be announced in due course.

- End -

CONTROLLING OFFICER'S REPLY

HHB257

(Question Serial No. 0956)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The Scientific Committee on Vaccine Preventable Diseases under the Centre for Health Protection of the Department of Health (DH) makes recommendations regarding the Hong Kong Childhood Immunisation Programme (HKCIP) from the public health perspective, under which children from birth to 5 years of age can receive immunisation at Maternal and Child Health Centres, whereas vaccination for primary school children is provided at schools by the DH's outreaching School Immunisation Teams. In this connection, will the Government advise this Committee on:

1. in tabular form, the estimated number of vaccine recipients, the actual number of people vaccinated, the uptake rate, the expenditure involved and the implementation details of the HKCIP over the past 3 years;
2. the uptake rate of children at recommended age of different vaccines, including those available under and those not covered by the HKCIP;
3. whether the Government has explored the feasibility of fully subsidising children under the HKCIP to receive vaccination at private healthcare facilities;
4. whether the Government has taken any measures to ensure that children of the age cohort suitable for vaccination receive all necessary vaccines; if yes, the details; if no, the reasons; and
5. whether the Government has taken any measures (such as assisting schools in handling administrative procedures or providing policy incentives) to encourage school participation in the Seasonal Influenza Vaccination School Outreach Programme, under which vaccines for the outreach vaccination service are provided to participating schools by the DH; if yes, the details; if no, the reasons?

Asked by: Hon NGAN Man-yu (LegCo internal reference no.: 14)

Reply:

The Government attaches great importance to children's health, and is committed to providing children with quality medical and health services. The 29 Maternal and Child Health Centres (MCHCs) in operation under the Department of Health (DH) are set up in all 18 districts in Hong Kong, providing health promotion and disease prevention services for newborn babies, children up to 5 years old and women of reproductive age, including free vaccination services and continuous monitoring of children's growth and development. Data also shows that the overall coverage for relevant vaccines among locally born pre-school children remains at a remarkably high level of over 98%. The DH is discussing the streamlining of maternal health services with the Primary Healthcare Commission and the Hospital Authority to make better use of resources and enhance service efficiency.

1. to 2.

The DH provides free vaccination services for eligible children under the Hong Kong Childhood Immunisation Programme (HKCIP) for the prevention of 12 communicable diseases with public health significance, namely Tuberculosis, Hepatitis B (Hep B), Poliomyelitis, Tetanus, Pertussis, Measles, Diphtheria, Mumps, Rubella, Varicella, Pneumococcal Disease and Human Papilloma Virus (HPV) Infection. With a view to preventing children from contracting communicable diseases, Bacillus Calmette-Guerin (BCG) vaccine and the first dose of Hep B vaccine are first given to newborn babies in hospitals under the current arrangement. Pre-school children (aged 0 to 5) then receive different types of vaccines and boosters at recommended ages of vaccination at the DH's Maternal and Child Health Centres (MCHCs). As for primary school children, vaccination is provided at schools by the DH's outreach School Immunisation Teams (SITs). The Student Health Service (SHS) of the DH also provides free mop-up vaccination at Student Health Service Centres (SHSCs) for secondary school students who have not completed immunisation as recommended.

i. Number of vaccines administered

Eligible newborn babies to children aged 5

Eligible newborn babies to children aged 5 can receive vaccination free-of-charge at the MCHCs. Over 90% of local newborn babies receive services including vaccination at the MCHCs each year. The number of vaccines administered at the MCHCs under the HKCIP for newborn babies to children aged 5 over the past 3 years (2022 to 2024) are tabulated below:

Calendar year	Target population#	Doses of vaccines administered*
2022	32 950	323 000
2023	33 288	315 000
2024	36 767	319 000

Total registered live births

* The number only includes children who received vaccines under the HKCIP at the MCHCs (rounded to the nearest thousand)

Eligible primary school children

The SITs of the DH provide free vaccination to eligible Primary 1 school children, Primary 5

school girls and Primary 6 school children across the territory under the HKCIP. Over the past 3 years (2022 to 2024), the number of vaccines administered by the SITs under the HKCIP for school children are tabulated below:

Calendar year	Target population#	Doses of vaccines administered*
2022	139 560	201 000
2023	135 605	210 000
2024	133 130	202 000

The number includes all Primary 1 and 6 students and all Primary 5 girls. The number of registered students for 2022 and 2023 is obtained from the Education Bureau's website at https://www.edb.gov.hk/attachment/en/about-edb/publications-stat/figures/Enrol_2023.pdf while the number of registered students for 2024 is an estimate.

* rounded to the nearest thousand

Eligible secondary school students

The number of mop-up vaccines administered by the SHS under the HKCIP for secondary school students over the past 3 years (2022 to 2024) are tabulated below:

Calendar year	Doses of mop-up vaccines administered^
2022	447
2023	2 673
2024	4 408

^ The number of students served by the SHS was higher in 2023 than that in 2022 due to the SHS's limited services as a result of COVID-19 in 2022.

ii. Vaccination coverage rate

Eligible newborn babies to children aged 5

The DH conducts territory-wide surveys on immunisation coverage on a regular basis to monitor the vaccination rates among pre-school children in Hong Kong (i.e. the percentage of children having received vaccination as recommended under the HKCIP) and carries out random inspections of children's immunisation records. The latest survey covering pre-school children born between 2018 and 2020 is still underway and the results are expected to be released in the second quarter of 2025.

The results of the survey conducted in 2021 on the overall immunisation coverage of vaccination under the HKCIP (among pre-school children born between 2015 and 2017) are tabulated below:

Type of vaccine^	Year of birth		
	2015	2016	2017
BCG Vaccine	99.9%	99.5%	99.3%
Received Hep B vaccine	99.5%	99.2%	98.9%

Received Poliomyelitis vaccine	98.0%	97.9%	97.4%
Received Diphtheria-Pertussis-Tetanus vaccine	98.7%	98.0%	97.5%
Received Measles vaccine	99.9%	99.0%	99.1%
Received Mumps vaccine	99.9%	99.0%	99.1%
Received Rubella vaccine	99.9%	99.0%	99.1%
Received Varicella vaccine	99.1%	98.7%	98.7%
Received Pneumococcal vaccine	93.5%	94.7%	94.9%

^ includes vaccines received in private healthcare organisations and outside of Hong Kong

Eligible primary school children

The SITs check immunisation records of students while visiting schools. The overall immunisation coverage rates among primary school students based on these records are tabulated below:

Type of vaccine		School year		
		2021/22	2022/23	2023/24
Primary 1	Received Diphtheria, Tetanus, acellular Pertussis & Inactivated Poliovirus vaccine	96.9%	97.2%	96.9%
	Received Measles, Mumps, Rubella & Varicella vaccine	95.8%	95.4%	95.3%
Primary 5	HPV vaccine (female students)	88.9%	93.5%	93.5%
Primary 6	Received Diphtheria, Tetanus, acellular Pertussis (reduced dose) & Inactivated Poliovirus vaccine	96.1%	96.0%	96.2%
	Received Measles, Mumps & Rubella vaccine	97.9%	98.5%	98.2%
	Received Hep B vaccine	98.8%	99.3%	99.2%
	Received HPV vaccine (female students)	89.3%	91.9%	92.0%

The DH does not maintain data on vaccination coverage rates other than those under the HKCIP.

The expenditure for the HKCIP, dispersed across multiple cost components, cannot be

separately identified.

3.

To protect children's health, the vaccines currently covered by the HKCIP can prevent 12 communicable diseases with public health significance. The DH provides free and necessary vaccines to children of the age cohort suitable for vaccination through a comprehensive immunisation network and vaccination services, including vaccination programmes implemented by the MCHCs and the SITs under the DH. Data shows that the overall immunisation coverage rates of most vaccines recommended for pre-school children and school children are maintained at a very high level, providing an effective barrier of protection for children. For other vaccines that are not included in the HKCIP from the public health perspective, parents may seek professional advice from their family doctors to decide whether to arrange for their children to receive such vaccines for personal protection.

In the long run, the Government will progressively consolidate certain existing primary healthcare services under the DH (including maternal and child health service and student health service) in the primary healthcare system in order to enhance children's healthcare services in Hong Kong and create a better environment for receiving healthcare services and healthy growth. In respect of vaccination, the Government will ensure the very high coverage rate be maintained and convenient services continue to be provided.

4.

The Government has been facilitating childhood vaccination on all fronts by including the vaccines that are conducive to the protection of children's health and the overall public health in the HKCIP or other vaccination schemes/programmes launched by the Government, such as the Seasonal Influenza Vaccination (SIV) programmes. Apart from implementing vaccination schemes/programmes through a comprehensive immunisation network and vaccination services, the DH also takes various measures to ensure children to receive the vaccines at the recommended age under the HKCIP, including following up on cases where children have not been brought to the MCHCs for vaccination at the recommended age by phone or other means of contact. In addition to administering vaccines to students through outreach programmes, the SITs have set up sub-offices to provide mop-up vaccination for primary school students who have not completed immunisation as recommended under the HKCIP. Besides, the DH's SHS offers checking of immunisation record for secondary school students who have joined the Student Health Service, and arranges mop-up vaccination for those who have not completed the immunisation under the HKCIP.

The DH promotes vaccination through a variety of publicity and promotional channels, both online and offline. These promotional efforts include broadcasting Announcements in the Public Interest on vaccination on television and radio, as well as publicity through social media, newspapers, parent-child magazines and means of transport, etc. These measures aim to widely disseminate the importance of vaccination, encourage the public to actively participate in the vaccination schemes/programmes, so as to ensure that the community maintains a high immunisation coverage rate and to protect children's health to the best possible extent.

5.

The DH has taken the initiative to encourage and support schools in organising the SIV school outreach activities. Upon commencement of the SIV School Outreach Programme

(SIVSOP) since 2024/25, the DH has reached out to non-participating schools one by one to understand their difficulties, offer necessary assistance (including providing outreach vaccination services to schools in remote area or those that could not identify an appropriate private doctor for the outreach vaccination activity) and facilitate them to participate in the SIVSOP.

To boost the SIV coverage rate among school children and attract schools to participate in the SIVSOP, special arrangements have been made under the SIVSOP this year to offer a more flexible choice of vaccine options. Kindergartens and child care centres can choose both injectable inactivated influenza vaccines (IIV) and live attenuated influenza vaccines (LAIV) (i.e. nasal vaccines) for the same or different outreach vaccination activities. As a pilot scheme, the LAIV is also provided to primary and secondary schools that indicated their preference for the LAIV earlier this year.

In addition, to encourage school children to receive the SIV, the DH has launched a commendation scheme under the SIVSOP this year. Participating schools with a high uptake rate will be awarded certificates in recognition of their efforts.

The DH has also contacted relevant association of early childhood educators and medical associations, as well as the Federations of Parent-Teacher Associations to appeal for their support for schools to participate in the SIVSOP. The DH has also issued letters to the associations of heads of kindergartens and child care centres through the Education Bureau and contacted school sponsoring bodies to appeal to non-participating schools to arrange for the SIV activities.

As at 23 March 2025, about 1 020 kindergartens/child care centres (97%), about 640 primary schools (98%) and about 490 secondary schools (98%) have completed or will conduct SIV school outreach activities, which is higher than last year's participation rates (80% of kindergartens/child care centres, 95% of primary schools and 70% of secondary schools). This fully reflects the schools' strong support for the SIVSOP.

- End -

CONTROLLING OFFICER'S REPLY**HHB258****(Question Serial No. 0976)**Head: (37) Department of HealthSubhead (No. & title): (-) Not SpecifiedProgramme: (5) RehabilitationControlling Officer: Director of Health (Dr. Ronald LAM)Director of Bureau: Secretary for HealthQuestion:

At present, the Department of Health (DH) runs 7 Child Assessment Centres (CACs) for children under 12 years of age suspected or diagnosed to have developmental-behavioural problems or disorders, which formulate follow-up plans for them according to their individual needs. In this connection, will the Government please advise this Committee on the following information:

1. Normally, children are referred to the Child Assessment Service (CAS) for further assessment at a CAC as and when necessary after initial assessment by a registered medical practitioner. The CAS also accepts referrals from Maternal and Child Health Centres (MCHCs), registered medical practitioners and clinical or educational psychologists. Please provide in the table below details of the referral sources to the CAS in the past 5 years:

Means of referral	Number of cases				
	2020	2021	2022	2023	2024
MCHCs and other specialties (DH)					
Paediatricians, General Out-Patient Clinics and other specialties (Hospital Authority(HA))					
Doctors in private practice					
Psychologists (including HA, Education Bureau & Social Welfare Department)					
Psychologists (non-governmental organisations)					
Psychologists (private practice)					
Others					

Means of referral	Number of cases				
	2020	2021	2022	2023	2024
Total					

2. Regarding CACs under the DH, please provide in the table below the number of children assessed by the CAS, the rate for completion of assessment for new cases within 6 months, the waiting time for assessment of new cases, and the attendance at the 7 CACs in the past 5 years.

Number of children assessed by the CAS and completion rate of new case assessment within 6 months

	2020	2021	2022	2023	2024
Number of children assessed by CAS					
Rate for completion of assessment for new cases within 6 months (%)					

Waiting time for attendance at CACs under the DH (%)

	2020	2021	2022	2023	2024
Less than 3 months					
3 to less than 6 months					
6 to less than 9 months					
9 to less than 12 months					
12 to less than 15 months					
15 to less than 18 months					
18 months or above					

Attendance at the 7 CACs

CACs	2020	2021	2022	2023	2024
Central Kowloon CAC					
Ha Kwai Chung CAC					
Pamela Youde CAC (Kwun Tong)					
Pamela Youde CAC (Sha Tin)					
Fanling CAC					
Tuen Mun CAC					
Ngau Tau Kok CAC					
Total:					

3. The CAS of the DH serves children who are under 12 years of age suspected to have developmental-behavioural problems or disorders. Please advise on the number of newly

referred cases received, the age distribution and the average age of the children involved, in the past 5 years.

4. Please set out the number of children diagnosed with developmental disorders by symptom of developmental disorder in each of the past 3 years and the age distribution in detail.

5. Please advise on the expenditure and staff establishment of the CACs in the last and the next financial years. Besides, what is the rough estimate of CACs' average expenses of each assessment? How does it compare with the assessment fees in the private sector?

6. The Primary Healthcare Commission has been actively expanding its work since its official establishment in July 2024 to strengthen the primary healthcare service network in the community. It is understood that the Government is planning to transfer the CAS of the DH to the HA for management, with the aim to consolidate public paediatrics services, facilitate collaboration among various specialties and enhance service delivery. Please provide the details of the plan, including its implementation timetable, specific details and objectives.

Asked by: Hon NGAN Man-yu (LegCo internal reference no.: 34)

Reply:

1 & 3. The Child Assessment Service (CAS) of the Department of Health (DH) receives referrals from doctors and psychologists for clinical assessment of children under the age of 12 with suspected developmental problems. New cases are referred through different channels, including the Maternal and Child Health Centres (MCHCs), the Hospital Authority (HA), private practitioners and psychologists, etc. Details of the referral sources to the CAS in the past 5 years are as follows:

Means of referral	Number of cases				
	2020	2021	2022	2023	2024 (Provisional figures)
MCHCs and other service units of the DH	5 357	8 817	7 589	6 639	6 273
Paediatricians, General Out-Patient Clinics and other specialties of HA	944	1 243	925	941	880
Doctors in private practice	753	1 173	860	843	688
Psychologists (including HA, Education Bureau, Social Welfare Department, non-governmental organisations and private psychologists)	472	929	778	902	753
Others	0	4	2	1	2
Total	7 526	12 166	10 154	9 326	8 596

We do not have the breakdown of number of new cases by age group.

2. The number of children assessed by the CAS, the rate for completion of assessment for new cases within 6 months and the attendance at the 7 Child Assessment Centres (CACs) in the past 5 years are as follows:

	*2020	*2021	*2022	2023	2024 (Provisional figures)
Number of children assessed by the CAS#	14 507	16 626	14 251	18 637	17 757
Rate for completion of assessment for new cases within 6 months (%)	65	73	61	70	68

The figure includes both newly registered referral cases and follow-up cases.

Attendance at CACs	*2020	*2021	*2022	2023	2024 (Provisional figures)
Central Kowloon CAC	3 583	4 258	3 672	4 567	4 124
Ha Kwai Chung CAC	4 290	5 954	4 870	5 529	5 661
Pamela Youde CAC (Kwun Tong)	4 879	6 199	4 753	5 028	4 860
Pamela Youde CAC (Sha Tin)	5 110	6 298	5 131	6 039	6 169
Fanling CAC	3 729	5 036	4 284	4 821	4 868
Tuen Mun CAC	4 121	5 780	4 665	5 270	5 236
Ngau Tau Kok CAC	1 569	1 853	1 427	1 576	1 534
Total:	27 281	35 378	28 802	32 830	32 452

* The figures (of 2020 and 2022 in particular) were affected by the COVID-19 pandemic. Even though the CAS services remained available during the pandemic, some parents were reluctant to take their children out at the beginning of 2020, thus postponing the registration of new cases or the assessment. As a result, there was an accumulation of children requiring assessment in 2021 when the epidemic situation slightly eased. The number dropped again in 2022 due to the outbreak of the fifth wave.

In the past 5 years, all cases newly referred to the CAS were first seen by nurses within 3 weeks after registration. The CAS has adopted a triage system to ensure that children with urgent and more serious conditions are accorded with higher priority for assessment upon preliminary assessment by nurses. The actual waiting time for assessment depends on the complexity and conditions of individual cases. The CAS does not maintain statistics on the waiting time for assessment of new cases.

4. The number of newly diagnosed cases of developmental conditions in the CAS in the past 3 years is as follows:

Developmental conditions	Number of newly diagnosed cases		
	2022	2023	2024 (Provisional figures)
Attention/Hyperactive Problems/Disorders	2 422	3 156	2 996
Autism Spectrum Disorder	1 861	2 415	2 195
Borderline Developmental Delay	2 105	2 479	2 752
Developmental Motor Coordination Problems/Disorders	2 256	2 765	3 018
Dyslexia & Mathematics Learning Disorder	229	359	298
Hearing Loss (Moderate to profound grade)	50	58	90
Language Delay/Disorders and Speech Problems	4 147	5 441	6 974
Physical Impairment (i.e. Cerebral Palsy)	34	38	45
Significant Developmental Delay/Intellectual Disability	1 527	1 914	2 261
Visual Impairment (Blind to Low Vision)	6	46	46

Note: A child might have been diagnosed with more than one developmental condition.

We do not maintain statistics on the breakdown of children's developmental conditions by age group.

5. The revised estimate and the estimate for the CAS for 2024-25 and 2025-26 are \$157.7 million and \$202.3 million respectively. In 2024-25 and 2025-26, the approved establishments of the CAS are 183 and 190 respectively.

We do not have the estimated average expenses for each assessment.

6. As announced by the Chief Executive in his 2024 Policy Address, to enhance the health of the people of Hong Kong, improve healthcare protection and quality, and capitalise on our healthcare professions' strengths, the Government is conducting a comprehensive review of the positioning and objectives of the healthcare system, reforming the functions and division of work among the HA, the DH and the Primary Healthcare Commission (PHCC). This includes a reform of the HA's - governance effectiveness to enhance the standards and efficiency of its specialist and in-patient services, while the PHCC and the DH will strengthen their efforts in health promotion and disease prevention in order to continue to reverse the system imbalance that emphasises on treatment rather than prevention. The DH will also strengthen its role as the Government's health adviser and regulatory authority, and would focus on its public health functions. In this connection, the DH is gradually transferring its specialist clinical services and primary healthcare services to the HA and the PHCC respectively.

The DH is liaising with the HA on the detailed arrangements for integrating the CAS into the Hong Kong Children's Hospital under the HA, with a view to consolidating public paediatrics services to facilitate collaboration among various specialties and

streamline service delivery. This will ensure that children suspected of having developmental or behavioural problems can receive the necessary integrated and multi-disciplinary assessment, treatment and rehabilitation services in a timely manner, while the referral arrangements and services for patients can be optimised. Relevant details will be announced at an appropriate juncture.

- End -

CONTROLLING OFFICER'S REPLY

HHB259

(Question Serial No. 2784)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions, (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

1. At present, health screening staff are stationed at all boundary control points every day to conduct body temperature screening for inbound travellers. Please advise on the total number of posts and the pertaining salary expenditure over the past 3 years; and
2. given that the COVID-19 pandemic has now passed, whether the Government will consider reducing the manpower and costs in this regard or introducing technology products such as artificial intelligence systems to reduce the manpower involved and facilitate revenue-raising and expenditure-cutting?

Asked by: Hon QUAT Elizabeth (LegCo internal reference no.: 19)

Reply:

In accordance with the power conferred by the Prevention and Control of Disease Ordinance of Hong Kong and with regard to the guidelines of the International Health Regulations, the Department of Health (DH) enforces various preventive measures at boundary control points (BCPs) to prevent the introduction or spreading of infectious diseases into or out of Hong Kong. The Port Health Division under the DH carries out health screening work at each BCP (including conducting regular body temperature screening for arrivals and setting up health stations). Taking into account the design of each BCP and its traveller and vehicle flow, the DH deploys appropriate manpower to conduct body temperature screening for all arrivals; and performs, in accordance with the mechanism, further health assessments for travellers with fever or in need (such as travellers who self-reported being unwell) to understand their symptoms, travel history, contact history, etc., in order to make appropriate referrals and follow-up, including compulsory referral of persons with suspected infection of major infectious diseases to Hong Kong public hospitals for checking, recommending other travellers with fever or in need to seek medical treatment at medical institutions with issuance of referral letters, and assisting persons in need to call for ambulance service for further treatment at Accident and Emergency Department.

The Hong Kong Special Administrative Region (HKSAR) Government has been maintaining close co-operation with entry-exit health inspection and quarantine authorities of the Mainland to safeguard the well-being and safety of residents and travellers of the 2 places.

The Health Bureau and the General Administration of Customs of the People's Republic of China (GACC) signed the Co-operation Arrangement for Entry-exit Health Inspection and Quarantine between the GACC and the Health Bureau of the HKSAR Government in 2023. Under the normalisation arrangements for epidemic prevention and control, the 2 parties agreed to focus on the health inspection and quarantine of their respective inbound personnel travelling between the HKSAR and the Mainland BCPs.

The HKSAR Government will maintain close liaison with the relevant Mainland authorities and, taking into account factors such as cost-effectiveness and appropriateness, actively review the entry health inspection and quarantine arrangements (including temperature screening) from the public health perspective.

(1)

From 2020 to 2024, the average number of health screening shifts of the DH per day at various BCPs (some health screening posts involve more than 1 shift according to the operation of BCPs) is as follows:

	2022	2023	2024
Total Number of Health Screening Posts	880	751	722

Note:

The DH redeploys health screening posts in view of the actual circumstances. Some of the posts at BCPs where operation has been suspended would be redeployed to other BCPs. Health screening service of Kai Tak Cruise Terminal and Ocean Terminal was not included as it was only provided during stopover of cruises.

The expenditure incurred by health screening shifts listed in the table above is set out below:

	Financial Year		
	2022-23	2023-24	2024-25
Expenditure (\$ million)	239	240	205

(2)

Ongoing health screening, which facilitates early identification of potential infectious diseases imported into Hong Kong, is vital to safeguarding public health. Currently, health screening measures are in place for inbound travellers at all BCPs between Hong Kong and the Mainland.

The DH mainly employs an Infrared Thermal Imaging System at various BCPs to detect the body temperatures of multiple travellers simultaneously to reduce the manpower required for such work. However, drivers and all passengers in a cross-boundary private car are allowed to remain in their vehicle while passing through the kiosks of the Immigration Department, the Customs and Excise Department and the DH without the need to get off from the vehicle or go to the traveller's clearance hall. Due to site constraints, the Infrared Thermal Imaging System cannot be used to measure the forehead temperature of drivers and passengers passing through the vehicle lanes. As a result, hand-held infrared thermometers are used to measure the body temperature of inbound passengers on board the vehicles at the DH vehicle kiosks.

The DH reviews the health screening arrangements from time to time and deploys manpower as appropriate at various BCPs according to the actual circumstances to provide appropriate services for inbound travellers. For instance, the additional personnel deployed during the COVID-19 epidemic in the light of the actual needs have been reduced after the epidemic, and the manpower at relevant BCPs has basically returned to the pre-epidemic level. Meanwhile, the DH also keeps a close eye on technological development and actively explores the adoption of innovative technology in collaboration with other departments at BCPs to reduce the manpower need for health screening and optimise the use of human resources.

- End -

CONTROLLING OFFICER'S REPLY

HHB260

(Question Serial No. 2785)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The Department of Health launched the Human Papillomavirus (HPV) Vaccination Catch-up Programme last year, providing catch up vaccination for female Hong Kong residents born between 2004 and 2008 to prevent HPV-related diseases. In this connection, please advise on:

1. whether the Government will review the reasons behind the current suboptimal uptake rate given that both the uptake rate and school participation in the first phase fell short of expectations; the measures to further increase school participation and vaccination uptake rate, such as strengthening publicity and education and further enhancing the communication with schools; if yes, the details; if no, the reasons;
2. the timetable for and details of the second and third phases of the programme; whether key performance indicators will be considered for the second and third phases of the programme to ensure their effectiveness;
3. whether subsidies will be considered for schoolgirl vaccination of HPV in private clinics alongside school vaccination to facilitate parental accompaniment; and whether more service locations will be available.

Asked by: Hon QUAT Elizabeth (LegCo internal reference no.: 20)

Reply:

1.

In response to the World Health Organization's (WHO) recommendation, the Centre for Health Protection (CHP) of the Department of Health (DH) has implemented an HPV vaccination programme for Primary Five and Primary Six school girls under the Hong Kong Childhood Immunisation Programme (HKCIP) since the 2019/20 school year. The interim target coverage rate for completion of 2 doses of HPV vaccination as stated in the Hong Kong Cancer Strategy 2019 is 70%. In the 2023/24 school year, the coverage rate for completion of 2 doses of HPV vaccination among eligible school girls under the HKCIP was over 90%.

In 2022, the WHO further recommended the provision of catch-up vaccinations to girls aged between 9 and 18. The Scientific Committee on Vaccine Preventable Diseases under the CHP also agreed earlier to expand the target group of HPV vaccination to older girls aged 18 or below. Taking into account the scientific evidence, the Government decided to launch a one-off HPV Vaccination Catch-up Programme (the Catch-up Programme) in phases starting from 2 December 2024, for female Hong Kong residents who were born in 2004 or after, and have not been covered by the HKCIP (i.e. girls aged 18 or below as in 2022, and not being covered by the existing programme) to receive free HPV vaccination, providing protection for the remaining group of older girls (estimated to be around 190 000). Each eligible person can receive 2 doses of free vaccination, while immunocompromised persons have to receive 3 doses of vaccination (all free of charge). The Catch-up Programme will be implemented in 3 phases over about 2 years.

The first phase of the Catch-up Programme commenced on 2 December 2024. Targeted recipients are eligible full-time female students studying in Hong Kong secondary schools (including secondary sections of special schools). Schools can engage participating outreach private vaccination teams to provide free HPV vaccination service to eligible female students at schools. The CHP would provide free vaccines for the outreach vaccinations along with a subsidy of \$105 per dose to doctors. If eligible female students miss the outreach vaccination activities at their schools, the School Immunisation Teams' (SIT) sub-office and Student Health Service Centre (SHSC) under the DH can provide mop-up vaccination. The SIT would also provide outreach vaccination services to schools in remote area or those that could not identify an appropriate private doctor to provide the outreach vaccination activity.

The Government has been strongly urging schools to join the Catch-up Programme and actively assisting schools in organising outreach vaccination activities. The CHP has, on multiple occasions, issued letters through the Education Bureau (EDB) to relevant secondary schools to invite them to join the first phase of the programme, and arranged an online briefing for schools to introduce programme details and answer schools' queries concerning the programme. The CHP has also held a media interview and issued a press release to announce the programme, while promotion through social media has also been conducted. Since the launch of the first phase of the Catch-up Programme, the CHP has reached out to individual schools that have yet to participate in the programme to understand their difficulties and provide necessary assistance to facilitate their participation. In addition, the CHP referred the list of schools that refused to participate in the Catch-up Programme or have not yet replied to the EDB, enabling the latter to contact the schools concerned and encourage them to actively participate.

On 5 March 2025, with the assistance from the EDB, the CHP sent a letter to parents through schools to further explain to parents the details of the Catch-up Programme and remind parents that this is a one-off catch-up vaccination activity. Eligible female students who do not participate in the programme can only be vaccinated at their own expense in private clinics in the future. The cost of vaccination may exceed \$1,200 per dose. A webinar was also held on 19 March 2025 for parents to learn more about the HPV vaccine. In addition, the DH has produced a series of video clips on the vaccine, which are disseminated through social media to enhance students' understanding of the vaccine and urge them to actively participate in the Catch-up Programme.

As at 1 April 2025, over 510 schools (approximately 98% of eligible schools) indicated their participation. Among these, nearly 280 schools have already conducted vaccination activities, with over 14 000 doses administered. Counting doses administered under the Catch-up Programme and self-arranged vaccinations, the coverage rate for the first-dose HPV vaccine is over 70%. After the deadline for reply from schools (i.e. 31 March 2025), the DH has requested the remaining few that did not arrange for outreach vaccination to issue a notice to inform parents about the schools' arrangement. A list of those non-participating schools has been uploaded to the CHP's webpage so that parents of relevant schools may arrange their daughters to receive mop-up vaccination at a SIT sub-office or a SHSC under the DH.

Due to the nature of the Catch-up Programme as a one-off programme, any direct comparison with the coverage rates of the HPV vaccination programme under the regular HKCIP is not appropriate. Moreover, there are currently no international benchmarks for HPV vaccination coverage rates for the age group covered by the Catch-up Programme. The Government will continue to step up its publicity efforts through various channels and endeavour to encourage eligible female Hong Kong residents to actively participate in the programme.

2. and 3.

The second phase of the Catch-up Programme commenced in mid-March 2025. Targeted recipients are female Hong Kong residents studying in local post-secondary institutions or universities who were born between 2004 and 2008. Participating institutions could choose to provide catch-up vaccination services to eligible female students at their healthcare services clinics or arrange outreach teams to provide service on campus. The CHP would provide free vaccine along with subsidies to doctors. The CHP had sent letter to post-secondary institutions or universities in December 2024, inviting them to join the programme. As at 1 April 2025, all invited post-secondary institutions and universities have enrolled in the programme, with 6 of them having commenced catch-up vaccination in mid-March already.

The third phase of the Catch-up Programme will start in the first half of 2025. Targeted recipients are female Hong Kong residents born between 2004 and 2008 who have already completed their studies in Hong Kong. The third phase will also cover the rest of female Hong Kong residents born between 2004 and 2008 who have not yet completed their HPV vaccination. The CHP together with the Primary Healthcare Commission are discussing the arrangement for the third phase, with preliminary plans of providing catch-up vaccination services at the Women Wellness Satellites and District Health Centres under the district health network. The arrangements will be announced in due course.

- End -

CONTROLLING OFFICER'S REPLY

HHB261

(Question Serial No. 2786)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Breast cancer is the most common form of cancer among women in Hong Kong. Regarding the efforts to strengthen the prevention and treatment of breast cancer in Hong Kong, please inform this Committee of the following:

1. the respective expenditures of the Department of Health, Hospital Authority and other organisations subvented by the Government on breast cancer prevention, screening and treatment in each of the past 3 financial years; the Government's overall estimated expenditure on breast cancer prevention, screening and treatment for the financial year 2025-26; whether the Government will consider reviewing the allocation ratio between the resources earmarked for breast cancer prevention, screening and treatment so as to enhance breast cancer prevention and screening, thereby reducing the total social cost of breast cancer treatment in the long run; if yes, the details; if no, the reasons;
2. whether the Government will consider providing free mammography screening for eligible women starting from the financial year 2025-26; if yes, the work plan and the estimated expenditure involved; if no, the reasons;
3. whether the Government will develop a one-stop information website and a mobile application on breast cancer prevention and treatment to consolidate information on breast cancer prevention, screening, diagnosis, treatment, rehabilitation and care for users to facilitate information search on the Internet, gain a better understanding of the entire process of breast cancer prevention and treatment when browsing the website or using the mobile application, and identify the corresponding services available according to individual needs at different stages; if yes, the details, the timetable and the estimated expenditure involved; if no, the reasons; and
4. whether the Government will make reference to the mode of publicity for the Colorectal Cancer Screening Programme as well as colorectal cancer prevention and treatment to step up the publicity for breast cancer prevention and treatment, including enhancing the public awareness of and concern for breast cancer prevention and treatment through diverse channels; if yes, the details and the estimated expenditure involved; if no, the reasons?

Asked by: Hon QUAT Elizabeth (LegCo internal reference no.: 21)

Reply:

The Government attaches great importance to cancer prevention and control work. Fighting against cancer is an important part of the strategy to prevent and control non-communicable diseases. In 2001, the Government established the Cancer Coordinating Committee (CCC) to formulate strategies on cancer prevention and control and to steer the direction of work covering cancer prevention and screening, surveillance, research and treatment.

The Cancer Expert Working Group on Cancer Prevention and Screening (CEWG) under the CCC regularly reviews local and international scientific evidence, with a view to making recommendations to the Government on suitable evidence-based measures for cancer prevention and screening for the local population. Based on the CEWG's recommendations on cancer screening, the Government has rolled out the Cervical Screening Programme, the Colorectal Cancer Screening Programme and the Breast Cancer Screening Pilot Programme (BCSPP).

When considering recommendations for any disease screening, the Government will refer to the evidence-based risk assessment and views of relevant experts from the perspective of public health. A number of factors will be carefully assessed, such as local prevalence of the cancer, accuracy and safety of the screening tests, effectiveness in reducing incidence and mortality rates as well as feasibility of implementation of a screening programme. The perspective of good utilisation of medical resources will be taken into account to determine the priority. Excessive screening under public health programmes not only wastes resources for the overall public health, but also runs out of resources that can be invested on other projects in greater need, and may pose unnecessary health risks to individuals, often causing more harm than good.

Primary prevention (i.e. reducing exposure to cancer risk factors) is the most important strategy for reducing the risk of developing cancer. The Department of Health (DH) has all along been encouraging members of the public to adopt a healthy lifestyle, including avoidance of smoking and alcohol, healthy diet, regular physical activity and maintenance of a healthy body weight and waist circumference, in order to reduce the risk of non-communicable diseases including cancer.

(1) & (2)

Based on the CEWG's recommendations on prevention and screening, the Government adopts a risk-based approach for breast cancer screening and launched Phase I of the BCSPP in 2021. Women aged between 44 and 69 with certain combinations of personalised risk factors (including presence of history of breast cancer among first-degree relatives, a prior diagnosis of benign breast disease, nulliparity or late age of first live birth, early age of menarche, high body mass index and physical inactivity) putting them at increased risk of breast cancer are recommended to consider mammography (MMG) screening every 2 years.

In the two-year Phase I of the BCSPP (which ran from September 2021 to December 2023), a total of 27 807 women aged between 44 and 69 have received breast cancer risk assessment in Woman Health Centres (WHCs), 4 Maternal and Child Health Centres and 18 Elderly Health Centres (EHCs). 7 785 (about 28%) of them were referred to 5 outsourced imaging centres based on the risk assessment and underwent the MMG screening. Among the women with abnormal MMG results who had been referred to specialists for treatment, 409

cases were followed up in public hospitals, among which 68 were confirmed to have breast cancer. The breast cancer detection rate per 1 000 MMG screenings was 8.7, which was comparable to the international standard of about 5 cases per 1 000 MMG screenings. Of the 68 breast cancer cases identified through the MMG screening, 97% were at stage II or below. Following the review of Phase I of the BCSPP, the breast cancer risk assessment and screening have been included as part of the regular services provided by the Woman Health Service and the Elderly Health Service.

The Woman Health Service under the DH will be integrated into the district health network of the Health Bureau Primary Healthcare Commission within 2025. The service points, to be named Women Wellness Satellites, will form a network with District Health Centres (DHCs)/DHC Expresses in all 18 districts across Hong Kong to provide eligible women with prevention-based and more personalised primary healthcare services, including breast cancer screening. In parallel, the DHCs/DHC Expresses actively promote the “Life Course Preventive Care Plan”. In line with the core principles of prevention-oriented and whole-person care, a personalised preventive care plan will be formulated based on the most updated evidence and the health needs of citizens across different life stages. Family doctors and primary healthcare professionals will collaborate to promote healthy lifestyles and disease prevention, including providing education and vaccination for cancer prevention, and advising on cancer screening services according to personal risk factors.

Based on the recommendations of the CEWG, the Government is now preparing for Phase II of the BCSPP to provide subsidised breast cancer screening services for women at high risk of developing breast cancer (i.e. carriers of certain gene mutations and/or with strong family history of breast cancer or ovarian cancer) through Public-Private Partnership programmes in collaboration with non-governmental organisations. Phase II of the BCSPP, of which details will be announced in due course, is expected to be launched around the second quarter of 2025.

As for treatment, the Hospital Authority (HA) adopts an integrated and multi-disciplinary approach as appropriate in treating cancer patients according to their clinical conditions. As different specialties and multiple service locations may be involved in cancer treatment, the expenditure and estimate cannot be separately identified.

The expenditure of Phase I of the BCSPP is subsumed under the overall provision for WHCs and EHCs, thus a breakdown of such expenditure is not available. The resources and manpower involved in cancer prevention education activities are subsumed into the overall provision of the DH and cannot be separately identified as well.

(3) & (4)

The Government launched the Hong Kong Cancer Strategy (Cancer Strategy) in July 2019 with a view to reducing the cancer burden of the local population and improving the quality of life and survivorship of cancer patients through setting work priorities and directions. As one of the expected outcomes of the Cancer Strategy, the Government launched the Cancer Online Resource Hub (www.cancer.gov.hk) in July 2020 to provide the public with one-stop health information relating to cancer, including breast cancer prevention, screening, diagnosis and treatment.

Hospital Authority's Smart Patient Website (SPW), a one-stop patient information hub, provides patients and their carers with disease information, caring tips, preparation for general surgeries and procedures as well as information on community resources, to empower on disease management and self-care skills. The SPW provides various information on breast cancer, including its preventive measures, causes and symptoms, screening and diagnosis, treatment options, pre- and post-operative care. Such information will help breast cancer patients to better understand the disease and confront the cancer with a positive attitude.

The DH promotes a healthy lifestyle as a primary strategy for preventing cancer and common non-communicable diseases. This includes avoiding tobacco and alcohol, maintaining a healthy diet, exercising regularly, and maintaining a healthy body weight. The DH has all along attached importance to the public education of cancer (including breast cancer) and has been promoting breast cancer prevention and screening through various channels and media such as television, radio, websites, printed materials, newspapers, social media, online campaigns and media interviews. In addition, the DH has produced health education materials such as posters and pamphlets on breast cancer in at least 8 ethnic minority languages (including Hindi, Nepali, Urdu, Thai, Indonesian, Filipino, Punjabi and Vietnamese) for ethnic minorities to comprehend the health information on breast cancer prevention and screening.

- End -

CONTROLLING OFFICER'S REPLY

HHB262

(Question Serial No. 2787)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

For the prevention and cure of breast cancer, the Department of Health has launched the Breast Cancer Screening Pilot Programme (BCSPP) and the Phase I of which ended in September 2023. Please advise this Committee on:

1. the specific work plan, timetable and estimated expenditure of Phase II of the BCSPP to be implemented by the Government in 2025 for a period of 3 years;
2. whether the Government will consider deploying resources to revise the arrangements for the Phase II of the BCSPP, such as lowering the age threshold for the BCSPP to 40, including women with medium-to-high risk of breast cancer; if yes, the details and the estimated expenditure involved; if no, the reasons;
3. given that only 2D mammography (MMG) screening was subsidised for eligible women in Phase I of the BCSPP, whether the Government will consider subsidising 3D MMG screening which is more accurate; or allowing women subsidised for 2D MMG screening to choose to receive 3D MMG screening by paying the price difference in Phase II of the BCSPP; and
4. as it is learnt that only 4 private healthcare facilities in Hong Kong joined Phase I of the BCSPP, whether the Government will consider strengthening public-private partnership in Phase II of the BCSPP by, for example, including more private clinics and testing centres, encouraging participation of more private clinics and testing centres, etc., with a view to increasing the number of service points for breast cancer screening in the 18 districts across Hong Kong with longer service hours for the convenience of both working and non-working women; if yes, the details and timetable; if no, the reasons.

Asked by: Hon QUAT Elizabeth (LegCo internal reference no.: 22)

Reply:

The Cancer Expert Working Group on Cancer Prevention and Screening (CEWG) under the Cancer Coordinating Committee chaired by the Secretary for Health regularly reviews local and international scientific evidence, with a view to making recommendations to the Government on suitable evidence-based measures for cancer prevention and screening for the

local population. Based on the CEWG's recommendations on cancer screening, the Government has rolled out the Cervical Screening Programme, the Colorectal Cancer Screening Programme and the Breast Cancer Screening Pilot Programme (BCSPP).

When considering recommendations for any disease screening, the Government will refer to the evidence-based risk assessment and views of relevant experts from the perspective of public health. A number of factors will be carefully assessed, such as local prevalence of the cancer, accuracy and safety of the screening tests, effectiveness in reducing incidence and mortality rates as well as feasibility of implementation of a screening programme. The perspective of good utilisation of medical resources will be taken into account to determine the priority. Excessive screening under public health programmes not only wastes resources for the overall public health, but also runs out of resources that can be invested on other projects in greater need, and may pose unnecessary health risks to individuals, often causing more harm than good.

Primary prevention (i.e. reducing exposure to cancer risk factors) is the most important strategy for reducing the risk of developing cancer. The Department of Health (DH) has all along been encouraging members of the public to adopt a healthy lifestyle, including avoidance of smoking and alcohol, healthy diet, regular physical activity and maintenance of a healthy body weight and waist circumference, in order to reduce the risk of non-communicable diseases including cancer.

(1), (2) & (4)

Based on the recommendations of the CEWG, the Government adopts a risk-based approach for breast cancer screening and launched Phase I of the BCSPP in 2021. Women aged between 44 and 69 with certain combinations of personalised risk factors (including presence of history of breast cancer among first-degree relatives, a prior diagnosis of benign breast disease, nulliparity or late age of first live birth, early age of menarche, high body mass index and physical inactivity) putting them at increased risk of breast cancer are recommended to consider mammography (MMG) screening every 2 years.

In the two-year Phase I of the BCSPP (which ran from September 2021 to December 2023), a total of 27 807 women aged between 44 and 69 have received breast cancer risk assessment in Woman Health Centres, 4 Maternal and Child Health Centres and 18 Elderly Health Centres. 7 785 (about 28%) of them were referred to 5 outsourced imaging centres based on the risk assessment and underwent the MMG screening. Among the women with abnormal MMG results who had been referred to specialists for treatment, 409 cases were followed up in public hospitals, among which 68 were confirmed to have breast cancer. The breast cancer detection rate per 1 000 MMG screenings was 8.7, which was comparable to the international standard of about 5 cases per 1 000 MMG screenings. Of the 68 breast cancer cases identified through the MMG screening, 97% were at stage II or below. Following the review of Phase I of the BCSPP, the breast cancer risk assessment and screening have been included as part of the regular services provided by the Woman Health Service and the Elderly Health Service.

The Woman Health Service under the DH will be integrated into the district health network of the Health Bureau Primary Healthcare Commission within 2025. The service points, to be named Women Wellness Satellites, will form a network with District Health Centres

(DHCs)/DHC Expresses in all 18 districts across Hong Kong to provide eligible women with prevention-based and more personalised primary healthcare services, including breast cancer screening. In parallel, the DHCs/DHC Expresses actively promote the “Life Course Preventive Care Plan”. In line with the core principles of prevention-oriented and whole-person care, a personalised preventive care plan will be formulated based on the most updated evidence and the health needs of citizens across different life stages. Family doctors and primary healthcare professionals will collaborate to promote healthy lifestyles and disease prevention, including providing education and vaccination for cancer prevention, and advising on cancer screening services according to personal risk factors.

Based on the recommendations of the CEWG, the Government is now preparing for Phase II of the BCSPP to provide subsidised breast cancer screening services for women at high risk of developing breast cancer (i.e. carriers of certain gene mutations and/or with strong family history of breast cancer or ovarian cancer) through Public-Private Partnership programmes in collaboration with non-governmental organisations. Phase II of the BCSPP, of which details will be announced in due course, is expected to be launched around the second quarter of 2025.

(3)

Based on the recommendations of the CEWG, there is insufficient evidence to support the use of 3D MMG screening as the routine screening tool for breast cancer. According to the findings of overseas studies, there is a lack of evidence that screening with 3D MMG is more cost-effective than screening with 2D MMG in terms of detecting breast cancer and reducing breast cancer mortality. Since 3D MMG screening incurs higher costs and requires a longer time for specialists to review the MMG screening images, most regions that provide breast cancer screening services generally use 2D rather than 3D MMG machines. The CEWG will continue to review the latest progress of breast cancer screening tools.

- End -

CONTROLLING OFFICER'S REPLY

HHB263

(Question Serial No. 2788)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Regarding the prevention of cervical cancer in the public healthcare system, please advise on:

1. the respective quotas for cervical screening provided by Woman Health Centres (WHCs), District Health Centres (DHCs) and Maternal and Child Health Centres (MCHCs) and the respective number of women receiving cervical screening service at the WHCs, DHCs and MCHCs in each of the past 3 years;
2. in the light of the Government's plan to integrate the services of WHCs and DHCs, whether their provision of cervical screening service for women will be affected by the integration; if yes, the details;
3. whether the Government will consider setting quotas for cervical screening provided by MCHCs to eligible low-income women on a free or subsidised basis in the 2025-26 financial year; if yes, details of the plan and estimated expenditure; if no, the reasons; and
4. the expenditure incurred by the Government on promoting cervical screening service in each of the past 3 years, and whether the Government will consider adjusting the publicity expenditure concerned in 2025-26 and seeking more channels to convey the message of regular cervical screening to local women; if yes, details of the work plan and the estimated expenditure; if no, the reasons.

Asked by: Hon QUAT Elizabeth (LegCo internal reference no.: 23)

Reply:

The Cancer Expert Working Group on Cancer Prevention and Screening (CEWG) under the Cancer Coordinating Committee chaired by the Secretary for Health regularly reviews local and international scientific evidence, with a view to making recommendations to the Government on suitable evidence-based measures for cancer prevention and screening for the local population. Based on the CEWG's recommendations on cancer screening, the Government has rolled out the Cervical Screening Programme (CSP), the Colorectal Cancer Screening Programme and the Breast Cancer Screening Pilot Programme.

When considering recommendations for any disease screening, the Government will refer to the evidence-based risk assessment and views of relevant experts from the perspective of

public health. A number of factors will be carefully assessed, such as local prevalence of the cancer, accuracy and safety of the screening tests, effectiveness in reducing incidence and mortality rates as well as feasibility of implementation of a screening programme. The perspective of good utilisation of medical resources will be taken into account to determine the priority. Excessive screening under public health programmes not only wastes resources for the overall public health, but also runs out of resources that can be invested on other projects in greater need, and may pose unnecessary health risks to individuals, often causing more harm than good.

Primary prevention (i.e. reducing exposure to cancer risk factors) is the most important strategy for reducing the risk of developing cancer. The Department of Health (DH) has all along been encouraging members of the public to adopt a healthy lifestyle, including avoidance of smoking and alcohol, healthy diet, regular physical activity and maintenance of a healthy body weight and waist circumference, in order to reduce the risk of non-communicable diseases including cancer.

(1)

Cervical screening service for women is available at the Maternal and Child Health Centres (MCHCs) and Woman Health Centres (WHCs) under the Family Health Service of the Department of Health (DH).

The MCHCs provide cervical screening service with no fixed service quota. The DH will flexibly allocate resources to ensure that women have access to the services they need.

As for the WHCs, healthcare personnel will arrange for appropriate examinations and tests, including cervical screening, for women according to their health assessment results and individual needs. The annual quota for women health services is 24 000. To implement the primary healthcare policy directions and related measures outlined in the Primary Healthcare Blueprint, the Woman Health Service under the DH will be integrated into the district health network of the Primary Healthcare Commission (PHC Commission) of the Health Bureau (HHB). The HHB announced on 23 January 2025 that it will commence the integrated women health services within this year in an orderly manner to provide eligible women with prevention-based and more personalised primary healthcare services. The PHC Commission will initiate the integration of women health services in an orderly manner within this year. 3 service points named Women Wellness Satellites (WWSs) will be operated by non-governmental organisations appointed through open tender to provide primary healthcare services for women. As such, the DH ceased accepting new appointments for women health services starting from 24 January 2025. During the transition period of service integration, those who have already made appointments or have paid their annual fee and are still within the service period will continue to receive relevant services from the DH.

The numbers of women receiving cervical screening service at the MCHCs and WHCs in 2022, 2023 and 2024 are tabulated below:

Service location	Number of women receiving cervical screening service		
	2022	2023	2024

MCHCs	59 389	47 470	55 568
WHCs	9 944	8 695	6 938
Total:	69 333	56 165	62 506

(2)

The integration of women and elderly health services under the DH to the district health network of the PHC Commission aims to optimise the use of resources while strengthening the primary healthcare network which focuses on prevention, and is district-based and family-oriented.

Located at Chai Wan, Lam Tin and Tuen Mun, the 3 WWSs will commence operations in phases in 2025, replacing the WHCs of the DH. The Chai Wan WWS will commence service in the second quarter of this year, while the Lam Tin and Tuen Mun WWSs are expected to come into operation in the third quarter of this year. The District Health Centres/Expresses (DHCs/DHCEs) in the 18 districts across the territory will also step up promotion and education relating to women's health and provide a new women's health nurse clinic to encourage and assist the public in self-care management. Basic health assessments and individual consultations will also be provided to identify women in need and referrals will be made for them to receive women health services at WWSs or the general outpatient clinics of the Hospital Authority.

Specifically, the DHCs/DHCEs will provide basic health services and conduct initial health assessment for women, arranging referrals for services at WWSs if and when necessary. The WWSs will offer more personalised primary healthcare services for women. Apart from the existing health assessment and screenings for breast and cervical cancer, etc., the WWSs will offer personalised options in preventive care or specific consultation services based on their health risks and needs, with a view to enhancing preventive-based primary healthcare services for women.

(3) & (4)

The MCHCs of the DH provide government-subsidised cervical screening service for eligible women at only \$100 per screening. At present, human papillomavirus (HPV) testing is the primary screening method employed by the MCHCs for cervical cancer for women aged 30 to 64, who undergo cervical screening every 5 years if her last examination result is normal, allowing them to pay only \$100 for cervical screening for a duration of 5 years. Besides, the DH will provide free cervical screening service to eligible persons such as those in receipt of the Comprehensive Social Security Assistance, holders of waivers of medical charges under the Medical Fee Waiving Mechanism of Public Hospitals and Clinics, etc.

The DH has all along attached importance to the public education of women's cancer (including cervical cancer) and has been promoting cervical cancer prevention and screening through various channels and media such as television, radio, websites, printed materials, newspapers, social media, online campaigns and media interviews. In addition, the DH has produced health education materials such as posters and pamphlets on cervical cancer in at least 8 ethnic minority languages (including Hindi, Nepali, Urdu, Thai, Indonesian, Filipino, Punjabi and Vietnamese) for ethnic minorities to comprehend the health information on cervical cancer prevention and screening.

To further increase the screening coverage, the DH will continue to promote the CSP to the general public through various channels. Since 2023, the DH has been regularly sending SMS and push notifications to women of the appropriate age group via the eHealth mobile application to remind them to undergo regular cervical screening.

The resources and manpower involved in women's health education activities and the services related to the CSP are subsumed into the overall provision of the DH and cannot be separately identified.

Besides, in response to the World Health Organization's (WHO) recommendation, the Centre for Health Protection (CHP) of the DH implemented an HPV vaccination programme to Primary 5 and Primary 6 school girls under the Hong Kong Childhood Immunisation Programme (HKCIP) since the 2019/20 school year as an important public health intervention to prevent cervical cancer. In 2022, the WHO further recommended the provision of catch-up vaccinations to girls aged between 9 and 18. Taking into account the scientific evidence, the Government decided to launch a one-off HPV Vaccination Catch-up Programme in phases starting from December 2024, for female Hong Kong residents who were born in 2004 or after, and have not been covered by the HKCIP to receive free HPV vaccination.

- End -

CONTROLLING OFFICER'S REPLY

HHB264

(Question Serial No. 0206)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions, (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The work of the Department of Health (DH) includes preventing and controlling importation and spread of infectious diseases through port health measures. In this connection, will the Government inform this Committee of:

1. the details of the relevant work, the number of staff involved and the expenditure incurred;
2. the current staff establishment of DH stationed at various boundary control points (BCPs), the specific work of the staff concerned and the expenditure incurred; the number of travellers found to be suffering from fever or infectious diseases (broken down by type of disease) by staff stationed at various BCPs in the past 2 years, and the follow-up action taken afterwards; and
3. whether the Government will, in view of society's return to normalcy and the Government's need to manage expenditure growth, consider reducing the number of staff stationed at BCPs or deploying them to other duties; if yes, the details; if no, the reasons?

Asked by: Hon SHIU Ka-fai (LegCo internal reference no.: 7)

Reply:

In accordance with the power conferred by the Prevention and Control of Disease Ordinance of Hong Kong and with regard to the guidelines of the International Health Regulations, the Department of Health (DH) enforces various preventive measures at boundary control points (BCPs) to prevent the introduction or spreading of infectious diseases into or out of Hong Kong.

The Hong Kong Special Administrative Region (HKSAR) Government has been maintaining close co-operation with entry-exit health inspection and quarantine authorities of the Mainland to safeguard the well-being and safety of residents and travellers of the 2 places. The Health Bureau and the General Administration of Customs of the People's Republic of China (GACC) signed the Co-operation Arrangement for Entry-exit Health Inspection and Quarantine between the GACC and the Health Bureau of the HKSAR Government in 2023. Under the normalisation arrangements for epidemic prevention and control, the 2 parties

agreed to focus on the health inspection and quarantine of their respective inbound personnel travelling between the HKSAR and the Mainland BCPs.

The HKSAR Government will maintain close liaison with the relevant Mainland authorities and, taking into account factors such as cost-effectiveness and appropriateness, actively review the entry health inspection and quarantine arrangements (including temperature screening) from the public health perspective.

(1) & (2)

The Port Health Division under the DH enforces preventive measures at the seaport, Hong Kong International Airport and land BCPs of Hong Kong to prevent the importation and exportation of infectious diseases. Apart from implementing port health measures and quarantine clearance at sea, land and air BCPs (such as routine temperature screening for inbound travellers and setting up hygiene stations to conduct health assessments for suspected infection cases), the DH also monitors environmental hygiene at BCPs and the health conditions of cross-boundary conveyances. When necessary, the DH will also board incoming conveyances for further quarantine and medical assistance. In addition, the DH is also responsible for issuing relevant port health certificates (e.g. Free Pratique for incoming vessels, Ship Sanitation Control Exemption Certificate, Import Permit for Biological Materials such as infectious agents). Furthermore, the DH operates 2 Travel Health Centres to provide travel health services for outbound travellers. The Travel Health Service website also provides travellers with the latest epidemic information and disease prevention advice from around the world.

Taking into account the design of each BCP and its traveller and vehicle flow, the DH deploys manpower as appropriate to conduct body temperature screening for all arrivals; and performs, in accordance with the mechanism, further health assessments for travellers with fever or in need (such as travellers who self-reported being unwell) to understand their symptoms, travel history, contact history, etc., in order to make appropriate referrals and follow-up, including compulsory referral of persons with suspected infection of major infectious diseases to Hong Kong public hospitals for checking, advising other travellers with fever or in need to seek medical treatment at medical institutions with issuance of referral letters, and assisting persons in need to call for ambulance service for further treatment at Accident and Emergency Department.

The above health screening tasks are primarily carried out by non-civil service contract staff and outsourced personnel. At present, 46 permanent staff members are assigned to supervise frontline staff at various BCPs. In 2024, the average number of health screening shifts of the DH per day at various BCPs (some health screening posts involve more than 1 shift according to the operation of BCPs) is as follows:

	2024
Airport	122
Lo Wu	40
Lok Ma Chau Spur Line	30
Lok Ma Chau	94
Man Kam To	36

Sha Tau Kok	0
Shenzhen Bay	94
Hong Kong-Zhuhai-Macao Bridge	130
Heung Yuen Wai	58
Express Rail Link West Kowloon	51
Hung Hom	0
Macau Ferry Terminal	45
China Ferry Terminal	22
Total	722

Note:

The DH redeploys health screening posts in view of the actual circumstances. Some of the posts at BCPs where operation has been suspended would be redeployed to other BCPs. Health screening service of Kai Tak Cruise Terminal and Ocean Terminal was not included as it was only provided during stopover of cruises.

The expenditure incurred by health screening shifts listed in the table above amounts to approximately \$205 million. The permanent establishment and total expenditure of the Port Health Division for the 2024-25 financial year are as follows:

Financial Year	Permanent Establishment	Total Expenditure (including the cost of the above health screening)
2024-25	157 (as at February 2025)	\$395 million (Revised Estimate)

In 2023 and 2024, the total number of inbound travellers confirmed with fever during temperature screening at BCPs was 4 759 and 4 214 respectively. The number of inbound travellers compulsorily referred to public hospitals upon fulfilling the reporting criteria of any major infectious disease is set out below:

		2023	2024
Suspected Infection of COVID-19*	Airport	2	0
	Shenzhen Bay	48	0
	Hong Kong-Zhuhai-Macao Bridge	1	0
	Express Rail Link West Kowloon	0	0
	Man Kam To	8	0
Suspected Infection of Avian Influenza	Airport	0	2
	Express Rail Link West Kowloon	1	0
Suspected Infection of Middle East Respiratory Syndrome	Airport	0	2
	Macau Ferry Terminal	1	0
Suspected Infection of Measles	Kai Tak Cruise Terminal	0	1
Suspected Infection of Malaria	Airport	0	1

*The compulsory isolation arrangement imposed on persons infected with COVID-19 has been rescinded since 30 January 2023.

(3)

Ongoing health screening, which facilitates early identification of potential infectious diseases imported into Hong Kong, is vital to safeguarding public health. Currently, health screening measures are in place for inbound travellers at all BCPs between Hong Kong and the Mainland.

The DH mainly employs an Infrared Thermal Imaging System at various BCPs to detect the body temperatures of multiple travellers simultaneously to reduce the manpower required for such work. However, drivers and all passengers in a cross-boundary private car are allowed to remain in their vehicle while passing through the kiosks of the Immigration Department, the Customs and Excise Department and the DH without the need to get off from the vehicle or go to the traveller's clearance hall. Due to site constraints, the Infrared Thermal Imaging System cannot be used to measure the forehead temperature of drivers and passengers passing through the vehicle lanes. As a result, hand-held infrared thermometers are used to measure the body temperature of inbound passengers on board the vehicles at the DH vehicle kiosks.

The DH reviews the health screening arrangements from time to time and deploys manpower as appropriate at various BCPs according to the actual circumstances to provide appropriate services for inbound travellers. For instance, the additional personnel deployed during the COVID-19 epidemic in the light of the actual needs have been reduced after the epidemic, and the manpower at relevant BCPs has basically returned to the pre-epidemic level. Meanwhile, the DH also keeps a close eye on technological development and actively explores the adoption of innovative technology in collaboration with other departments at BCPs to reduce the manpower need for health screening and optimise the use of human resources.

- End -

CONTROLLING OFFICER'S REPLY

HHB265

(Question Serial No. 0438)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The work of the Department of Health involves ensuring the safety, quality and efficacy of pharmaceutical products through product registration and licensing control. Regarding the Government's "1+" mechanism for the approval of new drugs ("1+" mechanism), please provide:

1. a breakdown of the approved applications for drug registration in Hong Kong under the "1+" mechanism since its implementation, the registration approvals obtained from drug regulatory authorities in one of the reference places (instead of the original 2) along with these reference places; and
2. the shortest, average, median and longest time taken from application to approval for the registration of new drugs in general over the past 5 years, as well as the shortest, average, median and longest time taken from application to approval for the drugs to be approved for registration in Hong Kong under the "1+" mechanism since its implementation.

Asked by: Hon SHIU Ka-fai (LegCo internal reference no.: 16)

Reply:

As mentioned in the Chief Executive's Policy Address in 2023 and 2024, the Hong Kong Special Administrative Region (HKSAR) Government will enhance the current evaluation and registration mechanism for drugs, and establish an internationally renowned regulatory authority of drugs and medical devices. To this end, the HKSAR Government set up a Preparatory Office for the Hong Kong Centre for Medical Products Regulation (CMPR) in the Department of Health (DH) in June 2024. The Preparatory Office is proactively reviewing the regulatory functions of the DH, including the regulation of Chinese and Western medicines and medical devices; studying the potential restructuring and strengthening of the regulatory and approval regime for medicines, medical devices and medical technology; and putting forward proposals and steps for the establishment of the CMPR which will be a step towards the transition to the "primary evaluation" approach in approving applications for registration of new medical products. This will help accelerate the clinical application of new drugs and medical devices, and foster the development of emerging industries related to the research and development as well as testing of medical

products. The Preparatory Office is drawing up the timetable for establishing the CMPR and the roadmap towards adoption of “primary evaluation”, and will announce them in the first half of 2025 as scheduled.

1.

According to the Pharmacy and Poisons Ordinance (Cap. 138), pharmaceutical products must satisfy the criteria of safety, efficacy and quality for registration with approval from the Pharmacy and Poisons Board of Hong Kong (the Board) before they can be sold or supplied in the HKSAR. Applicants for registration of pharmaceutical products are required to submit the necessary documents in accordance with the Guidance Notes on Registration of Pharmaceutical Products/Substances as promulgated by the Board. In general, applicants for new drug registration are required to, in accordance with the Guidance Notes on Registration of Pharmaceutical Products Containing a New Chemical or Biological Entity as promulgated by the Board, provide documentary proof for registration issued by at least 2 drug regulatory authorities of specified reference places in order to provide supporting evidence that relevant products have been rigorously evaluated before being placed on the market (i.e. the “secondary evaluation” approach).

To enhance the drug regulatory regime and implement the “primary evaluation” approach in the long run, the Government has launched on 1 November 2023 the “1+” mechanism for approval of new drugs and widened its applicability to all new drugs on 1 November 2024. For pharmaceutical products containing new chemical or biological entities that are supported with local clinical data and scope of application recognised by local relevant expert, applicants concerned are only required to submit approval from 1 reference drug regulatory authority (instead of the 2 or more) to apply for registration in Hong Kong.

Since the implementation of the “1+” mechanism (as at 28 February 2025), a total of 11 new drugs have been granted registration approval in accordance with the mechanism, including 6 drugs for treating cancers, 1 for treating haematological disease, 2 for treating hypercalcaemia and 2 for treating anaemia caused by chronic kidney disease, bringing new hope for treatment to patients and facilitating good drugs for use in Hong Kong. The Hong Kong registration numbers of and the diseases/symptoms treated by these new drugs, along with the specified reference places from which registration approval was first obtained are set out below:

	Hong Kong Registration Number	Diseases/Symptoms Treated	Specified Reference Place from which Registration Approval was First Obtained
1	HK-68111	Metastatic Colorectal Cancer	Mainland China
2	HK-68112	Metastatic Colorectal Cancer	Mainland China
3	HK-68402	Paroxysmal Nocturnal Haemoglobinuria	United States
4	HK-68424	Hypercalcaemia in Patients with Parathyroid Carcinoma and in Certain Patients with Primary Hyperparathyroidism	Japan
5	HK-68425	Hypercalcaemia in Patients with Parathyroid Carcinoma and in Certain Patients with Primary Hyperparathyroidism	Japan

6	HK-68439	Anaemia caused by Chronic Kidney Disease	Mainland China
7	HK-68440	Anaemia caused by Chronic Kidney Disease	Mainland China
8	HK-68459	Extensive-stage Small Cell Lung Cancer	United States
9	HK-68550	Extensive-stage Small Cell Lung Cancer	United States
10	HK-68581	Locally Advanced or Metastatic Non-small Cell Lung Cancer	Mainland China
11	HK-68582	Locally Advanced or Metastatic Non-small Cell Lung Cancer	Mainland China

2.

The DH has pledged to process at least 90% of applications for pharmaceutical products registration (including applications for new drugs) in support of the Board within 5 months upon submission of all required documents by the applicants. From 2020 to 2024, an average of 99.9% of applications have been processed within 5 months upon receipt of the required documents. When implementing the “1+” mechanism, the Board has made reference to the relevant procedures of other drug regulatory authorities and hence introduced a target processing timeline set at 150 days, namely the “stop-clock mechanism”. All new drug applications submitted under the “1+” mechanism have met this target thus far. To further enhance the efficiency in processing new drug applications, we will, as announced in the Chief Executive’s 2024 Policy Address, introduce a consultation service for new drug applications under the “1+” mechanism in the first quarter of 2025. The Board and the DH do not maintain statistics on the shortest, average, median and longest time taken for the registration approval of new drugs.

- End -

CONTROLLING OFFICER'S REPLY

HHB266

(Question Serial No. 0525)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The Department of Health has conducted 34 000 inspections for smoking offences, commercial sale and supply of alcohol to minors and related offences under the Smoking (Public Health) Ordinance (Cap. 371), the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600) and Part 5 of the Dutiable Commodities (Liquor) Regulations (Cap. 109B) in 2024, will the Government please inform this Committee of:

1. the number of inspections conducted on each of the above fronts, the number of people prosecuted and the penalties of the convicted; and
2. the participating Government departments and the number of staff involved?

Asked by: Hon SHIU Ka-fai (LegCo internal reference no.: 22)

Reply:

1.

The Tobacco and Alcohol Control Office (TACO) of the Department of Health (DH) is the principal enforcement agency for the Smoking (Public Health) Ordinance (Cap. 371) and the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600). The TACO will conduct inspections and investigation in response to smoking and related complaints. In general, the TACO will issue fixed penalty notices (FPNs) to smoking offenders without warning. Apart from smoking offences, the TACO also issued summonses for offences under Cap. 371 (including aiding and abetting smoking offences, offences relating to smoking product advertisements, the promotion, manufacture, sale, or possession for commercial purposes of alternative smoking products (ASPs), obstruction of inspectors, etc.), and for the offence of importing ASPs under the Import and Export Ordinance (Cap. 60). The numbers of complaints/referrals received, inspections conducted, warning letters issued, and FPNs/summonses issued by the TACO in 2024 for smoking and other offences are at **Annex 1**.

In addition, the sale and supply of intoxicating liquor to minors in the course of business are prohibited under Part 5 of the Dutiable Commodities (Liquor) Regulations (Cap. 109B). In 2024, the TACO conducted more than 4 000 inspections to check retailers' compliance with

such legal requirements and carried out investigation and enforcement actions upon receipt of intelligence or complaints. Over the past 3 years, the TACO received 63 complaints regarding the sale or supply of intoxicating liquor to minors in the course of business. No violation was found upon plainclothes patrol and follow-up investigation.

Apart from the stipulation above, Cap. 109B also requires vendors which sell or supply intoxicating liquor in face-to-face distributions to display a prescribed notice in a prominent position at the premises in the course of business. The Tobacco and Alcohol Control Inspectors will conduct inspections at these premises to ensure that vendors comply with this requirement. Over the past 3 years, the TACO issued 10 summonses to offenders in this respect.

2.

The TACO has been closely monitoring the market situation and taking stringent enforcement actions against violation of the Smoking (Public Health) Ordinance, and will appropriately adjust its enforcement strategies according to the actual circumstances from time to time, including conducting joint operations with other government departments now and then. In order to further curb the distribution of illicit cigarette leaflets, the TACO has been strengthening joint operations with the Police, the Housing Department (HD) and the Customs and Excise Department (C&ED) against the sale of illicit cigarettes and related promotional activities in public housing estates since 2023. A total of over 250 joint operations were conducted in the past 3 years. The TACO, the C&ED, the Police and the HD will continue working together to enhance intelligence exchange and strengthen the co-operation mechanism, as well as to make adjustments to their enforcement strategies having regard to the actual situation, and to take joint enforcement actions and refer suspected illegal cases to the relevant departments, with a view to undertaking the tobacco control initiatives and enforcing the relevant legislation.

The approved establishment of the TACO in 2024-25 is at **Annex 2**. The manpower and resources for the implementation of alcohol and tobacco control initiatives cannot be separately identified.

Annex 1

Numbers of complaints / referrals received, inspections conducted, warning letters issued, and FPNs / summonses issued by TACO for smoking and other offences under the Smoking (Public Health) Ordinance (Cap. 371), the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600) and the Import and Export Ordinance (Cap. 60)

		2024
Complaints/referrals received		29 205
Inspections conducted		30 162 ^(Note 3)
Warning letters issued ^(Note 1)		10
FPNs issued (for smoking offences)		13 488 ^(Note 3)
Summonses issued	for smoking offences	64
	for other offences ^(Note 2)	871

Note

- 1 In general, the TACO will prosecute smoking offenders without prior warning. The TACO will only consider issuing warning letters if the smoking offenders are found to be persons under 15 years old.
- 2 Other offences include willful obstruction, failure to produce identity document, displaying smoking product advertisement, ASP related offences, and aiding and abetting another person committing a smoking offence, etc.
- 3 To effectively mitigate the impact of passive smoking on the public and enhance the deterrent effect against illegal smoking, TACO has flexibly deployed resources and adopted new enforcement strategies since 2023, including extension of the time of surveillance and inspections in no smoking areas, deploying plain-clothes officers to take proactive enforcement actions, strengthening enforcement action in venues (such as bars and food premises) where waterpipes were offered for smoking, as well as prosecuting people inciting, aiding and abetting illegal smoking. The number of prosecutions against illegal smoking has surged due to the new enforcement strategies, reflecting their enhanced effectiveness.

Approved Establishment of
the Department of Health's Tobacco and Alcohol Control Office

Rank	Number of staff in 2024-25
<u>Head, TACO</u>	
Consultant	1
<u>Enforcement</u>	
Senior Medical & Health Officer	1
Medical & Health Officer	1
Scientific Officer (Medical)	1
Land Surveyor	1
Police Officer	5
Overseer/ Senior Foreman/ Foreman	125
Senior Executive Officer/ Executive Officer	13
<i>Sub-total</i>	<u>147</u>
<u>Health Education and Smoking Cessation</u>	
Senior Medical & Health Officer	1
Medical & Health Officer	1
Scientific Officer (Medical)	2
Nursing Officer/ Registered Nurse	3
Hospital Administrator II	4
<i>Sub-total</i>	<u>11</u>
<u>Administrative and General Support</u>	
Senior Executive Officer/ Executive Officer	4
Clerical and support staff	19
Motor Driver	1
<i>Sub-total</i>	<u>24</u>
Total	<u>183</u>

- End -

CONTROLLING OFFICER'S REPLY

HHB267

(Question Serial No. 0530)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (3) Health Promotion

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The Hong Kong Council on Smoking and Health (COSH) delivered 433 publicity/educational activities in 2024 under the Department of Health's subsidy. In this connection, will the Government inform this Committee of:

1. the publicity and education activities of the COSH in the past 5 years, with a breakdown of each activity's expenditure by year; and
2. the advertisements produced by the COSH in the past 5 years, with a breakdown of each advertisement's expenditure by year?

Asked by: Hon SHIU Ka-fai (LegCo internal reference no.: 24)

Reply:

1. & 2.

The Hong Kong Council on Smoking and Health (COSH) is a statutory body established in accordance with the Hong Kong Council on Smoking and Health Ordinance (Cap. 389) to enhance public awareness of the harm of tobacco through publicity, education and research.

To mobilise community efforts, the Department of Health (DH) subvents the COSH to carry out a series of smoke-free activities targeting different sectors and stakeholders, which include educational activities (e.g. school education theatre programmes, tailor-made programmes to equip teenagers with knowledge on the hazards of smoking, including the use of alternative smoking products), publicity and community involvement activities (e.g. production of Announcements in the Public Interest (APIs) on television and radio, district-based community involvement activities) and research programmes on tobacco control. The COSH is also dedicated to disseminating smoke-free messages to corporations, schools and all walks of life through different efforts such as collaborating with district service organisations on promotional activities, smoking cessation competitions and smoking cessation counselling. It also implements the "Smoke-free Drivers Club", the "Quit to Win" Smoke-free Community Campaign, the Smoke-free Women Project and the Elderly Smoking Cessation Promotion Project on a regular basis, targeting young people, women and the

elderly with the aim of spreading the smoke-free message to every corner of the society and uniting community efforts to promote smoking cessation and create a smoke-free environment.

In addition, the COSH launches publicity campaigns through the mass media and social media to convey messages about the hazards of smoking to different groups in the community. It also produces 1 to 2 television and radio APIs every year to promote the benefits of a smoke-free life and disseminate information on smoking cessation to encourage smokers to quit smoking. The COSH launched a new API named “Let’s make Hong Kong Tobacco-free” in March this year and, by joining hands with various sectors of the community, shared information on smoking hazards through special television programmes to call for public participation in creating a smoke-free environment and encourage smokers to quit smoking.

The number of publicity/educational activities delivered by the COSH during 2020 to 2024 is set out below:

	2020	2021	2022	2023	2024
Publicity Activities (including advertisements)	275	196	227	244	238
Educational Activities	157	236	205	188	195
Total	432	432	432	432	433

In 2020-21 to 2024-25, the amount of funding received by the COSH is as follows:

2020-21 Actual (\$ million)	2021-22 Actual (\$ million)	2022-23 Actual (\$ million)	2023-24 Actual (\$ million)	2024-25 Revised Estimate (\$ million)
26.0	26.2	26.8	26.6	27.9

Expenditure on individual publicity activities cannot be separately identified.

- End -

CONTROLLING OFFICER'S REPLY

HHB268

(Question Serial No. 0533)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (3) Health Promotion

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The Department of Health has stated that it will continue to strengthen the publicity and education programme and adopt a community approach on smoking prevention and cessation in 2025-26. In this connection, will the Government advise on the details of the work and programme concerned along with a breakdown of the estimated expenditure?

Asked by: Hon SHIU Ka-fai (LegCo internal reference no.: 25)

Reply:

The Government's tobacco control policy seeks to safeguard public health by discouraging smoking, containing the proliferation of tobacco use and minimising the impact of passive smoking on the public. To this end, the Government adopts a progressive and multi-pronged approach comprising legislation, enforcement, publicity, education, smoking cessation services and taxation.

The Government announced in June 2024 its plan to introduce 10 tobacco control measures in the short term. Among these initiatives, the Government has proposed to strengthen smoking cessation services as well as publicity and education through measures such as increasing the number of smoking cessation service points, enhancing Chinese medicine smoking cessation services, offering smoking cessation services through District Health Centres (DHCs) with a case-management model, enhancing smoking cessation training for primary healthcare practitioners, assisting people in smoking cessation through mobile applications, and incorporating more elements related to the harm of smoking into regular school curriculum.

Over the years, the Government has been actively promoting a tobacco-free environment through publicity for smoking prevention and cessation services. To leverage community effort, the Department of Health (DH) collaborates with the Hong Kong Council on Smoking and Health (COSH), non-governmental organisations (NGOs) and healthcare professionals to promote smoking cessation, provide smoking cessation services and organise publicity programmes on smoking prevention.

Apart from operating an integrated Smoking Cessation Hotline (Quitline: 1833 183) to handle general enquiries and provide professional counselling on smoking cessation, the DH coordinates the provision of smoking cessation services in Hong Kong. It arranges referrals to various smoking cessation services in the territory, including those provided by public clinics under the Hospital Authority (HA) (helping patients, especially those with chronic diseases, to quit smoking), and community-based cessation programmes operated by NGOs. There are a total of 15 full-time and 55 part-time centres operated by the HA which have been providing smoking cessation services to the general public since 2002, and there are 5 smoking cessation clinics for civil servants operated by the DH. Furthermore, the DH also collaborates with NGOs to provide a range of community-based smoking cessation services including counselling, consultations by doctors (including free postal delivery of smoking cessation drugs) or Chinese medicine practitioners, and designated services for smokers from different ethnicities, immigrant smokers and workplace smokers. For young smokers, the DH collaborates with local universities to operate a hotline to provide them with dedicated counselling services over the phone. Besides, the DH has subvented 2 more service providers (from 2 to 4 in total) since 2023 to operate smoking cessation clinics with a focus on counselling and pharmacotherapy, and 3 more Chinese medicine smoking cessation service providers (from 1 to 4 in total) starting from this year to operate smoking cessation clinics with an emphasis on counselling and acupuncture. It is expected that the number of service users of the former type of clinics will increase by about 40% and the number regarding the latter type will double.

The DH subvents the COSH to organise publicity and education programmes in schools, such as health talks, training programmes and theatre programmes, to raise students' awareness of smoking hazards, including hazards from alternative smoking products. To prevent youngsters from picking up smoking, the DH collaborates with the NGOs to organise health promotional activities at schools. By using interactive teaching materials and setting up mobile classrooms, the programmes enlighten students in respect of the tactics used by the tobacco industry to market tobacco products, and equip them with the skills to resist picking up smoking due to peer pressure. The DH has also launched publicity campaigns through mass media to spread the message that smoking brings risks of serious illnesses. To encourage smokers to try quitting, it distributes free trial packs of smoking cessation drugs (nicotine replacement therapy) for 1 week at community pharmacies, smoking cessation clinics, DHCs and District Health Centre Expresses (DHC Expresses) during the Quit in June annual campaign starting from 2023. During the Quit in June campaign in 2024, the DH implemented the Chinese Medicine Ear Points Patches for Smoking Cessation Trial Programme at designated Chinese medicine smoking cessation clinics. To encourage and help all healthcare professionals to provide support and treatment for smokers who are quitting, the DH organises online and face-to-face training courses, compiles the Practical Handbook for Smoking Cessation Treatments and a clinical guide on smoking cessation with Chinese medicine and acupuncture, and provides related resources, among other initiatives.

Smoking cessation services and counselling for smokers are currently available at all DHCs/DHC Expresses in the 18 districts, which collaborate with smoking cessation service providers in their respective districts to provide information or arrange referrals for smokers in need.

In 2022, 2023 and 2024, the quitlines operated by the DH and local universities handled 9 216, 11 051 and 10 875 enquiries respectively. During these 3 years, there were 20 406, 27 715 and 28 512 smokers receiving smoking cessation services via quitlines, at cessation clinics under the HA and through community-based programmes operated by NGOs.

Smokers who receive smoking cessation treatment receive 52-week follow-up services to assess their quit status. For smokers who receive smoking cessation services via quitlines, at cessation clinics under the HA and through community-based programmes operated by NGOs, their 52-week quit rates, which refer to the percentage of service users self-reporting to have stayed quit in the past 7 days, range from 20% to 60%, which are comparable to those in overseas countries. Discrepancies in the quit rates concerning different smoking cessation programmes are due to differences in terms of their target groups and treatment methods (which include counselling, pharmacotherapy, and Chinese medicine with acupuncture). To become a successful quitter, smokers are encouraged to choose the cessation service that best caters for their personal needs.

The expenditure and provision in respect of health promotion activities organised and smoking cessation services provided by the DH's Tobacco and Alcohol Control Office and its subvented organisations between 2022-23 and 2025-26 is at **Annex**. Expenditure on individual publicity programmes cannot be separately identified.

The Government will continue to step up its work on smoking cessation and explore various tobacco control measures in the medium and long term in order to eliminate the social hazards posed by tobacco products in all aspects and safeguard the health of the community with a progressive and multi-pronged approach.

**Expenditure on/provision for
the Department of Health's Tobacco and Alcohol Control Office**

	2022-23 (\$ million)	2023-24 (\$ million)	2024-25 Revised Estimate (\$ million)	2025-26 Estimate (\$ million)
<u>Enforcement</u>				
Programme 1: Statutory Functions	100.4	123.3	167.4	174.8
<u>Health Education and Smoking Cessation</u>				
Programme 3: Health Promotion	149.0	151.4	170.5	180.9
<u>(a) General Health Education and Promotion of Smoking Cessation</u>				
TACO	73.0	83.7	88.2	87.0
Subvention to Hong Kong Council on Smoking and Health (COSH)	26.8	26.6	27.9	27.3
<i>Sub-total</i>	<u>99.8</u>	<u>110.3</u>	<u>116.1</u>	<u>114.3</u>
<u>(b) Expenditure on/Provision for Smoking Cessation and Related Services by Non-Governmental Organisations</u>				
Subvention to Tung Wah Group of Hospitals	29.4	10.2	14.0	17.8
Subvention to Pok Oi Hospital	7.6	14.8	17.9	20.9
Subvention to Lok Sin Tong	3.3	3.6	3.6	3.6
Subvention to United Christian Nethersole Community Health Service	5.8	6.1	8.9	13.8
Subvention to Life Education Activity Programme	2.8	2.9	3.0	3.0
Subvention to Christian Family Service Centre	-	3.5	7.0	4.5
Subvention to The University of Hong Kong	0.3	-	-	3.0
<i>Sub-total</i>	<u>49.2</u>	<u>41.1</u>	<u>54.4</u>	<u>66.6</u>
Total	<u>249.4</u>	<u>274.7</u>	<u>337.9</u>	<u>355.7</u>

- End -

CONTROLLING OFFICER'S REPLY**HHB269****(Question Serial No. 2649)**Head: (37) Department of HealthSubhead (No. & title): (-) Not SpecifiedProgramme: (5) RehabilitationControlling Officer: Director of Health (Dr. Ronald LAM)Director of Bureau: Secretary for HealthQuestion:

Given that assessment services concerning special educational needs require professionals such as psychologists and psychiatrists, please provide related figures with a breakdown by profession, covering public and private organisations, and advise on the increase in resources in respect of the relevant professionals in the coming 5 years, along with the relevant breakdown.

Asked by: Hon TIK Chi-yuen (LegCo internal reference no.: 29)Reply:

The Child Assessment Service (CAS) of the Department of Health (DH) provides comprehensive assessment and diagnosis of physical and mental development for children under the age of 12 who are suspected to have developmental problems.

The CAS adopts a multi-disciplinary team approach. The team comprises healthcare and professional staff, including paediatricians, nurses, audiologists, clinical psychologists, occupational therapists, optometrists, physiotherapists and speech therapists. The relevant approved establishment for 2024-25 is as follows:

Grade	Approved establishment
Medical and Health Officer	25
Registered Nurse	40
Clinical Psychologist	22
Audiologist	3
Speech Therapist	16
Optometrist	2
Occupational Therapist	9
Physiotherapist	7

Apart from the DH, assessment services are also provided by the Hospital Authority (HA), the Education Bureau, non-governmental organisations and recognised professionals in the private sector. The DH does not maintain data on the related professionals dedicated to assessing special educational needs who are serving in other institutions.

As announced by the Chief Executive in his 2024 Policy Address, to enhance the health of the people of Hong Kong, improve healthcare protection and quality, and capitalise on our healthcare professions' strengths, the Government is conducting a comprehensive review on the positioning and objectives of the healthcare system. The review covers the reform of the functions and division of work among the HA, the DH and the Primary Healthcare Commission (PHC Commission). The relevant initiatives include reforming the HA's governance effectiveness to enhance the standards and efficiency of its specialist and in-patient services. At the same time, the PHC Commission and the DH will strengthen their efforts in health promotion and disease prevention in order to continue to redress the imbalance in the existing system which emphasises on treatment rather than prevention. The DH will also strengthen its role as the Government's adviser and regulatory authority in respect of public health, and will focus on its functions in this aspect. In this connection, the DH is gradually transferring its specialist clinical services and primary healthcare services to the HA and the PHC Commission respectively.

The DH is liaising with the HA on the detailed arrangements for integrating the CAS into the Hong Kong Children's Hospital under the HA, with a view to consolidating the public paediatrics services to facilitate collaboration among various specialities and streamline the procedure for service delivery. In this way, the children suspected of having developmental or behavioural problems can receive the necessary integrated multi-disciplinary assessment, treatment and rehabilitative services in a timely manner, while the referral arrangements and services for patients can be further enhanced. Relevant details will be announced in due course.

- End -

CONTROLLING OFFICER'S REPLY

HHB270

(Question Serial No. 2650)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (5) Rehabilitation

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

As far as the special education need (SEN) assessment over the past 5 years is concerned, please advise on whether the children suspected of having SENs could have assessment completed by the age of 6 (i.e. pre-school age); or the percentage of those who could have assessment completed by the age of 6 (i.e. pre-school age); the number of children who could only be assessed during primary or secondary school years; and their waiting time for assessment.

Asked by: Hon TIK Chi-yuen (LegCo internal reference no.: 30)

Reply:

The Child Assessment Service (CAS) of the Department of Health (DH) receives referrals from doctors and psychologists for comprehensive assessment and diagnosis of children under the age of 12 who are suspected to have developmental problems. New cases are referred through different channels, including the Maternal and Child Health Centres (MCHCs), the Hospital Authority (HA), private practitioners and psychologists, etc. In 2024, the CAS received 8 596 new case referrals, which included 7 814 children under 6 and 782 children aged 6 to below 12 (provisional figures). Apart from the DH, assessment services are also provided by the HA, the Education Bureau (EDB), non-governmental organisations and recognised professionals in the private sector.

In the past 5 years, all cases newly referred to the CAS were first seen by nurses within 3 weeks after registration. The CAS has adopted a triage system to ensure that children with urgent and more serious conditions are accorded with higher priority for assessment upon preliminary assessment by nurses. The actual waiting time for assessment depends on the complexity and conditions of individual cases. The CAS does not maintain statistics on the waiting time for assessment of new cases. While children are waiting for assessment and rehabilitation services, the CAS provides interim support services for parents, such as seminars, workshops and practical training, with the aim of enhancing parents' knowledge on child development and providing practical skills to enable parents to better understand their

children's conditions and learn about relevant community resources. In addition, the Social Welfare Department (SWD)'s Tier-1 Support Services for Kindergartens/Kindergarten-cum-Child Care Centres and the EDB's special education support services in primary schools also provide support services for children with mild behavioral and developmental problems, including early intervention and training.

The number of new case referrals received by the CAS, the rate for completion of assessment for new cases within 6 months, and the number of children assessed are as follows:

	2020	2021	2022	2023	2024 (Provisional figures)
Number of new cases referred to the CAS	7 526	12 166	10 154	9 326	8 596
Percentage of new cases with appointment time within 3 weeks (%)	100	100	100	100	100
Rate for completion of assessment for new cases within 6 months (%)	65	73	61	70	68
Number of children assessed by the CAS#	14 507	16 626	14 251	18 637	17 757

The figure includes both newly registered referral cases and follow-up cases.

The DH does not maintain statistics on the number of children assessed with breakdown by the stage of schooling.

As announced by the Chief Executive in his 2024 Policy Address, to enhance the health of the people of Hong Kong, improve healthcare protection and quality, and capitalise on our healthcare professions' strengths, the Government is conducting a comprehensive review on the positioning and objectives of the healthcare system. The review covers the reform of the functions and division of work among the HA, the DH and the Primary Healthcare Commission (PHC Commission). The relevant initiatives include reforming the HA's governance effectiveness to enhance the standards and efficiency of its specialist and in-patient services. At the same time, the PHC Commission and the DH will strengthen their efforts in health promotion and disease prevention in order to continue to redress the imbalance in the existing system which emphasises on treatment rather than prevention. The DH will also strengthen its role as the Government's adviser and regulatory authority in respect of public health, and will focus on its functions in this aspect. In this connection, the DH is gradually transferring its specialist clinical services and primary healthcare services to the HA and the PHC Commission respectively.

The DH is liaising with the HA on the detailed arrangements for integrating the CAS into the Hong Kong Children's Hospital under the HA, with a view to consolidating the public paediatrics services to facilitate collaboration among various specialities and streamline the procedure for service delivery. In this way, the children suspected of having developmental or behavioural problems can receive the necessary integrated multi-disciplinary assessment, treatment and rehabilitative services in a timely manner, while the referral arrangements and

services for patients can be further enhanced. Relevant details will be announced in due course.

- End -

CONTROLLING OFFICER'S REPLY

HHB271

(Question Serial No. 0001)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions, (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The Government has been preventing and controlling importation and exportation of infectious diseases through port health measures, which include quarantine clearance at air, sea and land boundary control points (BCPs), such as conducting routine temperature screening for inbound travellers, setting up health posts to conduct health assessment for suspected infectious cases, and providing medical assistance for travellers in need. In this connection, please advise on the following:

1. the respective number of posts and expenditure for “conducting routine temperature screening for inbound travellers” and “setting up health posts” over the past 5 years, with a breakdown by year and BCP;
2. the respective number of cases in the past 3 years where inbound travellers were hospitalised upon temperature measurement for treatment due to suspected infection of Severe Acute Respiratory Syndrome, with a breakdown by BCP; and
3. whether the Government has any plans to further adopt innovation and technology to streamline manpower or related resources. If yes, the details; if no, the reasons.

Asked by: Hon TSE Wai-chuen, Tony (LegCo internal reference no.: 77)

Reply:

In accordance with the power conferred by the Prevention and Control of Disease Ordinance of Hong Kong and with regard to the guidelines of the International Health Regulations, the Department of Health (DH) enforces various preventive measures at boundary control points (BCPs) to prevent the introduction or spreading of infectious diseases into or out of Hong Kong. The Port Health Division under the DH carries out health screening work at each BCP (including conducting regular body temperature screening for arrivals and setting up health stations). Taking into account the design of each BCP and its traveller and vehicle flow, the DH deploys manpower as appropriate to conduct body temperature screening for all arrivals; and performs, in accordance with the mechanism, further health assessments for travellers with fever or in need (such as travellers who self-reported being unwell) to understand their symptoms, travel history, contact history, etc., in order to make appropriate referrals and follow-up, including compulsory referral of persons with suspected infection of

major infectious diseases to Hong Kong public hospitals for checking, advising other travellers with fever or in need to seek medical treatment at medical institutions with issuance of referral letters, and assisting persons in need to call for ambulance service for further treatment at Accident and Emergency Department.

The Hong Kong Special Administrative Region (HKSAR) Government has been maintaining close co-operation with entry-exit health inspection and quarantine authorities of the Mainland to safeguard the well-being and safety of residents and travellers of the 2 places. The Health Bureau and the General Administration of Customs of the People's Republic of China (GACC) signed the Co-operation Arrangement for Entry-exit Health Inspection and Quarantine between the GACC and the Health Bureau of the HKSAR Government in 2023. Under the normalisation arrangements for epidemic prevention and control, the 2 parties agreed to focus on the health inspection and quarantine of their respective inbound personnel travelling between the HKSAR and the Mainland BCPs.

The HKSAR Government will maintain close liaison with the relevant Mainland authorities and, taking into account factors such as cost-effectiveness and appropriateness, actively review the entry health inspection and quarantine arrangements (including temperature screening) from the public health perspective.

(1)

From 2020 to 2024, the average number of health screening shifts of the DH per day at various BCPs (some health screening posts involve more than 1 shift according to the operation of BCPs) is as follows:

	2020	2021	2022	2023	2024
Airport	270	244	226	125	122
Lo Wu	40	0	0	40	40
Lok Ma Chau Spur Line	30	0	0	30	30
Lok Ma Chau	90	90	111	94	94
Man Kam To	27	27	41	36	36
Sha Tau Kok	37	37	20	8	0
Shenzhen Bay	137	171	182	116	94
Hong Kong-Zhuhai-Macao Bridge	141	178	178	116	130
Heung Yuen Wai	28	28	28	68	58
Express Rail Link West Kowloon	6	6	31	51	51
Hung Hom	18	18	18	0	0
Macau Ferry Terminal	42	42	45	45	45
China Ferry Terminal	22	22	0	22	22
Total	888	863	880	751	722

Note:

The DH redeploys health screening posts in view of the actual circumstances. Some of the posts at BCPs where operation has been suspended would be redeployed to other BCPs. Health screening service of Kai Tak Cruise Terminal and Ocean Terminal was not included as it was only provided during stopover of cruises.

The expenditure incurred by health screening shifts listed in the table above is set out below:

	Financial Year				
	2020-21	2021-22	2022-23	2023-24	2024-25

Expenditure (\$ million)	215	205	239	240	205

(2)

From 2022 to 2024, no arrivals were suspected to be infected with Severe Acute Respiratory Syndrome (SARS) upon temperature measurement at various BCPs. On the other hand, the number of inbound travellers compulsorily referred to public hospitals upon fulfilling reporting criteria of any major infectious disease is set out as follows:

	2022	2023	2024
Number of Inbound Travellers Compulsorily Referred to Public Hospitals upon Fulfilling Individual Reporting Criteria of Any Major Infectious Disease	250	61	6

Note:

The compulsory isolation arrangement imposed on persons infected with Coronavirus Disease 2019 (COVID-19) has been rescinded with effect from 30 January 2023.

(3)

Ongoing health screening, which facilitates early identification of potential infectious diseases imported into Hong Kong, is vital to safeguarding public health. Currently, health screening measures are in place for inbound travellers at all BCPs between Hong Kong and the Mainland.

The DH mainly employs an Infrared Thermal Imaging System at various BCPs to detect the body temperatures of multiple travellers simultaneously to reduce the manpower required for such work. However, drivers and all passengers in a cross-boundary private car are allowed to remain in their vehicle while passing through the kiosks of the Immigration Department, the Customs and Excise Department and the DH without the need to get off from the vehicle or go to the traveller's clearance hall. Due to site constraints, the Infrared Thermal Imaging System cannot be used to measure the forehead temperature of drivers and passengers passing through the vehicle lanes. As a result, hand-held infrared thermometers are used to measure the body temperature of inbound passengers on board the vehicles at the DH vehicle kiosks.

The DH reviews the health screening arrangements from time to time and deploys manpower as appropriate at various BCPs according to the actual circumstances to provide appropriate services for inbound travellers. For instance, the additional personnel deployed during the COVID-19 epidemic in the light of the actual needs have been reduced after the epidemic, and the manpower at relevant BCPs has basically returned to the pre-epidemic level. Meanwhile, the DH also keeps a close eye on technological development and actively explores the adoption of innovative technology in collaboration with other departments at BCPs to reduce the manpower need for health screening and optimise the use of human resources.

- End -

CONTROLLING OFFICER'S REPLY**HHB272****(Question Serial No. 1189)**Head: (37) Department of HealthSubhead (No. & title): (-) Not SpecifiedProgramme: (2) Disease PreventionControlling Officer: Director of Health (Dr. Ronald LAM)Director of Bureau: Secretary for HealthQuestion:

Expanding the Elderly Health Care Voucher Greater Bay Area Pilot Scheme (Pilot Scheme) is mentioned in the Programme as one of the matters requiring special attention in 2025-26. In this connection, will the Government advise this Committee on:

- (1) the number of voucher claim transactions, the amount claimed and the average amount per claim transaction in the past year for each of the 9 service points of the medical/dental institutions in the Greater Bay Area that allow the use of EHCVs;
- (2) the number of voucher claim transactions, the amount claimed and the average amount per claim transaction in the past year regarding dental services provided at each of the 9 service points;
- (3) the number of voucher claim transactions, the amount claimed and the average amount per claim transaction in the past year for each of the 3 major types of dental service received by elderly persons at the 9 service points;
- (4) whether consideration will be given to allow the use of both EHCVs and the national medical insurance to pay for the same medical service; if yes, the details; if not, the reasons?

Asked by: Hon WONG Kwok, Kingsley (LegCo internal reference no.: 9)Reply:

(1) & (2)

In 2024, the number of voucher claim transactions, the amount of vouchers claimed, along with the average amount of vouchers per claim transaction for eligible Hong Kong elderly persons using the Elderly Health Care Vouchers (EHCVs) at 9 service points in the Greater Bay Area (GBA) under the Elderly Health Care Voucher Scheme (EHVS), as well as those related to dental / stomatological services, are tabulated below:

GBA Medical Institution	Number of Voucher Claim Transactions [related to Dental / Stomatological Services]	Amount of Vouchers Claimed [related to Dental / Stomatological Services] (HK\$ '000)	Average Amount of Vouchers per Claim Transaction [related to Dental / Stomatological services] (HK\$)

University of Hong Kong - Shenzhen Hospital (HKU-SZH)	61 841 [2 137]	19,487 [1,046]	315 [489]
Huawei Li Zhi Yuan Community Health Service Center (Huawei CHC)	609 [Note 1]	70 [Note 1]	115 [Note 1]
The First Affiliated Hospital, Sun Yat-sen University (FAH-SYSU) (since 28 June 2024)	1 865 [192]	931 [180]	499 [938]
Zhongshan Chen Xinghai Hospital of Integrated Traditional Chinese and Western Medicine (ZSCXH) (since 18 July 2024)	2 052 [179]	995 [100]	485 [559]
Shenzhen New Frontier United Family Hospital (NFUFH) (since 14 August 2024)	1 402 [329]	1,594 [262]	1,137 [796]
Dongguan Tungwah Hospital (Tungwah Hospital) (since 6 September 2024)	790 [134]	451 [104]	571 [776]
Nansha Division of The First Affiliated Hospital, Sun Yat-sen University (FAH-NS) (since 6 September 2024)	246 [Note 2]	95 [Note 2]	386 [Note 2]
Shenzhen C.K.J Stomatological Hospital (CKJSH) (since 14 August 2024)	8 903	15,264	1,714
Dental Bauhinia Specialty Service Center (Shenzhen)/ Dental Bauhinia General Care Center (Shenzhen) (Dental Bauhinia) (since 14 August 2024)	210	452	2,152
Total:	77 918 [12 084]	39,339 [17,408]	505 [1,441]

Note 1: The Department of Health (DH) only maintains data on the total claims made by the Huawei CHC and is therefore unable to provide a breakdown of healthcare services.

Note 2: The FAH-NS's Dental Department / Department of Stomatology has yet to commence operation.

(3)

Among the voucher claim transactions related to dental / stomatological services at various GBA service points under the EHVS in 2024, the number of voucher claim transactions, the amount of vouchers claimed, and the average amount of vouchers per claim transaction of the

3 types of dental services with the highest number of voucher claim transactions (by principal reason for visit) are tabulated as follows:

GBA Medical Institution	The 3 Types of Dental Services with the Highest Number of Voucher Claim Transactions (Principal Reason for Visit)	Number of Voucher Claim Transactions	Amount of Vouchers Claimed (HK\$ '000)	Average Amount of Vouchers per Claim Transaction (HK\$)
HKU-SZH	1. Preventive Care	1 182	532	450
	2. Follow-up/ Monitoring of long term conditions	678	336	496
	3. Management of acute episodic conditions	167	106	635
FAH-SYSU (since 28 June 2024)	1. Management of acute episodic conditions	69	27	391
	2. Follow-up/ Monitoring of long term conditions	65	21	323
	3. Rehabilitative Care	35	100	2,857
ZSCXH (since 18 July 2024)	1. Preventive Care	84	24	286
	2. Follow-up/ Monitoring of long term conditions	66	36	545
	3. Management of acute episodic conditions	17	2	118
NFUFH (since 14 August 2024)	1. Preventive Care	210	95	452
	2. Management of acute episodic conditions	109	157	1,440
	3. Follow-up/ Monitoring of long term conditions	10	11	1,100
Tungwah Hospital (since 6 September 2024)	1. Preventive Care	85	57	671
	2. Management of acute episodic conditions	29	18	621
	3. Follow-up/ Monitoring of long term conditions	18	28	1,556
CKJSH (since 14 August 2024)	1. Follow-up/ Monitoring of long term conditions	4 180	7,082	1,694
	2. Rehabilitative Care	2 370	7,620	3,215

	3. Preventive Care	2 266	362	160
Dental Bauhinia (since 14 August 2024)	1. Follow-up/ Monitoring of long term conditions	93	199	2,140
	2. Preventive Care	69	65	942
	3. Rehabilitative Care	31	132	4,258

Note 1: The DH only maintains data on the total claims made by the Huawei CHC and is therefore unable to provide a breakdown of healthcare services.

Note 2: The FAH-NS's Dental Department / Department of Stomatology has yet to commence operation.

(4)

The Government's policy of allowing EHCVs to be used in the GBA aims to provide more convenience and flexibility for eligible Hong Kong elderly persons residing in Mainland cities in the GBA by offering them more service points to use EHCVs to meet their primary healthcare needs and improve their health. However, under the Pilot Scheme, eligible Hong Kong elderly persons cannot use EHCVs and the national medical insurance simultaneously to pay for the fees of the same healthcare service encounter at various GBA service points.

As the insuring clauses of national medical insurance vary across different cities in the GBA, where discrepancies in arrangements are bound to emerge, and the applicable medical items may differ from those covered by EHCVs (in that the scope of using EHCVs in the Mainland is the same as in Hong Kong where inpatient services, prepaid healthcare services and day surgery procedures are excluded). To avoid confusion and maintain consistency, the 2 healthcare benefits cannot be used at the same time, so as to prevent complications and misunderstandings in the use of EHCVs.

- End -

CONTROLLING OFFICER'S REPLY

HHB273

(Question Serial No. 1327)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Respiratory syncytial virus (RSV) infection in young children can cause respiratory tract diseases such as infection of the airway, lungs and middle ear. Regarding the prevention of RSV, will the Government inform this Committee of:

1. the number of RSV infections of infants/toddlers aged 2 or under reported to the Centre for Health Protection, the number of RSV infections of infants/toddlers resulting in admissions to Hospital Authority hospitals, the number of RSV infections of infants/toddlers admitted to paediatric intensive care units due to the infection or related complications, and the number of RSV-attributable deaths of infants/toddlers in each of the past 3 years;
2. whether the Government will allocate additional resources to strengthen monitoring measures concerning local RSV activity, and to step up public education on the prevention of RSV infection in infants/toddlers; if yes, the work plans and the estimated expenditure; if no, the reasons; and
3. whether the Government will, with reference to the measures adopted in places such as the United States, the United Kingdom and Australia, study the inclusion of RSV vaccines (registered in Hong Kong and suitable for administration to infants and young children) into the Hong Kong Childhood Immunisation Programme along with the subsidies to reduce the risk of severe illness and complications from RSV infections in infants/toddlers; if yes, the work plans and the estimated expenditure; if no, the reasons?

Asked by: Hon YANG Wing-kit (LegCo internal reference no.: 5)

Reply:

(1)

Respiratory syncytial virus (RSV) can cause respiratory tract diseases such as infection of the airway, lungs and middle ear. It is transmitted by direct contact with infectious secretions or by droplets spread, or indirectly through contact with contaminated hands, eating utensils

or objects contaminated by nasal or throat discharges of an infected person. In general, most people develop mild symptoms after contracting RSV.

RSV infection is not a notifiable infectious disease. As most people infected with RSV show mild symptoms, hospitalisation is not required. Since the symptoms of these infections in the community resemble those of other viral respiratory infections, confirmation by laboratory testing is typically not pursued. For the above reasons, the Centre for Health Protection (CHP) of the Department of Health (DH) does not maintain statistics on the number of RSV infections in infants/toddlers aged 2 or under. Nonetheless, the CHP has been monitoring the number local public hospital admissions due to RSV infections and the situation concerned. The numbers of hospitalisation cases in public hospitals, admissions to intensive care units (ICUs) during hospitalisation and RSV-attributable deaths in relation to infants/toddlers aged 2 or under in each of the past 3 years (2022 to 2024) are tabulated below:

Year	Number of Public Hospital Admissions*	Number of Admissions to ICUs in Public Hospitals	Number of Deaths
2022	241	17	0
2023	2 659	182	0
2024	1 274	81	0

* Including cases where patients were admitted to ICUs.

(2)

Apart from public hospital admissions, the CHP has also been closely monitoring the local RSV activity through laboratory testing and disease outbreak reports, etc. The CHP also engages in public education on the prevention of viral respiratory infections (including RSV infections) through channels such as thematic websites, social media and media interviews. Health information pertaining to RSV prevention has been uploaded to the CHP’s website for public access. As the expenditure in this respect is subsumed into the DH’s overall expenditure on surveillance, prevention and control of infectious diseases as well as health promotion, the expenditure on the work related to RSV infection cannot be separately identified.

(3)

Currently, there are 2 types of RSV vaccines registered in Hong Kong, both of which are intended for elderly persons aged 60 or above. One of them can also be administered to pregnant women between 32 and 36 weeks of gestation to prevent severe lower respiratory diseases caused by RSV infection in infants within the first 6 months after birth. However, there are currently no RSV vaccines available for infants/toddlers locally nor abroad.

Regarding the use of RSV vaccines, the Scientific Committee on Vaccine Preventable Diseases (SCVPD) under the CHP discussed issues related to RSV vaccination for pregnant women at a meeting in January 2025. The experts reviewed in detail the local epidemiological data on RSV, the scientific data on their efficacy and safety (including potential adverse effects such as preterm labour and gestational hypertension) and the recommendations of the World Health Organization and the international community on the use of these vaccines. Based on scientific evidence, the SCVPD considers that more safety

data on the use of RSV vaccines is required before further consideration of the proposal concerning universal RSV vaccination for pregnant women, who are advised to consult their doctor and consider receiving vaccination as an individual decision under informed consent.

In general, the inclusion of new vaccines in the Government's vaccination programmes is based on scientific evidence while taking into account a number of public health factors including the overall burden that the disease impose on society, the efficacy and safety of the vaccines, the availability of other effective preventive measures and the cost-benefit of mass vaccination. Personal health remains an individual's responsibility. While particular preventive measures are beneficial to personal health, they are not necessarily justified for public funding from a public health or healthcare policy perspective.

- End -

CONTROLLING OFFICER'S REPLY

HHB274

(Question Serial No. 1331)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention, (4) Curative Care

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The Matters Requiring Special Attention in 2025-26 under Programme (2) include overseeing the launching of the Primary Dental Co-care Pilot Scheme for Adolescents (PDCC) and the Community Dental Support Programme (CDSP). In this connection, will the Government advise this Committee on:

1. the service quotas of the CDSP, and whether the quotas will increase based on demand;
2. whether the CDSP will provide removable denture services, given that the Government will replace the Community Care Fund Elderly Dental Assistance Programme in 2026; if yes, the details; if not, the reasons; and
3. whether it will consider, with reference to the Pilot Scheme on Dental Services for Civil Service Eligible Persons in Shenzhen, expanding the PDCC to dental institutions in Shenzhen to reduce co-payment from adolescent participants; if yes, the details; if not, the reasons?

Asked by: Hon YANG Wing-kit (LegCo internal reference no.: 9)

Reply:

To safeguard the oral health of the public, the Chief Executive announced in the 2022 Policy Address to conduct a comprehensive review of the dental services provided or subsidised by the Government. The Working Group on Oral Health and Dental Care (Working Group) was subsequently established in end-2022. The Working Group published a final report in end-2024, recommending that the future development of dental services should make reference to the direction of the Primary Healthcare Blueprint emphasising prevention, early identification and timely intervention, with the goal of retention of natural teeth and enhancing the overall level of citizens' oral health.

The Government concurs with the views of the Working Group that providing or subsidising comprehensive curative dental services from public purse to all Hong Kong citizens regardless of their financial means does not align with the policy objectives of developing a prevention-oriented oral health and dental care system and encouraging citizens to take responsibility for their own oral health. This would exacerbate the current shortcomings of the treatment-oriented system, and would be neither cost-effective nor sustainable in terms of

utilisation of public resources. It would be financially untenable for the Government and would thin out the resources that could otherwise be used for other healthcare services.

In response to the final report of the Working Group, the Government has adopted the oral health policy that: (1) Oral health is an integral component of general health. The Government's oral health policy aims to enable all Hong Kong citizens to improve their oral hygiene and lifestyle conducive to both oral and overall health levels; (2) Through publicity, education, promotion and development of primary oral health and dental care, the Government facilitates citizens to manage their oral health, and put prevention, early identification and timely intervention of dental diseases into action with the objective of tooth retention; and (3) The Government provides appropriate oral health and dental care services targeting underprivileged groups with financial difficulties and special needs, ensuring these groups have access to essential dental care services.

In the Oral Health Action Plan formulated based on the Working Group's strategic recommendations, the Primary Dental Co-care Pilot Scheme for Adolescents (PDCC) is rolled out to actively develop prevention-oriented primary oral healthcare according to the strategy of community-wide preventive primary oral health care. Meanwhile, the Community Dental Support Programme (CDSP) is a service focusing on underprivileged groups who have difficulties in accessing dental care under the aforesaid strategy of ensuring these groups have access to essential dental care services.

1&2:

On top of the existing dental grants under the Comprehensive Social Security Assistance Scheme and the emergency dental service provided through General Public Sessions by government dental clinics, the Department of Health (DH) will increase the dental services to underprivileged groups with financial difficulties by launching the CDSP in 2025 and enhancing service capacity, increasing service points and expanding service scope, aiming to additionally offer at least twice the current number of quotas provided by the General Public Sessions of government dental clinics (i.e. 40 000 per year). The CDSP leverages the networks of non-governmental organisations and social welfare organisations serving underprivileged groups to provide services to persons with financial difficulties. In addition to tooth extraction, the CDSP provides dental fillings where dentists consider appropriate to encourage tooth retention. The DH will continuously monitor the utilisation rates of the service and gather feedback from service users regarding their needs, as well as the data on their oral health conditions to review the effectiveness of the CDSP in due course.

In addition, the CDSP will supplant the Community Care Fund Elderly Dental Assistance Programme (EDAP) in 2026. The Government concurs with the views of the Working Group that the EDAP's previous emphasis on removable dentures have misled the citizens that the services encouraged tooth extraction and dentures. In response to the Working Group's views, the EDAP was enhanced in July 2024 to allow eligible elderly to apply for subsidies and receive other specified dental services including oral check-ups, scaling, and fillings, even though they are not suitable for removable dentures. This enhancement aimed to encourage eligible elderly to choose other preventive and curative dental services for timely management of dental diseases and retain teeth as far as possible so as to avoid tooth extraction and dentures. Upon supplanting the EDAP by CDSP, the primary focus will continue to encourage prevention of dental diseases and retention of teeth. In future, the

CDSP will only provide related subsidies to underprivileged persons assessed to have difficulties in eating or chewing whose eating function can be restored through removable dentures.

3:

The DH launched the three-year PDCC on 20 March this year by the as an interface with the School Dental Care Service by providing partial subsidies for private dental check-up services for adolescents via a co-payment model to foster their establishment of partnership with dentists so as to promote their life-long habit of regular oral check-ups for prevention of dental diseases. Eligible adolescents can receive subsidised services once every calendar year. While the Government will provide a subsidy of \$200 each time, participants have to pay a co-payment fee as determined by their selected dentists. The co-payment for the subsidised services each time recommended by the Government is \$200. As at 18 March, there are around 270 registered dentists whose application to participate in the PDCC has been accepted by the DH, providing services at over 370 service locations. Among these dentists, over 67% charge a co-payment amount of \$200 or less while the minimum co-payment amount is \$50. The scope of subsidised services includes:

- i) Oral check-up;
- ii) Oral health risk assessment;
- iii) Dental scaling;
- iv) Personalised oral care advice;
- v) Fluoride application based on risk assessment; and
- vi) Oral check-up report.

To enhance the transparency of dental service fees other than the co-payment fee, the DH required dentists to disclose the fees for X-ray examinations, tooth fillings and extractions as charged under the PDCC.

The DH held 2 online briefing sessions for registered dentists in February and March to introduce the background, contents and dentist registration procedures of the PDCC. It also introduced the PDCC through a seminar organised by the Hong Kong Dental Association in mid-March.

Adolescents from age 13 to 17 (or will turn 13 in the calendar year when applying to join the PDCC), who hold a valid Hong Kong Identity Card and have registered in the Electronic Health Record Sharing System (eHealth) are eligible to join the PDCC. Eligible adolescents and their parents may, via the eHealth mobile application, access the thematic website and promotional videos launched by the DH in early March to learn about and participate in the PDCC. The DH has also disseminated letters through the Education Bureau to reach out to all secondary school students and their parents in the territory to publicise and promote the PDCC, while also approaching students visiting Student Health Service Centres and School Dental Clinics to publicise the scheme. About 370 000 adolescents are eligible to join each year, though the final number of participants will depend on the response from adolescents and their parents.

Adolescents and their parents who are interested in joining the PDCC can refer to the thematic website to view the list of registered dentists participating in the PDCC. After selecting a dentist, they can contact the relevant clinic directly to make an appointment for receiving the subsidised services. Details about the clinic addresses, telephone numbers, professional

qualifications and the co-payment amount required from scheme participants are also set out on the list of dentists. All clinics participating in the PDCC will display the signage of the scheme outside their premises or at a prominent place for easy identification.

The DH will continuously monitor the utilisation rates of the service and gather feedback from service users as well as the data on their oral health conditions to review the effectiveness of the PDCC in due course.

The Working Group noticed that there are suggestions in the community on purchasing dental services from the Mainland or providing subsidies to citizens for such services. The Working Group considered that the Government should bear the responsibility of protecting Hong Kong citizens' health by providing quality local healthcare services, rather than simply transferring the responsibility to the Mainland healthcare system. Hong Kong's private sector and NGOs should remain the most accessible service channels for citizens. The Working Group recommended the Government to focus on meeting citizens' dental service needs through the local healthcare system, by investing resources in promoting dental professional development, and work in close rapport with the professional sector to advance and strengthen the status and services of the local dental profession. There is no plan to expand the coverage of the PDCC to dental institutions in Shenzhen at present.

- End -

CONTROLLING OFFICER'S REPLY

HHB275

(Question Serial No. 3090)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Regarding the implementation of the Colorectal Cancer Screening Programme and the Breast Cancer Screening Pilot Programme (BCSPP), will the Government advise this Committee on:

1. the number of participants, the screening results, the number of cancer patients identified by screening (with a breakdown of cancer stages) and the expenditure incurred each year since the launch of the 2 programmes; and
2. whether the effectiveness of the BCSPP has been evaluated, and whether there has been any progress of late in Phase II of the BCSPP; if yes, the details; if not, the reasons?

Asked by: Hon YANG Wing-kit (LegCo internal reference no.: 39)

Reply:

The Cancer Expert Working Group on Cancer Prevention and Screening (CEWG) under the Cancer Coordinating Committee chaired by the Secretary for Health regularly reviews local and international scientific evidence, with a view to making recommendations to the Government on suitable evidence-based measures for cancer prevention and screening for the local population. Based on the CEWG's recommendations on cancer screening, the Government has rolled out the Cervical Screening Programme, the Colorectal Cancer Screening Programme (CRCSP) and the Breast Cancer Screening Pilot Programme (BCSPP).

When considering recommendations for any disease screening, the Government will refer to the evidence-based risk assessment and views of relevant experts from the perspective of public health. A number of factors will be carefully assessed, such as local prevalence of the cancer, accuracy and safety of the screening tests, effectiveness in reducing incidence and mortality rates as well as feasibility of implementation of a screening programme. The perspective of good utilisation of medical resources will be taken into account to determine the priority. Excessive screening under public health programme not only wastes resources for the overall public health, but also runs out of resources that can be invested on other projects in greater need, and may pose unnecessary health risks to individuals, often causing more harm than good.

Primary prevention (i.e. reducing exposure to cancer risk factors) is the most important strategy for reducing the risk of developing cancer. The Department of Health (DH) has all along been encouraging members of the public to adopt a healthy lifestyle, including avoidance of smoking and alcohol, healthy diet, regular physical activity and maintenance of a healthy body weight and waist circumference, in order to reduce the risk of non-communicable diseases including cancer.

(1) & (2)

The CRCSP

Based on the recommendations of the CEWG, the Government launched and fully implemented the CRCSP in September 2016 and 2020 respectively to subsidise asymptomatic Hong Kong residents aged between 50 and 75 to undergo regular screening. As at end-December 2024, more than 510 000 eligible persons have participated in the CRCSP. Among those participants who had undergone colonoscopy examination, about 40 000 were diagnosed to have colorectal adenomas and about 3 400 were diagnosed with colorectal cancer. A preliminary analysis of about 2 400 colorectal cancer cases revealed that about 56% belonged to early-stage (stage II or below) with a more favourable prognosis. For other colorectal cancer cases recorded by the Hong Kong Cancer Registry of the Hospital Authority, less than 40% of them belonged to early-stage, which demonstrates that participation in the CRCSP allows early detection and treatment of colorectal cancer, thereby leading to a more favourable prognosis. Such screenings can help in the early identification of those who have colorectal cancer before they present with symptoms, or those with higher risk of colorectal cancer, enabling them to receive early treatment, thus significantly improving the prognosis. The removal of colorectal adenomas in the course of colonoscopy also prevents them from turning into cancer.

A breakdown of the number of new participants by year from 2022 to 2024 is appended below:

Year	Number of New Participants
2022	72 600
2023	71 900
2024	86 000

The actual expenditure of the CRCSP in 2022-23 and 2023-24 and its revised estimate in 2024-25 are as follows:

Financial Year	Annual Expenditure (\$ million)
2022-23 (Actual)	151.6
2023-24 (Actual)	175.6
2024-25 (Revised Estimate)	222.7

The BCSP

Based on the recommendations of the CEWG, the Government adopts a risk-based approach for breast cancer screening and launched Phase I of the BCSP in 2021. Women aged between 44 and 69 with certain combinations of personalised risk factors (including presence of history of breast cancer among first-degree relatives, a prior diagnosis of benign breast

disease, nulliparity or late age of first live birth, early age of menarche, high body mass index and physical inactivity) putting them at increased risk of breast cancer are recommended to consider mammography (MMG) screening every 2 years.

In the two-year Phase I of the BCSPP (which ran from September 2021 to December 2023), a total of 27 807 women aged between 44 and 69 have received breast cancer risk assessment in Woman Health Centres (WHCs), 4 Maternal and Child Health Centres and 18 Elderly Health Centres (EHCs). 7 785 (about 28%) of them underwent the MMG screening on referral based on the risk assessment. Among the women with abnormal MMG results who had been referred to specialists for treatment, 409 cases were followed up in public hospitals, among which 68 were confirmed to have breast cancer. The breast cancer detection rate per 1 000 MMG screenings was 8.7, which was comparable to the international standard of about 5 cases per 1 000 MMG screenings. Of the 68 breast cancer cases identified through the MMG screening, 97% were at stage II or below. Following the review of Phase I of the BCSPP, the breast cancer risk assessment and screening have been included as part of the regular services provided by the Woman Health Service and the Elderly Health Service.

The expenditure of Phase I of the BCSPP is subsumed under the overall provision for WHCs and EHCs, thus a breakdown of such expenditure is not available.

The Woman Health Service under the DH will be integrated into the district health network of the Health Bureau Primary Healthcare Commission within 2025. The service points, to be named Women Wellness Satellites, will form a network with District Health Centres (DHCs)/DHC Expresses in all 18 districts across Hong Kong to provide eligible women with prevention-based and more personalised primary healthcare services, including breast cancer screening. In parallel, the DHCs/DHC Expresses actively promote the “Life Course Preventive Care Plan”. In line with the core principles of prevention-oriented and whole-person care, a personalised preventive care plan will be formulated based on the most updated evidence and the health needs of citizens across different life stages. Family doctors and primary healthcare professionals will collaborate to promote healthy lifestyles and disease prevention, including providing education and vaccination for cancer prevention, and advising on cancer screening services according to personal risk factors.

Based on the recommendations of the CEWG, the Government is now preparing for Phase II of the BCSPP to provide subsidised breast cancer screening services for women at high risk of developing breast cancer (i.e. carriers of certain gene mutations and/or with strong family history of breast cancer or ovarian cancer) through Public-Private Partnership programmes in collaboration with non-governmental organisations. Phase II of the BCSPP, of which details will be announced in due course, is expected to be launched around the second quarter of 2025.

- End -

CONTROLLING OFFICER'S REPLY

HHB276

(Question Serial No. 3378)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the usage of eHealth, will the Government inform this Committee of:

1. the number of citizens who have registered with eHealth in the past 5 years;
2. in respect of private healthcare providers, the number of clinics which have uploaded patients' health records to eHealth;
3. whether key performance indicators have been set for eHealth and will be set for the planned eHealth+; if so, what are the details; and
4. the measures to be introduced to encourage more private healthcare providers to use eHealth.

Asked by: Hon CHAN Hak-kan (LegCo internal reference no.: 42)

Reply:

eHealth is a territory-wide electronic health record sharing system launched by the Government in 2016 that enables citizens to authorise healthcare providers (HCPs) in the public and private sectors to view and share their electronic health records (eHRs) for healthcare purposes. Building on the strengths of the existing infrastructure of eHealth, the Government announced in the 2023 Policy Address the initiative to roll out a five-year development plan of eHealth+ to transform eHealth into a comprehensive healthcare information infrastructure that integrates multiple functions of data sharing, service delivery and care journey management. eHealth+ aims to facilitate care co-ordination, cross-sector collaboration, as well as health management and surveillance, thereby better serving our citizens in obtaining optimal healthcare services, and supporting the healthcare reform and various healthcare policies more effectively, such as primary healthcare and cross-boundary healthcare services. In July 2024, the Finance Committee of the Legislative Council (LegCo) approved a capital funding of \$1,395.8 million to support the eHealth+ development. The Government has formulated detailed work targets and timetables for the eHealth+ programme in accordance with the patient-centric principle and 4 strategic directions, namely, "One Health Record", "One Care Journey", "One Digital Front Door to Empowering Tool" and "One Health Data Repository". We are taking forward the eHealth+ programme in phases.

As of end-February 2025, over 6.1 million citizens have registered with e-Health, accounting for over 80% of the Hong Kong population. Over the past 5 years, the number of citizens registered with eHealth has increased significantly, and the relevant figures are tabulated as follows:

Financial Year	Number of Citizens Registered with eHealth (million)
2020-21	1.7
2021-22	5.3
2022-23	5.8
2023-24	6.0
2024-25 (As at 28 February 2025)	6.1

Under the strategic development direction of “One Health Record”, we seek to consolidate the longitudinal eHRs of citizens spread across a multitude of healthcare processes into their personal eHealth accounts. A comprehensive and complete eHR profile enables the HCPs authorised by citizens to respond to their health needs more effectively, thus enhancing clinical outcomes and saving costs of the care process. Nevertheless, while private HCPs have been actively using eHealth in supporting clinical processes as evidenced by the fact that nearly 60% of eHRs access by HCPs as of end-February 2025 were by private HCPs, more than 99% of some 4.5 billion eHRs shared on eHealth are from public HCPs.

The Government has been taking a multi-pronged approach to incentivise and facilitate the provision of citizens’ eHRs into eHealth by private HCPs, thereby assisting citizens in accessing, managing and using their own eHRs during the healthcare process more conveniently. Last year, the Government launched a platform enabling self-service data compliance testing to simplify the technical testing procedures, and provided dedicated technical support to healthcare institutions. When taking forward various public-private partnership (PPP) programmes, the Government would require HCPs to deposit the related medical records of the participating citizens into eHealth. The Government also rolled out the eHealth Adoption Sponsorship Pilot Scheme (Pilot Scheme) by partnering with electronic medical record (eMR) solutions vendors and medical groups to co-fund system enhancements in achieving seamless eHR sharing between eHealth and eMR systems in the market. From July 2023 to February 2025, about 80 private HCPs (involving around 480 private doctors and 200 service locations) connected to eHealth and provided more than 1.12 million eHRs under the Pilot Scheme.

With the Government’s endeavours, the number of eHRs provided by private HCPs to eHealth increased from 2.19 million in 2023 to 3.67 million in 2024. In future, the Government will continue to collaborate with the private healthcare sector to enhance the connectivity between eHealth and their eMR solutions. In particular, given the positive impacts of the Pilot Scheme, we have progressively expanded the scheme this year to include more eMR solution vendors, medical groups and other sectors, including Chinese medicine. We will also launch the eHealth+ accreditation scheme in 2025 to enable citizens to easily identify if an HCP has the capability to deposit health records into their personal eHealth accounts and the extent of

data involved. Citizens can make reference to such information in choosing a suitable HCP, to ensure that their medical records will be deposited in their personal eHealth accounts.

Besides, the Government introduced the Electronic Health Record Sharing System (Amendment) Bill 2025 (the Amendment Bill) into the LegCo this year to provide a legal framework to assist citizens in building a more comprehensive eHR profile. Among other things, the Amendment Bill will streamline the consent mechanism such that once citizens agree to join eHealth, their HCPs will be able to deposit health data into their personal eHealth accounts. Meanwhile, citizens will continue to retain full control over their personal data and can grant individual HCPs access to their eHealth records at their own will. The Amendment Bill will also empower the Secretary for Health to require specified HCPs to provide specified important health data into the personal eHealth accounts of citizens registered with eHealth with their consents, in order to facilitate citizens' easy access and control of their key health information. The Government will continue to provide support and collaborate with the private healthcare sector to enable the majority of private HCPs to seamlessly connect with eHealth; and will also consider providing additional assistance to healthcare institutions and healthcare professionals that are less prepared for digitalisation.

Under the strategic development direction of "One Care Journey", we will establish an effective information technology infrastructure that runs through the entire healthcare journey, links to different sectors and tiers of the healthcare system, facilitates citizens' participation in different health programmes and enables their full control of own healthcare journey. We are now building a one-stop "Strategic Health Service Operation Platform" in phases to support and standardise the workflow and documentation, both clinically and administratively, of all subsidised healthcare programmes and related public and private healthcare services. At present, the platform can support the Chronic Disease Co-Care Pilot Scheme and the Primary Dental Co-care Pilot Scheme for Adolescents (PDCC) launched in March this year. In 2025-26, we will continue to take forward the construction of the platform, gradually incorporating more primary healthcare services and both new and existing subsidised healthcare programmes into the platform, including the Women Health Service, the Elderly Health Service, Vaccination Subsidy Scheme, and Community Dental Support Programme, covering multiple layers of functions including enrolment, attendance registration, subsidy reimbursement, and participants' co-payment management, etc.

Under the strategic development direction of "One Digital Front Door to Empowering Tool", the eHealth mobile application (eHealth App) is positioned as a patient-centric integrated health tool for citizens to receive medical services at different locations, manage health service processes, access personal health information, monitor health condition, prevent diseases and build a healthier lifestyle. Currently, users are able to access 9 types of eHRs^{Note} through the eHealth App, and may self-input health data (e.g. blood pressure, blood sugar and body mass index) to facilitate the monitoring of health conditions. The eHealth App also provides functions such as healthcare programme management (e.g. Elderly Health Care Voucher balance enquiry, test results of the Colorectal Cancer Screening Programme and membership card of District Health Centres), "Cross-Boundary Health Record" and "Personal Folder" to facilitate citizens' participation in government-subsidised or PPP programmes and their use of eHRs outside Hong Kong. The new "e+Life" health challenge platform under eHealth was also launched in September 2024 to complement the Department of Health (DH)'s health promotion efforts, encouraging the general public to adopt a healthier

lifestyle. As of end-February 2025, the application has recorded more than 3.7 million downloads and an average monthly login frequency of about 800 000.

Note: Including personal identification and demographic data, allergies and adverse drug reactions, encounters/appointments, immunisation records, medication, laboratory and radiology reports, healthcare referrals, observation and lifestyle records, and medical certificates.

In 2025-26, the Government will continue to add and improve functions of the eHealth App. Among other things, we have developed the basic functions of “eBooking” and will gradually extend the function to cover more primary healthcare services provided by the Hospital Authority, the DH and other private healthcare organisations. To enable citizens to take control of their eHRs and those of their family members, we will gradually expand the scope of personalised eHRs accessible on the eHealth App, such as radiology images, Chinese medicine prescription records, dental check-up records and tooth conditions, etc. In addition, citizens will be able to manage relevant records under more government-subsidised healthcare programmes, such as those under the PDCC, through the eHealth App.

Under the strategic development direction of “One Health Data Repository”, the development of eHealth+ will further connect and consolidate the medical records of Hong Kong’s public and private healthcare systems, establishing a comprehensive and centralised health databank augmented by data analytic tools to support medical research, clinical trials and innovations and healthcare policy formulation by the Government. To create an enabling environment, we are exploring the establishment of an analytics platform with appropriate tools at the technical level. We will also develop an appropriate governance framework to ensure the safe and appropriate use of data with patients’ consent and sufficient safeguards for data security and personal data privacy.

We will continue to review the progress and effectiveness of various eHealth+ key development initiatives mentioned above to ensure that they are taken forward according to the 4 strategic development directions and specific targets, thereby effectively supporting various healthcare policies and enabling citizens to enjoy better healthcare services.

- End -

CONTROLLING OFFICER'S REPLY

HHB277

(Question Serial No. 4006)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: ()

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the crackdown on tobacco products in the past 3 years, will the Government inform this Committee of the total number of cases involving the illegal import of alternative smoking products detected by the Customs and Excise Department since the total ban on the sale of alternative smoking products (including electronic cigarettes, etc.) since end April 2022; and the quantities and values of the products seized?

Asked by: Hon CHAN Hak-kan (LegCo internal reference no.: 8)

Reply:

With effect from 30 April 2022, no person may import, promote, manufacture, sell, or possess for commercial purposes alternative smoking products (ASPs), including electronic smoking products, heated tobacco products and herbal cigarettes in accordance with the Smoking (Public Health) Ordinance (Cap. 371) and the Import and Export Ordinance (Cap. 60).

Since the legislation to prohibit the import of ASPs came into effect on 30 April 2022, a total of 4 622 cases involving the illegal import of ASPs had been intercepted by the Customs and Excise Department (C&ED) as at 31 December 2024, with about 20 million ASPs worth about \$120 million seized.

The C&ED will continue to fully co-operate with the Tobacco and Alcohol Control Office in the enforcement of the ban on the import of ASPs to prevent the entry of related products into Hong Kong.

- End -

CONTROLLING OFFICER'S REPLY**HHB278****(Question Serial No. 3413)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (3) Subvention: Hospital AuthorityControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

It is mentioned in the Matters Requiring Special Attention under this Programme that the Hospital Authority (HA) will open a total of 330 additional beds this year.

- I. Please set out the number of additional beds by specialty and hospital cluster;
- II. Please set out the number of additional general beds by specialty in each hospital cluster of the HA in the past 3 years, and of which, specify the number of beds under the first 10-year Hospital Development Plan;
- III. Please set out the ratio of doctors and nurses to general beds in each hospital cluster of the HA over the past 3 years.

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 40)Reply:

- I. The table below sets out the proposed number of additional hospital beds to be provided by the Hospital Authority (HA) in 2025-26 by cluster:

Hospital cluster	Proposed number of additional hospital beds to be provided in 2025-26
HKEC	4
HKWC	16
KCC	84
KEC	77
KWC	52*
NTEC	65
NTWC	44
HA Overall	342

- * Including 13 additional hospital beds to be provided upon re-planning the existing spaces of Yan Chai Hospital by converting 20 inpatient beds to 33 day inpatient beds

The abovementioned additional beds are still under planning. A detailed breakdown by specialty is not yet available.

II. The HA utilises the Government's financial provision each year to formulate measures through planning to enhance service capacity, including provision of additional hospital beds, in order to meet service demand. The numbers of additional general beds (by specialty) in each of the HA's hospital clusters under the annual planning for 2022-23, 2023-24, and 2024-25 are set out in the table below:

2022-23

Hospital cluster	Number of additional general beds									
	Medicine	Surgery	Cardiothoracic Surgery	Accident & Emergency	Obstetrics & Gynaecology	Clinical Oncology	Paediatrics	Intensive Care Unit	Neurosurgery	Total
HKEC	—	—	—	—	—	—	—	1	2	3
HKWC	—	—	—	—	—	—	3	—	—	3
KCC	15	1	2	40	—	—	2	1	1	62
KEC	78	—	—	—	—	—	—	—	—	78
KWC	66	—	—	—	6	—	—	—	—	72
NTEC	30	20	—	—	—	—	—	2	—	52
NTWC	65	40	—	—	10	10	—	4	—	129
HA Overall	254	61	2	40	16	10	5	8	3	399

2023-24

Hospital cluster	Number of additional general beds					
	Medicine	Surgery	Accident & Emergency	Orthopaedics & Traumatology	Rehabilitation	Total
HKEC	—	—	—	26	—	26
HKWC	—	—	—	—	—	—
KCC	—	—	6	—	2	8
KEC	10	—	—	—	—	10
KWC	—	—	—	—	—	—
NTEC	10	—	6	—	—	16
NTWC	—	8	—	—	—	8
HA Overall	20	8	12	26	2	68

2024-25 (as at 31 December 2024)

Hospital cluster	Number of additional general beds[^]						Total
	Medicine	Surgery	Accident & Emergency	Orthopaedics & Traumatology	Intensive Care Unit	Neurosurgery	
HKEC	—	—	—	—	—	—	—
HKWC	—	—	—	—	—	—	—
KCC	—	16	—	—	—	1	17
KEC	10	—	—	10	2	—	22
KWC	—	20	—	—	3	—	23
NTEC	50	—	4	—	—	—	54
NTWC	—	27	—	—	—	2	29
HA Overall	60	63	4	10	5	3	145

[^] The figures do not reflect the proposed additional 8 general beds in the KWC in the first quarter of 2025.

In 2016, the Government and the HA commenced the implementation of the First Hospital Development Plan (HDP). It consists of a total of 16 projects covering the redevelopment and expansion of 11 hospitals, the construction of a new acute hospital, 3 community health centres and 1 supporting services centre. Up till now, 15 projects under the First HDP have been upgraded to Category A. Approval for upgrading the remaining community health centre building projects to Category A will also be sought later. As at 31 December 2024, excluding the Kwong Wah Hospital redevelopment project (Phase 1 completed, Phase 2 in progress) of which the works are still in progress, 174 additional beds ^{Note (1)} have been provided by the other completed projects. Upon completion of the First HDP, it is anticipated that a total of about 2.2 million square metre of additional construction floor area, providing the space for provision of an addition of 6 557 bed spaces ^{Note (2)}, will be provided for the whole public healthcare system; and the total number of public hospital bed spaces under the HA will increase from about 30 000 in March 2022 to about 35 000 in 2031. As HA hospital clusters will deploy resources in accordance with their strategic plans and clinical service plans, as well as make use of the existing and additional space provided under the First HDP to adjust and enhance their services, it is not possible to set out whether the additional services, including the number of general beds, are directly related to the First HDP.

Note:

1. Including the additional beds provided in 2021-22 and 2022-23 (included in the table above).
2. The figures include the additional beds at Kai Tak New Acute Hospital, which are provided for the relocation of the services from Queen Elizabeth Hospital (QEH). Currently, QEH has around 1 940 acute and extended care beds and the reprovisioning of these beds will depend on the reallocation or redevelopment plan of its vacated buildings after its service relocation.

III.

The HA organises its services on the basis of clusters, and adopts an integrated and multi-disciplinary approach in service provision, so as to allow flexible deployment of staff to cope with service demands and operational requirements. As the healthcare professionals supporting in-patient services in the HA are also responsible for other services such as specialist out-patient services, the ratio of manpower for supporting in-patient services to the number of general beds cannot be separately quantified.

The tables below set out the number of general beds, full-time equivalent strength ^{Note (1)(2)(3)} of doctors and nurses under the HA by cluster in 2022-23, 2023-24 and 2024-25:

2022-23

Hospital cluster	Number of general beds, doctors and nurses [#]		
	General beds	Doctors	Nurses
HKEC	2 283	651	3 018
HKWC	2 797	666	2 899
KCC	5 353	1 383	6 184
KEC	2 844	796	3 562
KWC	3 753	1 110	5 038
NTEC	4 167	1 045	4 865
NTWC	3 060	881	3 992
Cluster Total	24 257	6 532	29 558

Figures as at 31 March 2023

2023-24

Hospital cluster	Number of general beds, doctors and nurses [#]		
	General beds	Doctors	Nurses
HKEC	2 309	683	3 031
HKWC	2 797	687	2 869
KCC	5 361	1 461	5 725
KEC	2 854	815	3 548
KWC	3 753	1 146	4 838
NTEC	4 183	1 072	4 744
NTWC	3 068	928	4 071
Cluster Total	24 325	6 792	28 826

Figures as at 31 March 2024

2024-25

Hospital cluster	Number of general beds, doctors and nurses [#]		
	General beds	Doctors	Nurses
HKEC	2 309	735	3 067
HKWC	2 797	749	2 924
KCC	5 378	1 522	5 970
KEC	2 876	857	3 599
KWC	3 776	1 190	4 994
NTEC	4 237	1 139	4 808
NTWC	3 097	977	4 138
Cluster Total	24 470	7 169	29 500

Figures as at 31 December 2024

The above bed information (including the number of beds for in-patients and day in-patients) refers only to the general beds in the HA. Infirmary, mentally ill and mentally handicapped beds constitutes about 20% of the total number of beds and are not included in the above bed information given their specific nature.

According to HA's classification, day in-patients refer to those who are admitted into hospitals for non-emergency treatment and discharged within the same day, while in-patients refer to those who are admitted into hospitals via the Accident & Emergency departments or those who have stayed for more than 1 day. Both in-patient and day-patient beds are included in the calculation of the number of beds.

Note:

1. The manpower figures above are calculated on full-time equivalent basis including permanent, contract and temporary staff in the HA. Individual figures may not add up to the total due to rounding.
2. The manpower figures of doctors above exclude those of Interns and Dental Officers.
3. The manpower figures of nurses include Senior Nursing Officers, Department Operations Managers, Nurse Consultants, Associate Nurse Consultants, Ward Managers, Nursing Officers, Advanced Practice Nurses, Registered Nurses, Enrolled Nurses, Nursing Trainees, etc.
4. Starting from January 2024, the full-time equivalent strength for temporary part-time staff is calculated based on their actual working hours. The figures before January 2024 are for reference only and cannot be directly compared with those under the current revised compilation method.

Abbreviations

HKEC – Hong Kong East Cluster

HKWC – Hong Kong West Cluster

KCC – Kowloon Central Cluster

KEC – Kowloon East Cluster

KWC – Kowloon West Cluster

NTEC – New Territories East Cluster
NTWC – New Territories West Cluster

- End –

CONTROLLING OFFICER'S REPLY

HHB279

(Question Serial No. 3414)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding fee waivers by the Hospital Authority (HA), please set out:

- I. the number of patients granted medical fee waivers for HA services in each of the past 5 years;
- II. the number of patients granted medical fee waivers for accident and emergency (A&E), specialist outpatient, general outpatient and inpatient services in each hospital cluster under the HA, the percentage of these patients in the total attendances for the respective services, the average number of attendances of these patients, and the average amount waived in each of the past 5 years; and
- III. the percentage of government subsidies in the attendance costs for HA's A&E, specialist outpatient, general outpatient and inpatient services in the past 5 years.

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 42)

Reply:

I.

The public healthcare services in Hong Kong are heavily subsidised by the Government with fees affordable to the general public. To ensure that no one will be denied adequate medical care due to lack of means, the Hospital Authority (HA) has put in place a medical fee waiver mechanism for in-patient and out-patient services to provide assistance to needy patients. The HA also provides subsidies, through the Samaritan Fund and Community Care Fund, to patients with financial difficulties who are in need of expensive self-financed drugs and medical devices.

Under the existing medical fee waiver mechanism of the HA, Comprehensive Social Security Assistance (CSSA) recipients, Old Age Living Allowance (OALA) recipients aged 75 or above (including those under the Guangdong Scheme and Fujian Scheme) and Level 0 Voucher Holders of the Residential Care Service Voucher (RCSV) Scheme for the Elderly are already waived from payment of medical fees.

As for other patients, including OALA recipients under the age of 75, Disability Allowance recipients and family members of Working Family Allowance recipients, if they are unable to afford medical fees due to financial difficulties, they may apply for medical fee waivers from the Medical Social Services Units of public hospitals and clinics, or the Integrated Family Service Centres or Family and Child Protective Services Units of the Social Welfare Department. When considering applications for fee waiver, Medical Social Workers (MSWs)/Social Workers (SWs) will take into account not only the economic situation of the patients' families but also the medical needs of individual patients as well as other non-financial factors to ensure that patients in need receive assistance.

Besides, the Government and the HA will press ahead with the implementation of the Public Healthcare Fees and Charges Reform (the Reform) announced at the end of March 2025, which aims to guide the public to make optimal use of healthcare resources through 3 aspects, namely reforming the subsidisation structure, reducing wastage and abuse, and enhancing healthcare protection. It also seeks to strengthen the healthcare protection on all fronts for patients who are "poor, acute, serious or critical". Such measures include relaxing the asset and income limits for the medical fee waiver mechanism and streamlining the related application procedures, with a view to ensuring that the limited healthcare resources can be directed in a more targeted manner to assist those patients most in need. This will thereby enhance the sustainability of the healthcare system and serve as a safety net for all.

The purpose of the medical fee waiver mechanism is to assist patients who are unable to pay for medical expenses due to genuine financial hardship or other difficulties. The number of applicants will depend on the usage of public healthcare services. Historical data and experience indicate that, apart from CSSA recipients and OALA recipients aged 75 or above, only a small portion of Eligible Persons who receive healthcare services require fee waivers.

The table below sets out the number of Eligible Persons ⁽¹⁾⁽²⁾ who were granted fee waivers in the past 5 financial years (including CSSA recipients, OALA recipients aged 75 or above and Level 0 Voucher Holders of the RCSV Scheme for the Elderly):

Financial Year	Number of Eligible Persons granted with medical fee waivers ⁽¹⁾						Number of Eligible Persons ⁽¹⁾ using HA's healthcare services (b)	Percentage of patients granted with medical fee waivers among all Eligible Persons ⁽¹⁾ using HA's healthcare services (a/b)
	CSSA recipients	OALA recipients aged 75 or above	Level 0 Voucher Holders of the RCSV Scheme for the Elderly	Medical fee waivers granted by MSWs/SWs	Other medical fee waivers	Total ⁽²⁾ (a)		
2020-21	255 500	217 000	500	16 800	129 100	598 400	2 757 900	21.7%
2021-22	254 700	227 700	600	15 700	59 100	543 500	2 851 600	19.1%
2022-23	241 500	256 700	700	14 200	820 100 ⁽³⁾	1 294 600 ⁽³⁾	2 800 500	46.2%
2023-24	241 200	281 900	1 000	14 000	33 000	557 100	3 023 500	18.4%
2024-25 (up to 31 December 2024)	224 700	290 500	1 100	12 800	22 400	541 200	not yet available	N.A.

Note:

- (1) According to the Gazette (G.N. 5708 issued on 27 September 2013), patients falling into the following categories are eligible for the rates of charges applicable to “Eligible Persons”:
 - i) holders of Hong Kong Identity Card issued under the Registration of Persons Ordinance (Chapter 177), except those who obtained their Hong Kong Identity Card by virtue of a previous permission to land or remain in Hong Kong granted to them and such permission has expired or ceased to be valid;
 - ii) children who are Hong Kong residents and under 11 years of age; or
 - iii) other persons approved by the Chief Executive of the HA.
- (2) Other medical fee waivers refer to those granted under special circumstances other than that for CSSA recipients, OALA recipients aged 75 or above, Level 0 Voucher Holders of the RCSV Scheme for the Elderly or medical fee waivers granted by MSW/SWs, such as medical fee waivers related to the combat of COVID-19.
- (3) During the same financial year, some patients received medical fee waivers as beneficiaries of different social welfare programmes. Therefore the sum of the beneficiaries from all medical fee waiver programmes does not equal the total number of patients granted with fee waivers in that year.
- (4) The figures include the number of patients granted with fee waivers for using out-patient clinic services arranged to cope with the peak of the COVID-19 epidemic, such as treating confirmed patients at designated clinics, and therefore should not be directly compared with other figures.

As a crucial component of the Reform, the HA will strengthen the healthcare protection on all fronts for patients who are “poor, acute, serious or critical”, which include enhancing the medical fee waiver mechanism by relaxing the income and asset limits for applications, thereby expanding the safety net to cover more patients in need and increasing assistance for the low-income group.

Regarding the underprivileged groups in the community with the least affordability, there are currently about 600 000 people eligible for full medical fee waivers, including about 270 000 CSSA recipients, about 330 000 OALA recipients aged 75 or above, about 4 000 beneficiaries of the RCSV Scheme for the Elderly (Level 0 Voucher Holders) and some additional 14 000 persons who are currently receiving full or partial fee waivers. They will continue to benefit and will not be affected by the Reform at all.

As for other patients, at present about 95% of patients in public hospitals pay less than \$2,500 on medical expenses throughout the year. Based on the current usage of services by HA patients, it is projected that after the implementation of the first phase of the Reform, about 80% of patients will still pay less than \$2,500 for in-patient and out-patient services throughout the year, while less than 10% of patients will pay more than \$4,500 per year. The above projections have not taken into account that under the enhanced medical fee waiver mechanism, patients with financial difficulties may apply for fee waivers and receive partial/full waivers according to the relevant criteria.

It is estimated that approximately 1.4 million persons will be eligible for fee waivers on top of the above 3 categories of persons eligible for full waivers under the enhanced medical fee waiver mechanism. At present, about 14 000 of the 300 000 eligible persons are granted with fee waivers upon application each year. On this basis, it is projected that among the

latest 1.4 million persons who are eligible, 66 000 non-CSSA/OALA recipients or Voucher Holders of the RCSV Scheme for the Elderly will apply for and be granted fee waivers.

Apart from relaxing the income and asset limits, the HA will also refine the definition of household under the means test. Currently, unmarried patients living with their families are required to submit information on their parents' income and assets for financial assessment. Upon the enhancement of the medical fee waiver mechanism, they only need to provide personal financial documents to apply for fee waivers. This measure not only shortens the processing time of fee waiver applications, but also reduces the documents that MSWs/SWs need to assess, thereby expediting the application process. In addition, the HA will expand the scope of coverage of all period waivers for individuals under the age of 65 to include episodic appointments in general out-patient clinics, and extend the maximum validity period of fee waivers from 12 months to 18 months, while streamlining the financial assessment process for reapplication within a maximum of 18 months. The HA will continue to communicate with stakeholders to implement the specific procedures for taking forward the above measures, with a view to streamlining the entire medical fee waiver application process, making it more convenient for the public and alleviating the workload of handling such applications.

II.

At present, a medical fee waiver granted after assessment is either be one-off or valid for a period of time. MSWs/SWs have the discretion to determine the validity period of fee waivers based on the actual needs and conditions of the patients, with the maximum validity period currently at 12 months. Patients do not need to make separate applications for fee waivers when using various medical services during the validity period. To facilitate patients with chronic diseases who frequently attend specialist out-patient (SOP) follow-up consultations, MSWs/SWs may grant in advance medical fee waivers for SOP services based on the conditions of individual patients. In addition, for the convenience of patients who have been granted medical fee waivers, the waiver certificates issued by MSWs/SWs are valid not only at public hospitals/clinics the patients are admitted to, attend or obtain the waiver certificates but also at public healthcare institutions providing the same services under the HA and the Department of Health, including inpatient services, out-patient services, and community health services.

The table below sets out the overall average numbers of times medical fee waivers were granted, and the average amounts waived, to all Eligible Persons⁽¹⁾⁽²⁾ who received medical fee waivers for using various medical services in all HA clusters in the past 5 financial years:

Year	Eligible Persons ⁽¹⁾⁽²⁾ who received medical fee waivers	
	Average number of times waivers were granted	Average amounts waived
2020-21	7	\$1,195
2021-22	7	\$1,324
2022-23 ⁽³⁾	4	\$574
2023-24	8	\$1,444
2024-25 (As at 31 December 2024)	7	\$1,137

Note:

- (1) According to the Gazette (G.N. 5708 issued on 27 September 2013), patients falling into the following categories are eligible for the rates of charges applicable to “Eligible Persons”:
 - i) holders of Hong Kong Identity Card issued under the Registration of Persons Ordinance (Chapter 177), except those who obtained their Hong Kong Identity Card by virtue of a previous permission to land or remain in Hong Kong granted to them and such permission has expired or ceased to be valid;
 - ii) children who are Hong Kong residents and under 11 years of age; or
 - iii) other persons approved by the Chief Executive of the HA.
- (2) The figures above include persons who are required to pay “inpatient charges for public wards” and “out-patient charges” under “Public Charges–Eligible Persons” in accordance with the List of Charges specified in the Government Gazette, as well as CSSA recipients, OALA recipients aged 75 or above (including recipients under the Guangdong Scheme and Fujian Scheme), and Level 0 Voucher Holders of the RCSV Scheme for the Elderly.
- (3) Due to medical fee waiver measures to combat COVID-19 (such as those for designated clinics), more persons were granted medical fee waivers in 2022-23, resulting in a decrease in the average number of waivers and the average amount waived.
- (4) In view of the COVID-19 epidemic in Hong Kong in early 2020, the HA adjusted its services in response to the epidemic. This should be taken into account when comparing the throughput of services provided by the HA across the years. With the cessation of anti-epidemic measures in early 2023, the HA’s services have gradually resumed normal.

The HA does not maintain separate statistics on the use of various medical services by patients granted medical fee waivers.

III.

The table below sets out the government subsidisation rates for the Accident & Emergency (A&E), specialist out-patient, general out-patient, and in-patient services of the HA from 2020-21 to 2023-24:

	2020-21	2021-22	2022-23	2023-24
A&E	93%	92%	93%	91%
Specialist outpatient clinics				
- First attendance	92%	92%	92%	92%
- Subsequent attendances	95%	95%	95%	95%
General outpatient clinics	92%	92%	93%	93%
Inpatient services				
- Acute general beds	99%	98%	99%	98%
Overall subsidisation rate ⁽¹⁾	98%	98%	98%	98%

Note:

- (1) Apart from the major public healthcare services listed in the table above, the overall subsidisation rate also covers other public healthcare services (such as day hospital services and community services).
- (2) Since the 2024-25 financial year has yet to close, information on government subsidisation rate for the year is not available at present.
- (3) In view of the COVID-19 epidemic in Hong Kong in early 2020, the HA adjusted its services in response to the epidemic. This should be taken into account when comparing the throughput of services provided by the HA across the years. With the cessation of anti-epidemic measures in early 2023, the HA's services have gradually resumed normal. As the costing information for 2019-20 to 2022-23 has reflected the impact of the epidemic outbreak on unit costs (if any), the costing information for different years may not be directly comparable.
- (4) The current public healthcare charges of the HA have been in effect since 18 June 2017.
- (5) The calculation of government subsidisation rates for the above services does not include medical fee waiver amounts.
- (6) The calculation of government subsidisation rates for the above services includes the costs of drugs prescribed to patients and the radiology services received. Therefore, the subsidisation rates above are not directly comparable to the government subsidisation rates after the implementation of the fees and charges reform.

The Government and the HA will press ahead with the implementation of the fees and charges reform for public healthcare announced recently in a gradual and orderly manner, with a view to enhancing the sustainability of the healthcare system so as to serve as a safety net for all through 3 aspects, namely reforming the subsidisation structure, reducing wastage and abuse, and enhancing healthcare protection. Under the fees and charges reform, the Government's commitment to the public healthcare system will not be lessened. All the gains from the reform will be wholly utilised for public healthcare services and the 90% overall public subsidisation rate will be maintained.

- End -

CONTROLLING OFFICER'S REPLY

HHB280

(Question Serial No. 3418)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

On strengthening centralised procurement of drugs and medical devices, please advise:

1. on the details about the numbers of medical devices procured by various clusters of the Hospital Authority (HA), the percentages of such devices from various places of origin as well as the relevant expenditures, broken down by place of manufacture, in the past 5 years; and
2. on the medical devices the HA plans to procure and the relevant expenditure in the next 3 financial years.

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 18)

Reply:

(1 & 2)

The Hospital Authority (HA) acquires and replaces a wide variety of medical equipment from time to time to tie in with its strategic directions and development needs.

The HA has formulated strategies for procuring medical equipment, including setting up 9 dedicated working groups to draw up standardised product specifications for selected equipment to facilitate centralised procurement and proactively identifying new sources of supply to introduce market competition. The aim is to introduce suitable and cost-effective medical technologies and products subject to quality and safety standards, so as to tie in with the strategic directions of the HA. Besides, the HA will enhance central co-ordination in procurement to achieve better cost-effectiveness and procurement efficiency, thereby further lowering costs while fulfilling the needs of clinical operations. In the past 5 years, the HA has procured nearly 180 000 medical equipment items mainly from the Mainland, the United States, the United Kingdom, Germany and Japan. Apart from introducing market competition and comparing cost effectiveness, the HA also takes into account diversification

of the place of origin in procurement so as to reduce the risk of bottlenecking in supply caused by heavy reliance on a single market.

Regarding the procedures for procuring medical equipment, minor medical equipment costing \$200,000 or less each are generally procured by individual hospital clusters and the HA does not maintain the relevant statistics. For the upgrade or acquisition of major medical equipment costing over \$200,000 each using designated funding from the Government, procurement is co-ordinated by the HA Head Office to enhance bargaining power and effectiveness. The table below sets out the quantity of major medical equipment procured by the HA in the past 5 years (2020-21 to 2024-25) and the expenditures involved.

	2020-21	2021-22	2022-23	2023-24	2024-25
Expenditures on major medical equipment (\$ billion)	1.2	1.2	1.2	1.2	1.2
Major medical equipment (Quantity)	1 049	919	1 034	1 095	1 431

The HA will continue to upgrade and acquire medical equipment with the designated funding, recurrent funding and other relevant funding provided by the Government each year.

- End -

CONTROLLING OFFICER'S REPLY

HHB281

(Question Serial No. 3421)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Health Bureau (HHB) will oversee the realignment of functions and responsibilities and transfer of services among the Hospital Authority (HA), the Department of Health (DH) and the Primary Healthcare Commission (PHCC). In this connection:

1. Please set out the strength and establishment of the PHCC (broken down by rank group), as well as its annual estimates of expenditure.
2. What is the latest progress of the HHB's efforts in reforming the functions and division of work among the HA, the DH and the PHCC?

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 39)

Reply:

1.

The Primary Healthcare Commission (PHCC) has an approximately 175-strong staff establishment for 2025-26, including healthcare professionals, and financial management, systems management, administration and supporting staff, and the actual strength as at 28 February 2025 was 134. The relevant estimated expenditure for 2025-26 is about \$220 million.

2.

As announced in the Chief Executive's 2024 Policy Address, to enhance the health of the people of Hong Kong, improve healthcare protection and quality, and capitalise on our healthcare professions' strengths, the Government is conducting a comprehensive review on the positioning and objectives of the healthcare system. The review covers the reform of the functions and division of work among the Hospital Authority (HA), the Department of Health (DH) and the PHCC, and among which a reform of the HA's governance efficiency, with a view to improving the standards and efficiency of its specialist and in-patient services is included. Meanwhile, the PHCC and the DH will enhance their work on health promotion

and disease prevention, continuing to shift the emphasis of the healthcare system from treatment-oriented to prevention-focused, so as to address the existing problem of system imbalance. The DH will also strengthen its role as the Government's public health adviser and the regulatory authority by focusing on its public health functions. To this end, the DH is gradually transferring its specialist clinical services and primary healthcare services to the HA and the PHCC respectively, including the following:

- (i) Transfer of the clinical genetic service to the HA was completed in early 2024;
- (ii) Woman health services will be integrated into the district health network, to be named as Women Wellness Satellites, of the PHCC under the Health Bureau within 2025, forming a network with District Health Centres / District Health Centre Expresses in all 18 districts across Hong Kong to provide eligible women with prevention-based and more personalised primary healthcare services. In addition, to further develop the multi-disciplinary primary healthcare service network, the PHCC plans to prepare for the integration of services of the Elderly Health Centres under the DH into the district health network in phases, starting from 2025-26, with a view to enhancing service synergy and minimising service duplication. Details of the transitional arrangements will be announced upon discussion with the DH; and
- (iii) In 2025-26, hospital dental services will be integrated into those under the HA and there is a plan to gradually transfer services such as child assessment service and tuberculosis and chest service to the HA.

- End -

CONTROLLING OFFICER'S REPLY

HHB282

(Question Serial No. 3314)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in the Matters Requiring Special Attention in 2025-26 that the Hospital Authority (HA) will augment the workforce by attracting and retaining staff through various measures. In this regard, will the Government inform this Committee of the details of the various measures and related expenditures in respect of attracting and retaining staff over the past 3 years, and whether the HA has reviewed the effectiveness of these measures? If so, what are the details? If not, what are the reasons?

Asked by: Hon CHAN Pui-leung (LegCo internal reference no.: 43)

Reply:

Over the years, the Hospital Authority (HA) has been closely monitoring its manpower situation and introduced a series of measures to attract, develop and retain talents. The HA has implemented ongoing measures within its overall budget including increasing the number of Resident Trainee posts to recruit local medical graduates, recruiting non-locally trained doctors to supplement local recruitment, improving promotion prospects to retain staff, hiring part-time healthcare staff (e.g. recruitment of locum staff), offering flexible full-time work arrangements, extending employment to suitable staff beyond retirement, enhancing the Home Loan Interest Subsidy Scheme, and providing better training opportunities for various grades through the establishment of the HA Academy. The above measures have begun to bear fruits, as evidenced by an increase in the number of the HA's healthcare staff in the past 2 years and a fall in attrition rate from the peak over the past 2 years.

In December 2019, the HA established the Task Group (TG) on Sustainability to review strategies including those for retaining staff. In line with the key directions recommended by the TG, the HA gradually rolled out further staff retention measures in 2023-24 and will continue with the relevant work in 2025-26, including:

- (1) increasing opportunities for Associate Consultants (AC) to be promoted to Consultant rank, with 400 AC posts upgraded to Consultant posts as at December 2024, so as to retain experienced medical personnel to address the service, manpower and training

needs in the HA;

- (2) providing Specialty Nurse Allowance to eligible registered nurses, with around 4 800 nurses receiving the allowance as at December 2024, so as to retain manpower and encourage professional development of nurses through recognising their specialty qualifications;
- (3) enhancing promotion opportunities of allied health professionals and offering Specialist Allied Health Professionals Allowance to eligible resident physiotherapists, occupational therapists and radiographers, so as to retain manpower and support specialist service needs and development, with about 66 applications received as at December 2024; and
- (4) continuing to implement the policy of Extending Employment Beyond Retirement to attract more retired staff who wish to stay after retirement. As at December 2024, there were 181 doctors, 565 nurses, 113 allied health professionals and 3 020 supporting/other grades staff working at the HA after retirement. Among all doctors/nurses/allied health professionals retiring from 2024-25 to 2028-29, at least 338 doctors, 880 nurses and 200 allied health professionals indicated interest/agreed to take up full-time or part-time employment after retirement.

The additional financial provision for the above items (1), (2) and (4) was around \$308 million and \$294 million in 2022-23 and 2023-24 respectively, while item (3) was introduced in 2024-25. The additional financial provision for the above 4 measures was around \$286 million in 2024-25.

The HA will continue to closely monitor the manpower situation and actively adopt measures to attract, develop and retain talents for supporting the overall service demand and development in the HA.

- End -

CONTROLLING OFFICER'S REPLY

HHB283

(Question Serial No. 3316)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in Matters Requiring Special Attention in 2025-26 that the Government will continue to implement the Voluntary Health Insurance Scheme (VHIS). Currently, insurance products for critical illnesses (such as cancer or rare diseases) that come with the features of “no age limit, having pre-existing condition coverage and available to all” are offered to patients by public health insurance institutions and secondary health insurance providers from the private sector in many countries and regions. These products provide patients who suffer from critical illnesses and have to pay high medical fees (for medication and non-medication treatments) with better protection, allowing them timely access to more advanced and effective treatments (such as gene therapy and targeted therapy). In this connection, will the Government inform this Committee of the following:

- (1) In the 2025-26 financial year, whether the authorities will allocate resources to study critical illness insurance and introduce relevant plans, and consider enhancing the current VHIS by incorporating critical illness insurance plans with the features of “no age limit, having pre-existing condition coverage and available to all” and establishing a risk pool for critical illnesses to attract and encourage Hong Kong citizens to purchase relevant plans. If so, what are the related work plans and estimated expenditure involved; if not, what are the reasons?
- (2) To enhance the overall take-up and renewal rates of the current VHIS and the possible critical illness insurance plans in the future, will the Government conduct a study in the 2025-26 financial year on the possibility of allowing citizens to pay premiums with part of their Mandatory Provident Fund contributions? If so, what are the work plan and estimated expenditure involved; if not, what are the reasons?

Asked by: Hon CHAN Pui-leung (LegCo internal reference no.: 45)

Reply:

- (1) The Voluntary Health Insurance Scheme (VHIS) has been fully implemented since April 2019, aiming to provide the general public with a choice of individual indemnity hospital insurance products which are subject to specific regulation and of high market

transparency. It offers consumers with greater confidence in purchasing health insurance and using private healthcare services when in need, thereby alleviating pressure on public healthcare system in the long run.

On protection for critical illnesses, Flexi Plans under the VHIS Certified Plans allow greater flexibility in product design by insurance companies to offer additional protection on top of the Standard Plan, such as higher benefit limits and broader benefit coverage to cater for the needs of different consumers. Besides, the Government has all along been providing a medical safety net for all Hong Kong citizens (including high-risk individuals) through public healthcare services, and will enhance protection for “poor, acute, serious, critical” patients on all fronts through the fees and charges reform for public healthcare, ensuring precise and targeted use of healthcare resources. As for the establishment of a risk pool for critical illnesses to provide premium subsidy for high-risk individuals, it involves a substantial amount of public resources and public consensus has not been reached. The Government shall make prudent use of public funds to meet the healthcare needs of high-risk individuals in the most cost-effective manner.

Since the full implementation of VHIS, the number of policies under the scheme has been increasing. That said, the period is relatively short and affected by the 3-year long COVID-19 epidemic. The Health Bureau will closely monitor the implementation of the VHIS and the market response, collect market data and listen to the views of various stakeholders. We will review the effectiveness of the VHIS and possible areas for refinement in due course, so as to respond to the latest trends in the healthcare market and dovetail with the various public health policies of the Government.

- (2) On the proposal of making premium payment with part of the Mandatory Provident Fund (MPF) contributions, any proposals allowing early withdrawal of accrued benefits from MPF system must take into consideration the corresponding reduction of scheme members’ accrued benefits meant for their retirement. MPF is a long-term investment with compounding effect. Its design is to allow MPF benefits to accumulate steadily and keep in the accounts for value growth during the working life of scheme members. Therefore, accrued benefits should be preserved in the system as far as possible and should only be withdrawn upon retirement of the employed persons.

At present, the MPF legislation only allows scheme members to make early withdrawal of accrued benefits before reaching the retirement age under certain exceptional circumstances. If the Government was to relax the preservation requirement on accrued benefits and allow scheme members to make early withdrawal to meet short-term financial needs or contingency, the accrued benefits would be leaked from the system from time to time and fail to accumulate for value growth, thereby undermining the integrity of the MPF system and rendering it difficult to achieve the purpose of assisting the working population in saving for their retirement. Based on the above considerations, the Government does not have plans to study the relevant proposal for the time being.

- End -

CONTROLLING OFFICER'S REPLY**HHB284****(Question Serial No. 3317)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (3) Subvention: Hospital AuthorityControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

As mentioned in the Matters Requiring Special Attention in 2025-26, the Health Bureau will continue to strengthen mental health services. In view of the community's growing concern about mental health in recent years, the Government put forth 10 enhanced measures in a bid to offer support to persons in mental recovery with a history of severe mental disorders and other persons with mental health needs in 2023. In this connection, will the Government inform this Committee of the following:

1. Please set out in the table below the manpower of case managers under the Case Management Programme, the number of patients with schizophrenia spectrum disorder, and the ratio between these 2 figures in the past 3 financial years. In addition, will the Government continue to set aside funding in future to optimise the manpower ratio of case managers on an ongoing basis?

Year	Manpower of case managers	Number of cases of severe mental disorders handled	Ratio
2022-23			
2023-24			
2024-25			
2025-26 (estimated)			

2. Regarding the Hospital Authority's (HA) (a) traditional oral drug; and (b) long-acting injections for severe mental disorders; and (c) new generation oral antischizophrenic drug, and (d) new generation antischizophrenic long-acting injections, please set out in the table below the following information: (i) the number of patients with schizophrenia spectrum disorder who were prescribed with such drugs or injections; and (ii) the expenditure in the past 3 financial years:

Financial year	Traditional antischizophrenic drug		New generation antischizophrenic drug	
	Number of patients prescribed with oral drug / expenditure	Number of patients prescribed with long-acting injections / expenditure	Number of patients prescribed with oral drug / expenditure	Number of patients prescribed with long-acting injections / expenditure
2022-23				
2023-24				
2024-25				

3. What were the expenditure on mental health services in the past 3 financial years and the estimated provision for such services earmarked for 2025-26?
4. The HA earmarked additional funding of \$127 million in the 2024-25 financial year to enhance mental health services, relevant measures include: (a) enhancing the community psychiatric services by further recruiting additional case managers; (b) strengthening nursing manpower as well as allied health and peer support for psychiatric inpatient and outpatient services; and (c) enhancing the use of long-acting injectable antipsychotics in the treatment of mental illness. Will the HA continue to set aside the funding in 2025-26; if yes, what are the details of the allocation; if not, the reasons for that?

Asked by: Hon CHAN Pui-leung (LegCo internal reference no.: 46)

Reply:

(1)

Since 2010-11, the Hospital Authority (HA) has launched the Case Management Programme (the Programme) by phases to provide intensive, continuous and personalised community support services for psychiatric patients. The Programme has been extended to all districts in Hong Kong since 2014-15. The case managers under the Programme will assess the needs, risks and clinical conditions of the patients and take appropriate follow-up actions, and maintain close liaison with community partners in providing support to psychiatric patients in the community.

Currently, the ratio of case managers to patients is about 1:38. The HA will regularly review the workload of each case manager as well as the progress and needs of the patients they support. The table below sets out the number of case managers and cases handled under the Programme from 2022-23 to 2024-25 (as of 31 December 2024).

Financial Year	Number of Case Managers	Number of Cases Handled
2022-23 (as of 31 March 2023)	430	18 108
2023-24 (as of 31 March 2024)	478	18 662
2024-25 (as of 31 December 2024)	484	18 155

(2)

The table below sets out the HA's drug consumption expenditure on prescribed anti-psychotic drugs in the past 3 years (i.e. 2022-23 to 2024-25).

	2022-23	2023-24	2024-25 (projection as of 31 December 2024)
drug consumption expenditure on prescribed new anti-psychotic drugs (\$ million)	365	404	443
drug consumption expenditure on prescribed traditional anti-psychotic drugs (\$ million)	42	42	37

The table below sets out the number of patients prescribed with oral anti-psychotic drugs and long-acting injections in the HA in the past 3 years (i.e. 2022-23 to 2024-25).

Financial year	Number of patients ^{1,2}			
	Prescribed with new generation oral anti- psychotic drugs	Prescribed with new generation anti-psychotic long-acting injections	Prescribed with traditional oral anti-psychotic drugs	Prescribed with traditional anti- psychotic long- acting injections
2022-23	107 300	4 600	28 300	8 500
2023-24	112 900	5 100	26 900	8 200
2024-25 (Projection as of 31 December 2024)	117 000	5 500	25 800	7 900

Note:

1. Figures are rounded to the nearest hundred.
2. The drugs prescribed may vary from time to time based on the clinical conditions and needs of patients. Some psychiatric patients may be prescribed with both oral and injectable psychiatric drugs concurrently.

(3)

The table below sets out the HA's expenditure on the provision of mental health services from 2022-23 to 2025-26.

Year	Expenditure on mental health services (\$ million)
2022-23	6,145
2023-24	6,585
2024-25 (revised estimate)	7,042
2025-26 (estimate)	7,321

Remark:

The expenditures on mental health services include direct staff costs (such as doctors, nurses and allied health staff) for providing services to patients; expenses incurred in providing various clinical support services (such as pharmacy); and other operating costs (such as meals for patients, utility expenses and repair and maintenance of medical equipment).

In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA adjusted its services to cope with the outbreak. This should be taken into consideration when comparing the service capacity of the HA in the respective years. With the subsiding of local COVID-19 epidemic situation and cessation of anti-epidemic measures in early 2023, the HA has been gradually resuming provision of all of its public healthcare services to tie in with the Government's normalcy measures. As the costing information for 2022-23 has reflected the impact (if any) of the epidemic outbreak on costs, the costing information across years may not be directly comparable.

(4)

The HA has earmarked an additional funding of around \$25 million in 2025-26 to enhance mental health services. Relevant measures include:

- (a) optimising the nursing manpower and allied health support for psychiatric inpatient and outpatient services;
- (b) enhancing mental health services for children and young people; and
- (c) strengthening the "Mental Health Direct" hotline service.

- End -

CONTROLLING OFFICER'S REPLY**HHB285****(Question Serial No. 3336)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (3) Subvention: Hospital AuthorityControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

It is mentioned in Matters Requiring Special Attention in 2025-26 that the Government will continue to strengthen mental health services. In this connection, please provide in the table below the number of psychiatric patients under the Hospital Authority in 2024.

	Aged 0-17	Aged 18-64	Aged 65 or above	Total
Schizophrenic spectrum disorder				
Depression				
Autism spectrum disorder				
Attention deficit/hyperactivity disorder				

Asked by: Hon CHAN Pui-leung (LegCo internal reference no.: 55)Reply:

The table below sets out the number of psychiatric patients receiving treatment in the Hospital Authority (HA) and diagnosed with schizophrenic spectrum disorder, depression, autism spectrum disorder or attention deficit/hyperactivity disorder by disease group and age group in 2024-25 (projection as of 31 December 2024).

		Age group ³			Total ⁴
		Aged 0-17	Aged 18-64	Aged 65 or above	
No. of psychiatric patients of the HA ^{1,2,5} (Projection as of 31 December 2024)		50 500	176 600	93 500	320 600
Disease group	Schizophrenic spectrum disorder ²	300	37 900	13 100	51 300
	Depression ²	2 100	46 500	22 900	71 600
	Autism spectrum disorder ²	18 900	6 900	<50	25 800
	Attention deficit/hyperactivity disorder ²	18 500	5 500	<50	24 000

Note:

1. Including inpatients, patients at specialist outpatient clinics and day hospitals.
2. Figures are rounded to the nearest hundred.
3. Delineated according to the age attained as of 30 June of the respective year.
4. Individual figures may not add up to the total due to rounding and the inclusion of patients of unknown age groups.
5. As the above table does not cover all types of disorder, the breakdown by type of disorder may not add up to the total number of psychiatric patients.

- End -

CONTROLLING OFFICER'S REPLY**HHB286****(Question Serial No. 3904)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: ()Controlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

The Government has implemented tax deduction arrangements for qualifying premiums paid under the Voluntary Health Insurance Scheme (VHIS) Policy since 2019. In this connection, would the Government inform this Committee of the following:

1. Please tabulate the numbers of persons benefitted from tax deduction and the amounts of tax deducted under the tax deduction arrangements mentioned above in each of the years since 2019.
2. Please tabulate the numbers of VHIS policies, as well as the amounts involved, in each of the years since 2019.
3. Has the Government evaluated the effectiveness of the relevant tax deduction arrangements? Have they achieved the expected results? What are the future targets?
4. Will the Government review and enhance the relevant tax deduction arrangements, including the proposal to increase the respective maximum deductible limits?

Asked by: Hon CHAN Pui-leung (LegCo internal reference no.: 4)Reply:

The Voluntary Health Insurance Scheme (VHIS) has been fully implemented since April 2019 as one of the healthcare reform initiatives of the Government. Taxpayer who or whose spouse is the policy holder of a VHIS Certified Plan may claim tax deduction up to \$8,000 per insured person for the premiums paid for the Certified Plan. The latest statistics are as follows:

Data on tax deduction (based on year of assessment)

	No. of taxpayers claimed tax deduction	No. of insured persons involved	Total amount of VHIS qualifying premiums allowed (HK\$ billion)
Year of assessment 2019-20	155 000	198 000	1.019
Year of assessment 2020-21	247 000	318 000	1.693
Year of assessment 2021-22	329 000	426 000	2.355

Year of assessment 2022-23	404 000	525 000	2.987
Year of assessment 2023-24 (preliminary figures)	456 000	593 000	3.480

Number of policies of VHIS Certified Plans (based on financial year)

	No. of policies
As at 31 March 2020	522 000
As at 31 March 2021	791 000
As at 31 March 2022	1 045 000
As at 31 March 2023	1 220 000
As at 31 March 2024	1 341 000

Total gross premiums of VHIS Certified Plans (based on calendar year)

	Total gross premiums (HK\$ billion)
2019 (April to December)	2.2
2020	4.7
2021	6.6
2022	8.2
2023	9.7

According to the information provided by the Inland Revenue Department, more than 70% of the insured persons benefitted from the VHIS tax deduction in the past years of assessment had their VHIS qualifying premiums claimed fully deductible. We believe that the current ceiling of tax deduction at \$8,000 is appropriate and will review the ceiling from time to time.

- End -

CONTROLLING OFFICER'S REPLY

HHB287

(Question Serial No. 4008)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

According to the figures provided in the Hospital Authority (HA) Annual Report, the total expenditure of the HA has increased by 31% over the past 5 years, with staff cost accounting for nearly 70% of the annual expenditure. The HA's total manpower has grown by 7.4% over the past 5 years, with the relevant cost rising by 28%. Is the Government aware of the reasons for the imbalance between the manpower growth and the increase in expenditure and the relevant cost? Will measures be taken to enhance the cost-effectiveness of the HA so as to ensure the optimisation of resources?

Asked by: Hon CHAN Wing-yan, JoePHY (LegCo internal reference no.: 23)

Reply:

The total manpower (number of staff on full-time equivalent basis) of the Hospital Authority (HA) increased from 84 501 in 2019-20 to 90 785 in 2023-24, representing a growth rate of 7.4%. Over the same period, the staff cost increased by 16% from HK\$53.7 billion to HK\$62.4 billion. Apart from the manpower growth due to rising demand for public healthcare services, the remaining increase in staff cost is mainly due to annual pay adjustment, pay point increment, as well as measures on attracting and retaining talents to ensure that the HA has stable manpower to cope with ad-hoc surges of demand pressure from time to time.

With an ageing population and the increasing prevalence of chronic diseases, the public healthcare system is facing increasing pressure. To further enhance the efficiency of public healthcare services, the HA Board set up the Task Group on Sustainability in 2019 to identify the major challenges faced by the HA and to develop relevant strategic directions in areas such as human resources, infrastructure, smart technology and operational efficiency, with a view to driving the sustainable development of the public healthcare system.

The HA has implemented corresponding measures to optimise use of resources and enhance efficiency. These include optimising the existing drug dispensing mechanism in public hospitals and adjusting the prescribing quantity of drugs as necessary to reduce wastage due to excessive drug prescription; expanding sources of drug supply, streamlining the workflow

for introducing new drugs and optimising the procurement procedures for medical equipment to control costs effectively; formulating infrastructure and digital technology solutions, integrating IT systems and data, leveraging technologies such as big data analysis and artificial intelligence to support hospitals on administrative operations and clinical management, thereby enhancing the quality and efficiency of healthcare services; and creating a green and sustainable healthcare system through hospital development and redevelopment projects as well as implementing various energy saving measures in hospitals to reduce energy consumption.

- End -

CONTROLLING OFFICER'S REPLY

HHB288

(Question Serial No. 3916)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

With regard to tobacco control policies, please advise this Committee of:

- 1) whether more support such as offering smoking cessation counselling or funding resources will be put in place by the Government to help smokers reduce or quit smoking; and
- 2) whether increasing the tobacco duty is a part of long-term health policy and whether any comparable measures will be implemented in the future.

Asked by: Hon HO Kwan-yiu, Junius (LegCo internal reference no.: 31)

Reply:

1)

The Government's tobacco control policy seeks to safeguard public health by discouraging smoking, containing the proliferation of tobacco use and minimising the impact of passive smoking on the public. To this end, the Government adopts a progressive and multi-pronged approach comprising legislation, enforcement, publicity, education, smoking cessation services and taxation.

Over the years, the Government has been actively promoting a tobacco-free environment through publicity for smoking prevention and cessation services. To leverage community effort, the Department of Health (DH) collaborates with the Hong Kong Council on Smoking and Health (COSH), non-governmental organisations (NGOs) and healthcare professionals to promote smoking cessation, provide smoking cessation services and organise publicity programmes on smoking prevention.

The DH operates an integrated Smoking Cessation Hotline (Quitline: 1833 183) to handle general enquiries and provide professional counselling on smoking cessation, and

co-ordinates the provision of smoking cessation services in Hong Kong. The DH also arranges referrals to various smoking cessation services in the territory, including those provided by public clinics under the Hospital Authority (HA) (helping patients, especially those with chronic disease, to quit smoking), and community-based cessation programmes operated by NGOs. There are a total of 15 full-time and 55 part-time centres operated by the HA which have been providing smoking cessation services to the general public since 2002, and there are 5 smoking cessation clinics for civil servants operated by the DH. Furthermore, the DH also collaborates with NGOs to provide a range of community-based smoking cessation services including counselling, consultations by doctors (including free postal delivery of smoking cessation drugs) or Chinese medicine practitioners, and designated services for smokers from different ethnicities, immigrant smokers and workplace smokers. For young smokers, the DH collaborates with local universities to operate a hotline to provide them with dedicated counselling service over the phone. Besides, the DH has subvented 2 more service providers (from 2 to 4 in total) since 2023 to operate smoking cessation clinics with a focus on counselling and pharmacotherapy, and 3 more Chinese medicine smoking cessation service providers (from 1 to 4 in total) starting from this year to operate smoking cessation clinics with an emphasis on counselling and acupuncture. It is expected that the number of service users of the former type of clinic will increased by about 40% and the number regarding the latter type will double.

The DH subvents the COSH to organise publicity and education programmes in schools, such as health talks, training programmes and theatre programmes, to raise students' awareness of smoking hazards, including hazards from alternative smoking products. To prevent youngsters from picking up smoking, the DH collaborates with NGOs to organise health promotional activities at schools. By using interactive teaching materials and setting up mobile classrooms, the programmes enlighten students in respect of the tactics used by the tobacco industry to market tobacco products, and equip them with the skills to resist picking up smoking due to peer pressure. The DH has also launched publicity campaigns through mass media to spread the message that smoking bring risks of serious illness. To encourage smokers to try quitting, it distributes free trial packs of smoking cessation drugs (nicotine replacement therapy) for 1 week at community pharmacies, smoking cessation clinics, District Health Centres (DHCs) and District Health Centre Expresses (DHC Expresses) during the Quit in June annual campaign starting from 2023. During the Quit in June campaign in 2024, the DH implemented the Chinese Medicine Ear Points Patches for Smoking Cessation Trial Programme at designated Chinese medicine smoking cessation clinics. To encourage and help all healthcare professionals to provide support and treatment for smokers who are quitting, the DH organises online and face to face training courses, compiles the Practical Handbook for Smoking Cessation Treatments and a clinical guide on smoking cessation with Chinese medicine and acupuncture, and provides related resources, among other initiatives.

Smoking cessation services and counselling for smokers are currently available at all DHCs and DHC Expresses in the 18 districts, which collaborate with smoking cessation service

providers in their respective districts to provide information or arrange referrals for smokers in need.

Smokers who receive smoking cessation treatment receive 52-week follow-up services to assess their quit status. For smokers who receive smoking cessation services via quitlines, at cessation clinics under the HA and through community-based programmes operated by NGOs, their 52-week quit rates, which refer to the percentage of service users self-reporting to have stayed quit in the past 7 days, range from 20% to 60%, which are comparable to those in overseas countries. Discrepancies in the quit rates concerning different smoking cessation programmes are due to differences in terms of their target groups and treatment methods (which include counselling, pharmacotherapy, and Chinese medicine with acupuncture). To become a successful quitter, smokers are encouraged to choose the cessation service that best caters for their personal needs.

The Government will continue to step up its work on smoking cessation and explore various tobacco control measures in the medium and long term in order to eliminate the social hazards posed by tobacco products in all aspects and safeguard the health of the community with a progressive and multi-pronged approach.

2)

Increasing tobacco duty is recognised internationally as the most effective means of reducing tobacco use. Through raising the costs of smoking, it provides a greater incentive for smokers to quit smoking, and dampens the eagerness of non-smokers, the youth in particular, to smoke. Past experience in increasing tobacco duty indicated that increasing tobacco duty is conducive to reducing smoking prevalence. The greater the tax hike, the greater the drop in smoking prevalence. The number of calls to the DH's Quitline immediately after the increase in tobacco duty is also a sensitive indicator of smokers' response (i.e. their intention to quit smoking) to the duty increase. In the first month after the duty increase was announced in the 2023-24 and 2024-25 Budget, the number of calls to the Quitline increased by about 3 times respectively when compared to the monthly number of calls received in the previous 3 months, reflecting the strong intention of smokers to quit smoking as a result of the duty increase. The number of calls received by the DH's Quitline increased from about 7 400 in 2022 to about 9 300 in 2024, representing an increase of more than 20%.

After the Government increased the tobacco duty in 2023, the result of the Thematic Household Survey (THS) on smoking pattern conducted by the Census and Statistics Department from May to August that year revealed that smoking prevalence dropped from 10.2% in 2019 and 9.5% in 2021 to 9.1% in 2023. The number of cigarettes consumed by smokers per day also dropped from 12.7 sticks in 2019 and 2021 to 12.1 sticks in 2023. The Government further increased tobacco duty in 2024. In this connection, a THS will be conducted later and it is expected that the reduction in the demand for tobacco products will be reflected in the survey.

The Health Bureau (HHB) introduced in June 2024 new tobacco control strategies, outlining the short, medium and long-term measures to further reduce smoking prevalence incrementally through various measures, with a view to minimising the harmful effects of tobacco products on the society and safeguarding public health through a multi-pronged approach. These measures are formulated around 4 directions under the tobacco control strategies, namely, reducing the demand for and supply of tobacco products, minimising the attractiveness of tobacco products, protecting the public from the hazard of second-hand smoke and strengthening the provision of smoking cessation services, aiming to take forward the tobacco control process incrementally. The HHB plans to introduce the proposed legislative amendment for the next phase of tobacco control measures to the Legislative Council for scrutiny by the end of this month.

- End -

CONTROLLING OFFICER'S REPLY

HHB289

(Question Serial No. 3834)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: Not Specified

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in paragraph 234(c) of the Budget Speech that the Financial Secretary has requested the relevant bureaux to review the expenditures on social welfare, healthcare and education. The recurrent expenditure on each of these 3 areas amounts to more than \$100 billion in this financial year. Regarding healthcare,

- (1) please provide in table form the total expenditures on each area of healthcare and their proportions of the overall healthcare expenditure over the past 5 years (from 2020-21 to 2024-25); and
- (2) according to paragraph 231(a) of the Budget Speech, a 2% reduction in recurrent government expenditure is required in 2025-26. However, according to the Supplement and Section II Recurrent Government Expenditure by Policy Area Group of Appendix B to the Budget, the 2025-26 Estimate for health is approximately \$115.3 billion, representing a 4.3% increase in real terms over the 2024-25 revised estimate. What are the reasons for the increase?

Asked by: Hon KAN Wai-mun, Carmen (LegCo internal reference no.: 53)

Reply:

(1)

The recurrent expenditure on Policy Area Group (PAG): Health covers a wide range of recurrent expenditure items. Details can be found in the Programmes relevant to Policy Area 15: Health in the Controlling Officer's Report of the respective Heads (including Heads 140, 37, 48 and 155). The table below sets out the breakdown of the total estimated recurrent expenditure of the 4 health-related Heads of Expenditure:

Heads of Expenditure	2020-21	2021-22	2022-23	2023-24	2024-25
	Actual expenditure				Revised estimate
	(\$ m)				
Head 140 – Government Secretariat: Health Bureau	78,042.0	84,288.1	111,251.2	93,493.5	98,458.4
Head 37 – Department of Health	9,486.4	13,968.9	15,677.5	10,347.4	10,665.8
Head 48 – Government Laboratory	65.6	66.9	68.1	73.3	83.2
Head 155 – Government Secretariat: Innovation and Technology Commission	4.2	4.9	4.9	3.6	4.1
Total (Note)	87,598.2	98,328.7	127,001.7	103,917.9	109,211.4
Note: The above includes the recurrent expenditure on health to cope with the COVID-19 epidemic since 2020. The breakdown may not add up to the total due to rounding.					

(2)

In 2025-26, the estimated recurrent expenditure of the Programmes relating to Policy Area 15: Health under PAG: Health is \$115.3 billion.

Under the reduced recurrent expenditure of the Programmes relating to PAG: Health, the Government has continued to increase the recurrent funding for the Hospital Authority (HA) according to the projected service demand, based on the triennium funding arrangement in 2017. The recurrent provision for HA in 2025-26 is \$99 billion, representing an increase of 3.7% over the 2024-25 revised estimate. Details of the expenditures related to other major initiatives of the Health Bureau (HHB) and the Department of Health under the PAG: Health can be found in Appendix 2 of the Budget Media Sheets (https://www.budget.gov.hk/2025/eng/pdf/2025-26_Media_Sheet.pdf).

The HHB will continue to review the healthcare-related expenditures to ensure more accurate and efficient use of resources, amongst which, in March 2025, the Government implemented the fees and charges reform for public healthcare which aims to guide the public to make optimal use of healthcare resources, reduce wastage and abuse, and enhance healthcare protection for “poor, acute, serious, critical” patients on all fronts, thereby enhancing the sustainability of the healthcare system as well as on the financial aspects.

- End -

CONTROLLING OFFICER'S REPLY

HHB290

(Question Serial No. 3348)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): (000) Operational expenses

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It was mentioned in Programme (2) that financial provision to the Government sector would amount to \$4.0853 billion in 2025-26, a 26.6% increase on 2024-25. In this connection, please advise this Committee of:

- 1) the details of implementation of the “Outreach Dental Care Programme for the Elderly” and the “Healthy Teeth Collaboration” programme in the 18 districts across Hong Kong; and
- 2) the numbers of beneficiaries of and expenditure involved under the 2 Programmes over the past 3 years.

Asked by: Hon KWOK Ling-lai, Lillian (LegCo internal reference no.: 51)

Reply:

To safeguard the oral health of the public, the Chief Executive announced in the 2022 Policy Address to conduct a comprehensive review of the dental services provided or subsidised by the Government. The Working Group on Oral Health and Dental Care (Working Group) was subsequently established in end-2022. The Working Group published a final report in end-2024, recommending that the future development of dental services should make reference to the direction of the Primary Healthcare Blueprint emphasising prevention, early identification and timely intervention, with the goal of retention of natural teeth and enhancing the overall level of citizens' oral health.

The Government concurs with the views of the Working Group that providing or subsidising comprehensive curative dental services from public purse to all Hong Kong citizens regardless of their financial means does not align with the policy objectives of developing a prevention-oriented oral health and dental care system and encouraging citizens to take responsibility for their own oral health. This would exacerbate the current shortcomings of the treatment-oriented system, and would be neither cost-effective nor sustainable in terms of utilisation of public resources. It would be financially untenable for the Government and would thin out the resources that could otherwise be used for other healthcare services.

In response to the final report of the Working Group, the Government has adopted the oral health policy that: (1) Oral health is an integral component of general health. The Government's oral health policy aims to enable all Hong Kong citizens to improve their oral hygiene and lifestyle conducive to both oral and overall health levels; (2) Through publicity, education, promotion and development of primary oral health and dental care, the Government facilitates citizens to manage their oral health, and put prevention, early identification and timely intervention of dental diseases into action with the objective of tooth retention; and (3) The Government provides appropriate oral health and dental care services targeting underprivileged groups with financial difficulties and special needs, ensuring these groups have access to essential dental care services.

In the Oral Health Action Plan formulated based on the Working Group's strategic recommendations, the Outreach Dental Care Programme for the Elderly (ODCP) and the Healthy Teeth Collaboration (HTC) programme are services focusing on underprivileged groups who have difficulties in accessing dental care under the aforesaid strategy of ensuring these groups have access to essential dental care services.

1 and 2:

Below are the implementation details, number of attendances and expenditures for the ODCP and the HTC provided by the Department of Health through non-governmental organisations (NGOs).

The ODCP

The ODCP has been implemented since October 2014 to provide free on-site oral check-up for elderly persons and oral care training to caregivers of residential care homes (RCHEs), day care centres (DEs) and similar facilities in the 18 districts of Hong Kong through outreach dental teams set up by NGOs. The timing for provision of the service is arranged between the NGOs and RCHEs/DEs; basically, elderly persons in RCHEs/DEs participating in the ODCP receive the service once a year. Free dental treatments will be provided on-site or at a dental clinic if the elderly person is considered suitable for further curative treatments. The outreach dental teams will also design personalised oral care plans for elderly persons to suit their oral care needs and self-care abilities. A total of 25 outreach dental teams from 11 NGOs have currently been set up under the ODCP. Each outreach dental team comprises at least 1 dentist and 1 dental surgery assistant.

Since implementation of the ODCP in October 2014 and up to end-January 2025, the number of attendances was about 428 000.

As at January 2025, around 80% of the RCHEs/DEs have participated in the ODCP. The distribution of outreach dental teams and the respective NGOs by administrative district of the Social Welfare Department (SWD) is at **Annex**.

The Government's actual expenditures in respect of implementing the ODCP in 2022-23 and 2023-24 and its revised estimate in 2024-25, as well as the number of RCHEs/DEs participating in the ODCP and the number of attendances under the ODCP in 2022-23, 2023-24 and 2024-25 (up to January 2025) are set out below:

Year	2022-23	2023-24	2024-25 (up to January 2025)
Annual Expenditure (\$ million)	48.6 (Actual)	55.8 (Actual)	63.7 (Revised Estimate)
Number of RCHEs/DEs Participating in the ODCP	706	830	823
Number of Attendances	39 146	47 931	45 334

The HTC programme

The Government has implemented the HTC since July 2018, which provides, through NGOs, free dental services including oral check-ups, dental treatments and oral health education for adults aged 18 or above with intellectual disability. The HTC was further extended from 16 July 2024 to March 2027 with 900 additional quotas for new cases every year and its scope extended to cover persons aged 18 or above with autism spectrum disorder (ASD). There are currently 8 participating NGOs, each with at least 1 dentist and 1 dental surgery assistant. Among them, 2 are located on Hong Kong Island, 5 in Kowloon and the remaining 1 in the New Territories.

The number of attendances in the past 3 service years is set out as follows:

Service Year ^{Note 1}	2022-23	2023-24	2024-25 ^{Note 2} (up to January 2025)
Number of Attendances	6 121	6 902	5 778

Note 1: A service year refers to the period from 16 July of the current year to 15 July of the following year.

Note 2: The service year of 2024-25 runs from 16 July 2024 to 31 March 2025. Starting from 16 July 2024, the HTC programme has been extended to include patients with ASD.

The Government's actual expenditures for implementing the HTC programme in 2022-23 and 2023-24, along with the revised estimate for 2024-25 are set out as follows:

HTC Programme	2022-23 (Actual)	2023-24 (Actual)	2024-25 (Revised Estimate)
Annual Expenditure (\$ million)	22.8	33.4	46.4

**The Distribution of Outreach Dental Teams and
the Respective NGOs under the ODCP
by Administrative District of the SWD**

SWD's Administrative District	Name of NGO	No. of Outreach Dental Teams*
Central, Western, Southern and Islands	Caritas Dental Clinics	1
	Hong Kong Tuberculosis, Chest and Heart Diseases Association	1
	Project Concern Hong Kong	1
	Tung Wah Group of Hospitals	1
Eastern and Wan Chai	Chi Lin Nunnery	1
	Hong Kong Tuberculosis, Chest and Heart Diseases Association	1
	Tung Wah Group of Hospitals	1
	Yan Chai Hospital	1
	Tak Shun Dental Clinic	1
Kwun Tong	Christian Family Service Centre	1
	Chi Lin Nunnery	1
	Haven of Hope Christian Service	1
	Tak Shun Dental Clinic	1
	Yan Oi Tong	1
Wong Tai Sin and Sai Kung	Christian Family Service Centre	1
	Chi Lin Nunnery	1
	Haven of Hope Christian Service	1
	Pok Oi Hospital	1
	Tak Shun Dental Clinic	1
	Yan Oi Tong	1
Kowloon City and Yau Tsim Mong	Christian Family Service Centre	1
	Chi Lin Nunnery	1
	Project Concern Hong Kong	1
	Pok Oi Hospital	1
	Tung Wah Group of Hospitals	1
	Tak Shun Dental Clinic	1
	Yan Oi Tong	2
Sham Shui Po	Caritas Dental Clinics	1
	Chi Lin Nunnery	1
	Christian Family Service Centre	1
	Project Concern Hong Kong	1
	Pok Oi Hospital	1
	Tung Wah Group of Hospitals	1
	Tak Shun Dental Clinic	1
	Yan Oi Tong	1
Tsuen Wan and Kwai Tsing	Caritas Dental Clinics	1
	Chi Lin Nunnery	1
	Pok Oi Hospital	1
	Tak Shun Dental Clinic	1

SWD's Administrative District	Name of NGO	No. of Outreach Dental Teams*
	Yan Chai Hospital	1
	Yan Oi Tong	1
Tuen Mun	Caritas Dental Clinics	1
	Chi Lin Nunnery	1
	Pok Oi Hospital	1
	Yan Chai Hospital	1
	Yan Oi Tong	1
Yuen Long	Caritas Dental Clinics	1
	Pok Oi Hospital	1
	Yan Oi Tong	1
Sha Tin	Caritas Dental Clinics	1
	Chi Lin Nunnery	1
	Pok Oi Hospital	1
	Yan Chai Hospital	1
	Yan Oi Tong	1
Tai Po and North	Caritas Dental Clinics	1
	Chi Lin Nunnery	1
	Tung Wah Group of Hospitals	1
	Yan Chai Hospital	1
	Yan Oi Tong	2

* Note: Some outreach dental teams under the ODCP have been assigned to serve more than 1 administrative district.

- End -

CONTROLLING OFFICER'S REPLY

HHB291

(Question Serial No. 3337)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Low back pain is a prevalent condition with diverse pathological causes including degeneration, tumors, soft tissue inflammation, pancreatic diseases, and retroperitoneal pathologies such as abdominal aortic disease. There are numerous so-called “pain relief centres” providing non-healthcare services, which pose a significant risk of delaying patrons from seeking appropriate treatment for serious illnesses. In this connection, will the Government inform this Committee of the following:

- 1) how the existing laws regulate those so-called pain relief centres providing non-healthcare services;
- 2) whether there are plans to eradicate shops claiming to provide non-healthcare service for pain relief;
- 3) whether there are plans to introduce medical guidelines for common pain conditions, aiming to standardise treatment approaches among related professionals including family doctors, Chinese medicine practitioners, physiotherapists, occupational therapists and chiropractors, etc., and to enable the public to make informed choices; If yes, the details, if no, the reasons.

Asked by: Hon LAM Tzit-yuen, David (LegCo internal reference no.: 44)

Reply:

(1)&(2) Premises providing pain relief services in the community can be classified into 3 categories:

- (1) involving healthcare services which should be provided by registered medical practitioners and/or dentists, e.g. prescription of painkillers or performance of surgical procedures, etc.;
- (2) involving healthcare services which should be provided by healthcare professions of other different disciplines; and
- (3) not providing healthcare services, e.g. conducting only massage which do not concern the practice of healthcare professionals.

As the premises under the aforementioned categories 1 and 2 provide healthcare services, they are regulated by relevant legislation on healthcare facilities and healthcare professions.

For premises under category 1, the Private Healthcare Facilities Ordinance (PHFO) (Cap. 633) has been regulating premises where registered medical practitioners and/or dentists practise since 2018. Operators are required to obtain a licence or letter of exemption in order to operate private healthcare facilities (PHFs). The Government has been implementing the regulatory regime under the PHFO in phases based on the types of PHFs and their risk levels. Licences for hospitals and day procedure centres with the relevant penalty provisions have taken effect respectively. The Government is now actively taking forward the regulatory work on clinics and expects to implement the relevant legal provisions, with a view to accepting applications from the sector this year.

Premises under category 2 involve healthcare services which are provided by healthcare professions of other multiple disciplines. Depending on the actual services performed, relevant ordinances (e.g. the Chinese Medicine Ordinance (Cap. 549), the Supplementary Medical Professions Ordinance (Cap. 359), the Chiropractors Registration Ordinance (Cap. 428), etc.) would come into play when healthcare services which must be provided by registered healthcare professionals are involved. This serves to prevent non-professionals from performing such acts so as to safeguard public health.

To prevent the public from seeking improper treatment of certain conditions regardless of the type of premises (i.e. premises under category 1, 2 and 3) which provides such services, the Undesirable Medical Advertisements Ordinance (Cap. 231) prohibits/restricts the publication of advertisements that will likely lead to the use of any medicine, surgical appliance or treatment for the purpose of treating or preventing diseases or conditions specified in Schedules 1 and 2 to the Ordinance. These include any disease of the musculo-skeletal system, including rheumatism, arthritis and sciatica. The Department of Health has put in place an established mechanism for screening advertisements. Appropriate actions will be taken in accordance with the law against any contravention of the Ordinance.

Through public education, the Government will continue to urge members of the public to carefully verify whether services claimed to be health or treatment-related are provided by regulated healthcare professionals and organisations when using such services, and to exercise caution in assessing the risks involved before using such services and seek professional advice where necessary.

(3) The Primary Healthcare Commission (PHCC) formulated the “Hong Kong Reference Framework for Common Musculoskeletal Problems in Primary Care Settings” in December 2022, which provides an in-depth elaboration on important issues relating to the preventive care and management of diseases such as low back pain and osteoarthritis of knee, and serves as a practical reference for primary healthcare professionals. The PHCC will continue to prioritise the development of new Reference Frameworks having regard to the comments from the Expert Panel and international development. Meanwhile, the Government will further explore strengthening the role of Chinese medicine (CM) in primary care, for example, to explore enhancing the role of CM practitioners in providing services for chronic disease management and diseases in which CM has an advantage through strategic purchasing.

- End -

CONTROLLING OFFICER'S REPLY

HHB292

(Question Serial No. 3432)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Apart from enrolling in the Chronic Disease Co-Care Pilot Scheme at District Health Centres (DHCs), eligible Hong Kong residents may also enrol directly at some participating clinics. Will the Government inform this Committee of:

1. the number of members of the public having successfully participated in the Scheme since its implementation, and the respective numbers of those having enrolled at DHCs and participating clinics;
2. the number of clinics currently participating in the Scheme and the number of those open for direct enrolment of the public;
3. the numbers of members of the public having enrolled at DHCs since the implementation of the Scheme (by district);
4. the number of participants who have completed the screening and been diagnosed with prediabetes, diabetes mellitus or hypertension, requiring referral letters for immediate hospital consultation and follow-up?

Asked by: Hon LEUNG Hei, Edward (LegCo internal reference no.: 19)

Reply:

(1) to (4)

The Government has launched the Chronic Disease Co-Care Pilot Scheme (CDCC Pilot Scheme) since 13 November 2023, which is the first major initiative under the Primary Healthcare Blueprint. The Scheme provides subsidised diabetes mellitus (DM) and hypertension (HT) screening services in the private healthcare sector to Hong Kong residents aged 45 or above with no known medical history of DM or HT, with a view to encouraging citizens to gain a better understanding of their own health status as early as possible through screening, so as to achieve the goals of “early prevention, early identification and early treatment”. The Government aims to establish a family doctor regime and position District Health Centres (DHCs) and DHC Expresses (DHCEs) as hubs to foster expansion of the community healthcare network, so as to properly manage chronic diseases in the community through a multi-disciplinary approach, thereby alleviating the pressure on secondary and

tertiary healthcare services, in particular the Specialist Out-patient Clinics (SOPCs) of the Hospital Authority (HA).

Members of the public can enrol in the CDCC Pilot Scheme at DHCs/DHCEs. DHCs/DHCEs also actively encourage public participation through various channels, such as promotion activities and recruitment booths. In addition, people can make appointments on the website of the CDCC Pilot Scheme and DHCs/DHCEs will then contact them for the relevant procedures. To further promote the concept of “Family Doctor for All” and encourage citizens to maintain a long-term doctor-patient relationship with their family doctors, starting from 25 March 2024, citizens may also choose to enrol in the CDCC Pilot Scheme at a number of participating clinics directly and pair with a family doctor at the clinic for screenings. As at 27 March 2025, over 600 family doctors have participated in the CDCC Pilot Scheme, covering 827 service points, of which 187 family doctors can directly register citizens for the CDCC Pilot Scheme at their clinics (223 service points).

The Government expects that 200 000 people will participate in the CDCC Pilot Scheme within the three-year pilot period. The Scheme has been well received since its launch. As at 27 March 2025 [provisional figures], about 114 200 citizens have joined the Scheme, of which around 105 400 enrolled in the Scheme at DHCs/DHCEs while around 8 800 chose to enrol directly at the clinics participating in the CDCC Pilot Scheme. Around 65 000 participants (i.e. nearly 60%) have completed the screenings for DM and HT, and around 25 230 of them (i.e. nearly 40%) have been diagnosed with prediabetes ^{Note 1}, DM or HT. The latter patients can proceed to the treatment phase and will be subsidised by the Government to continue their treatment with self-selected family doctors, and subject to their health conditions, be prescribed medication, or referred to follow-up care at nurse clinics and allied health services. In addition, the Government has established a bi-directional referral mechanism with the HA under CDCC Pilot Scheme. Family doctors can refer participants with clinical needs to receive a one-off specialist consultation at a designated SOPCs of the HA according to clinical diagnosis and pre-defined criteria and guidelines; 50 participants have received one-off specialist consultation at the HA through the mechanism.

As at 27 March 2025 [provisional figures], the numbers of participants in the CDCC Pilot Scheme with a breakdown by DHCs/DHCEs are tabulated below:

DHCs/DHCEs	Number of Participants in the CDCC Pilot Scheme (as at 27 March 2025) ^{Notes 2, 3} [Provisional Figures]
DHCs	
Kwai Tsing	11 100
Sham Shui Po	9 500
Tuen Mun	11 200
Wong Tai Sin	11 100
Southern	6 900
Yuen Long	14 200
Tsuen Wan	6 900
DHCEs	
Sai Kung	5 400

DHCs/DHCEs	Number of Participants in the CDCC Pilot Scheme (as at 27 March 2025) ^{Notes 2, 3} [Provisional Figures]
Kowloon City	4 000
Yau Tsim Mong	3 500
Wan Chai	2 100
North	3 200
Islands	1 600
Kwun Tong	5 900
Tai Po	3 100
Sha Tin	6 600
Central and Western	3 000
Eastern	5 000
Total	114 200

Note:

1. A blood glucose level ranging from 6.0 to 6.4% for glycated haemoglobin or a fasting glucose level of 6.1 to 6.9 mmol/L.
2. The figures refer to the numbers of citizens who have undergone assessments by nurses at DHCs/DHCEs, successfully paired with family doctors, and registered to participate in the CDCC Pilot Scheme.
3. Figures are rounded to the nearest hundred and may not add up to the total due to rounding.

- End -

CONTROLLING OFFICER'S REPLY

HHB293

(Question Serial No. 3433)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

One of the services provided by District Health Centres (DHCs) is subsidised physiotherapy, with a maximum charge of HKD 150 per session, approximately one hour each. Generally, up to 8 sessions are provided for people with lower back pain, and up to 12 sessions for those with degenerative knee arthritis pain. Such service is either provided at DHCs or by private physiotherapy providers from their networks. In this connection, will the Government advise this Committee on the following:

1. Since subsidised physiotherapy was introduced, how many citizens have successfully registered for and received such service with the help of DHCs (please list by district)? How many citizens have registered and are waiting for such service in each district?
2. Currently, how many private physiotherapy providers under DHC networks can provide physiotherapy services through referrals from DHCs (please list by district)?
3. It is said that the referral process by DHCs is rather complicated, requiring multiple visits to DHCs and private doctors to obtain referral letters, and some waiting time for scheduling appointments. Does the Government have any plans to reduce the hassle of receiving subsidised physiotherapy by streamlining the process?

Asked by: Hon LEUNG Hei, Edward (LegCo internal reference no.: 20)

Reply:

(1) to (3)

District Health Centres/District Health Centre Expresses (collectively referred to as DHCs) in all districts develop personalised health plans for the public according to their age, gender, lifestyle, etc. For knee osteoarthritis and back pain, the service providers under the district health network will provide personalised pain management and appropriate treatments (including physiotherapy, occupational therapy, nutritionist consultation and Chinese Medicine services) to DHC members. As at December 2024, there are more than 150

physiotherapists among the service providers under the district health network who have provided relevant services to more than 9 000 attendances.

To further enhance the services and convenience for the public, following the provision of dedicated nurse clinics and allied health services to participants of the Chronic Disease Co-Care Pilot Scheme (CDCC Pilot Scheme) with effect from 20 January 2025, the DHCs will set up dedicated nurse clinics and allied health services (including physiotherapy, occupational therapy, speech therapy, dietitian and Chinese medicine services) with effect from 15 April 2025 to provide services at over 20 services points across Hong Kong to DHC members who are not participants of the CDCC Pilot Scheme, including personalised chronic disease management, pain management and rehabilitation services. The Primary Healthcare Commission will review the service model and operational details in a timely manner and make enhancements as necessary to ensure its effectiveness, including the provision of more diversified and comprehensive primary healthcare services through strategic purchasing.

- End -

CONTROLLING OFFICER'S REPLY

HHB294

(Question Serial No. 3434)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

The Hospital Authority (HA) receives over 10 000 incident reports from hospitals through the Advance Incident Reporting System each year, including medical incidents involving patients in public hospitals. In this connection, will the Government inform this Committee of the following:

1. What was the number of reportable medical incidents involving patients in each cluster under the HA in each of the past 3 years; how many of them for which a Root Cause Analysis Panel was eventually set up to analyse the causes and make improvement recommendations?
2. How many of the abovementioned medical incidents were not reported to the HA Head Office within 24 hours through HA's internal Advance Incident Reporting System as required in each cluster in each of the past 3 years?
3. The Root Cause Analysis Panel only made improvement recommendations in the medical incident reports without giving an account of responsibilities regarding the incidents, making it more difficult for patients or their families to pursue responsibilities. As stated in the report of the Review Committee on the Management of the Public Hospital System released in 2024, an accountability mechanism covering all staff would be introduced by the HA. Has it been put into effect?

Asked by: Hon LEUNG Hei, Edward (LegCo internal reference no.: 21)

Reply:

1. Since October 2007, the Hospital Authority (HA) has followed international practices to implement a policy of reporting sentinel events (SE), aligning the definition of severe incidents and standardising the incident reporting, investigation and handling procedures among public hospitals. Later in 2010, the HA further improved the reporting mechanism with 2 categories of serious untoward events (SUE) added. At present, there are 9 categories of sentinel events and 2 categories of serious untoward events that are required to be reported.

Among the medical incidents reported by clusters annually in the past 3 years, about 100 cases were categorised as SE or SUE (with breakdown in the table below), in which Root Cause Analysis (RCA) panel was set up for each case of SE/ SUE under the existing mechanism to conduct in-depth analysis of the causes of the incident and make recommendations for improvement.

	Year (Figures quoted are statistical data of each year from October to September of the next year)		
	2021-2022	2022-2023	2023-2024
SE	26	19	29
SUE	87	78	80

2.

Once they become aware of the incidents, public hospitals reported all above SE and SUE to the HA Head Office within 24 hours according to the existing mechanism and handled the incidents in accordance with the established procedures, including setting up RCA panels to conduct detailed analysis of the incidents, identify their possible causes, as well as explore and formulate improvement measures or optimise clinical practice standards and guidelines to prevent similar incidents from happening again.

3.

The aim of setting up RCA panels is to conduct detailed analysis of the incidents, identify their possible causes, as well as explore and formulate improvement measures or optimise clinical practice standards and guidelines. The HA Head Office, as well as the management of the cluster and the hospital where the case occurred, would make reference to the analysis of the RCA Panel and follow up on the implementation of the recommendations so as to address the fundamental and systemic issues and prevent recurrence of similar incidents in future.

Besides, to manifest the commitment of the Government and the HA to the continuous improvement of the public healthcare system, the HA, as steered by the Health Bureau (HHB), established the Review Committee on the Management of the Public Hospital System (Review Committee) in 2024 to conduct a comprehensive systemic review. The Review Committee made a total of 31 improvement recommendations in 5 areas, namely, governance and accountability, safety culture, compliance and monitoring, incident management and enabling factors of the HA. These include considering incorporating safety metrics indicators into the performance appraisal of senior management and linking their assessment to appropriate performance ratings, rewards and sanctions, thereby promoting a culture of accountability with patient safety as the primary consideration, and revising the assessment criteria of staff appraisal to evaluate the performance of various ranks and grades of staff in terms of their contributions to delivering safe patient care and fostering a culture of patient safety. The HA fully accepted the review report and has set up a high-level Governance and Structure Reform Committee to take forward the recommendations in the report regarding governance, accountability and distribution of responsibilities of the HA, and relevant reform work. The HA is implementing various improvement measures in the review report. The HHB will continue to monitor its progress and effectiveness to ensure that the public

healthcare system will continue to provide quality, safe and effective healthcare services to the public.

- End -

CONTROLLING OFFICER'S REPLY

HHB295

(Question Serial No. 3491)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding the Pilot Scheme for Direct Cross-boundary Ambulance Transfer in the Greater Bay Area (Pilot Scheme), will the Government inform this Committee of the following:

1. the number of applications received and approved, as well as the expenditure involved since the launch of the Pilot Scheme;
2. the time scheduled by the Government for formally launching the scheme, and the expenditure earmarked for this purpose.

Asked by: Hon LEUNG Hei, Edward (LegCo internal reference no.: 130)

Reply:

The study on the provision of land-based cross-boundary transfer for non-emergency and non-critically ill patients and the exploration of rolling out a pilot co-operation scheme for cross-boundary referral of patients between designated public hospitals were put forward in the Outline Development Plan for the Guangdong-Hong Kong-Macao Greater Bay Area (GBA). The Chief Executive of the Hong Kong Special Administration Region (SAR) also put forward in the 2023 Policy Address the initiative to explore cross-boundary ambulance transfer arrangements between hospitals in the GBA. With the staunch support and guidance of various national ministries, the Hong Kong SAR Government, in collaboration with the Guangdong Provincial Government, the Shenzhen Municipal Government and the Macao SAR Government, officially launched the one-year Pilot Scheme for Direct Cross-boundary Ambulance Transfer in the GBA (the Pilot Scheme) on 30 November 2024.

The first phase of the Pilot Scheme starts by arranging direct cross-boundary ambulance transfer of patients from designated sending hospitals in Shenzhen and Macao (i.e. the University of Hong Kong - Shenzhen Hospital (HKU-SZH) and the Conde S. Januario Hospital (CHCSJ) of Macao) to designated public hospitals in Hong Kong.

Under the Pilot Scheme, upon assessment and agreement by the teams of designated cross-boundary collaborating hospitals, arrangements can be made for patients with specific clinical needs and suitable clinical conditions to be transferred directly to Hong Kong between designated hospitals in a point-to-point mode without the handover of patients between ambulances at boundary control points, thus minimising risks posed to patients during transfer.

The direct cross-boundary ambulance transfer arrangement is not an ambulance call service, but a cross-boundary inter-hospital transfer arrangement made by the relevant medical teams according to the medical conditions of individual patients. Hence, the Pilot Scheme has a mechanism in place to avoid abuse while ensuring the safety of cross-boundary transfer. Since medical conditions and needs vary among patients, doctors at the sending hospital will assess, on a case-by-case basis, the need for the patient to have cross-boundary inter-hospital transfer for continuous treatment or recovery services, taking the patient's clinical diagnosis and actual conditions into consideration. The doctors at the sending hospital will communicate with the Major Incident Control Centre of the Hospital Authority (HA) for joint assessment, information exchange and co-ordination with the receiving hospital to decide whether the transfer mechanism should be activated. The sending and receiving hospitals will also ensure that the patient's relatives and/or the patient have given consent to the relevant arrangements and are informed of the risks involved in the transfer.

As at early April 2025, the HA received a total of 10 cases of cross-boundary ambulance transfer, of which 7 were referred by the HKU-SZH and 3 were referred by the CHCSJ of Macao. According to professional medical assessment, the conditions of the patients in the above cases are relatively stable, but are unable to return to Hong Kong on their own and are unsuitable for transfer to Hong Kong ambulances via the existing boundary control points. A patient as referred by HKU-SZH was considered not meeting the criteria for transfer after the joint assessment of the case by the medical teams of the two places, and hence, the mechanism of transfer arrangement was not activated.

At present, ambulances, drivers, medical staff, medical equipment and medicines involved in cross-boundary ambulance transfer are provided by the HKU-SZH and the CHCSJ of Macao. The charges for cross-boundary ambulance transfer are determined by the above hospitals. Among them, the charges of the HKU-SZH are determined in accordance with the guidelines issued by the relevant Mainland authorities and have been reported to the relevant Mainland authorities. The current standard flat rate charge is RMB 4,990. The Hong Kong SAR Government will continue to keep in view the implementation of the scheme and maintain the transparency of the fees and charges with the collaborating sending hospitals, such that patients and their families will be clear about the relevant charges.

The public hospitals in Hong Kong, as the receiving hospitals for transferring patients, do not charge for the cross-boundary transfer arrangement and have no plan to provide subsidy to patients participating in the Pilot Scheme. Depending on whether a patient participating in the Pilot Scheme is an "Eligible Person" or a "Non-eligible Person", the HA will charge the patient in accordance with the scale of fees and charges as set out in the Gazette of the Hong Kong SAR Government for the continuation of the medical services provided to the patient in the public hospitals in Hong Kong.

The government departments of Guangdong, Hong Kong and Macao will review the effectiveness and operational experience of the Pilot Scheme in a timely manner to consider whether and how to expand the scheme, for example, by including more pilot hospitals and/or extending the scheme to a two-way arrangement.

- End -

CONTROLLING OFFICER'S REPLY

HHB296

(Question Serial No. 3502)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is mentioned in the Budget Speech that “the Government will upgrade the District Health Centre Expresses in Central and Western District, Eastern District and Yau Tsim Mong District into District Health Centres this year, with a view to strengthening the community healthcare system.” In this connection, will the Government inform this Committee of:

1. the estimated expenditure for upgrading the District Health Centre Expresses (DHCEs) in Central and Western District, Eastern District and Yau Tsim Mong District into District Health Centres (DHCs); and
2. the adjustments to staff establishments following the upgrade of the DHCEs in Central and Western District, Eastern District and Yau Tsim Mong District into DHCs?

Asked by: Hon LEUNG Hei, Edward (LegCo internal reference no.: 147)

Reply:

(1)&(2)

In April 2024, the Health Bureau launched a tender exercise for the operation of the Central and Western District Health Centre (DHC) and 3 women's health service points named Women Wellness Satellites located in Chai Wan, Lam Tin and Tuen Mun. A 3-year operation service contract with a total value of approximately \$531.7 million was subsequently awarded in January 2025. The Central and Western DHC is expected to commence operation in the third quarter of this year.

In addition, the Health Bureau conducted tender exercises for the operation of the Eastern and Yau Tsim Mong DHCs in July 2024. The service contracts for these 2 DHCs are expected to be awarded this year. The Primary Healthcare Commission is currently discussing the operational details, including manpower, with the operators and information on manpower is therefore not yet available.

Upon the upgrading of the 3 District Health Centre Expresses (DHCEs) to DHCs this year, the 11 existing DHCEs will gradually reduce to 8, while the number of DHCs will increase to 10. The estimated expenditure for DHCs and DHCEs (including provisions for service

contracts, site maintenance and rental cost) for 2025-26 are \$1.083 billion and \$213 million respectively.

- End -

CONTROLLING OFFICER'S REPLY**HHB297****(Question Serial No. 3503)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (2) HealthControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

As mentioned in Matters Requiring Special Attention in 2025-26, the Health Bureau will continue to take forward and enhance the development of District Health Centres (DHCs) and District Health Centre Expresses (DHCEs) across the territory. In this connection, will the Government inform this Committee:

1. of the establishment of healthcare personnel at various ranks and the operating expenses of each DHC and DHCE in 2024-25;
2. of the monthly service attendances of each DHC and DHCE in 2024-25; and
3. given that it has indicated that DHCs will be set up in 18 districts progressively, and currently only the DHCs in 7 districts have come into operation, with the DHCs in 3 more districts about to commence services this year, of the project plans and the expected service commencement dates for the DHCs in the remaining 8 districts.

Asked by: Hon LEUNG Hei, Edward (LegCo internal reference no.: 148)Reply:

(1)

The staff establishment (including healthcare professionals and other supporting staff) and revised estimate (including the provisions for service contracts, site maintenance and rental cost) of District Health Centres (DHCs) in Kwai Tsing, Sham Shui Po, Tuen Mun, Wong Tai Sin, Southern, Yuen Long and Tsuen Wan in 2024-25 are set out in the table below:

	DHC						
	Kwai Tsing	Sham Shui Po	Tuen Mun	Wong Tai Sin	Southern	Yuen Long	Tsuen Wan
Staff establishment Note 1							
Executive Director	1	1	1	1	1	1	1
Medical Consultant Note 2	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Chief Care	1	1	1	1	1	1	1

Co-ordinator							
Care Co-ordinator/ Nurse	21	18.5	26	25	16	29	21
Physiotherapist	3.5	2	3	3	3	3	2
Occupational Therapist	1.5	2	2	2	3	3	2
Dietitian	1	1	1	2	1	2	2
Pharmacist	1	1	1	1	1	1	1
Social Worker, Administrative Staff and Supporting Staff	55	69	62	62	59	50	48
Total	85.5	96	97.5	97.5	85.5	90.5	78.5
2024-25 Revised Estimate (\$ million)	62	63	80	69	58	73	78

Notes:

1. The staff establishment is proposed by DHC operators through tendering procedures according to the service demand in the community and manpower estimation, and is approved by the Government. The 0.5 staff establishment refers to a part-time position with half of the working hours of a full-time position. The actual number of staff may vary from time to time, depending on factors such as service demand and short-term manpower turnover, etc. The Government will continue to monitor the situation to ensure that services are not affected.
2. Medical Consultants are part-time or outsourced positions.

The staff establishment (including healthcare professionals and other supporting staff) and revised estimate (including the provisions for service contracts, site maintenance and rental cost) of all DHC Expresses (DHCEs) in 2024-25 are set out in the table below:

	DHCE										
	Central and Western	Eastern	Islands	Kowloon City	Kwun Tong	North	Sai Kung	Sha Tin	Tai Po	Wan Chai	Yau Tsim Mong
Staff establishment Notes 3,4											
Project Co-ordinator	1	1	1	1	1	1	1	1	1	1	1
Medical Consultant Note 5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Care Co-ordinator	3	3	3	1	2	1	2	5	5	5	1
Nurse	1	3		5	4	3	4				4
Physiotherapist	1	1	1	1	1	1	1	1	1	1	1

Occupational Therapist					1		1		0.5	1	
Pharmacist	0.5	0.5					1	1		1	
Dietitian				1	1	0.5	1		1		1
Social Worker, Administrative Staff and Supporting Staff	14	15	12	13	15.5	14.5	12	18	14	7.5	14
Total	21	24	17.5	22.5	26	21.5	23.5	26.5	23	17	22.5
2024-25 Revised Estimate (\$ million)	15	14	13	14	14	14	14	14	14	15	14

Note:

- The staff establishment is proposed by DHCEs according to the service demand in the community and manpower estimation, and is reviewed and approved by the Government before entering into contracts with operators. The 0.5 staff establishment refers to a part-time position with half of the working hours of a full-time position. The actual number of staff may vary from time to time, depending on factors such as service demand and short-term manpower turnover, etc. The Government will continue to monitor the situation to ensure that services are not affected.
- The staff establishment of each DHCE is dependent on the service demand and service delivery model of the district concerned, and so the figures are not directly comparable.
- Medical Consultants are part-time or outsourced positions.

(2)

The cumulative numbers of attendances of DHCs/DHCEs are set out in the table below:

DHC/DHCE Service Commencement Date	Cumulative Number of Attendances ^{Notes 1, 2, 3, 4} (as at 31 December 2024) [Provisional Figures]
<i>DHC</i>	
Kwai Tsing 24 September 2019	498 300
Sham Shui Po 30 June 2021	296 600
Tuen Mun 31 May 2022	344 100
Wong Tai Sin 30 June 2022	200 900
Southern	175 300

DHC/DHCE Service Commencement Date	Cumulative Number of Attendances ^{Notes 1, 2, 3, 4} (as at 31 December 2024) [Provisional Figures]
17 October 2022	
Yuen Long 24 October 2022	255 000
Tsuen Wan 30 December 2022	175 700
DHCE	
Sai Kung 1 September 2021	84 900
Kowloon City 1 October 2021	57 300
Yau Tsim Mong 1 October 2021	48 500
Wan Chai 4 October 2021	53 000
North 18 October 2021	53 700
Islands 18 October 2021	35 900
Kwun Tong 21 October 2021	49 300
Tai Po 22 October 2021	45 000
Sha Tin 30 October 2021	71 400
Central and Western 30 October 2021	50 200
Eastern 30 October 2021	54 700
Total	2 549 900

Notes:

1. Figures are rounded to the nearest hundred.
2. The figures only include service figures captured from the DHC/DHCE information system, and do not include those relating to medical laboratory tests.
3. As different services are provided by the 11 DHCEs, the attendance figures are not directly comparable.
4. The service figures above have included services provided by DHCs/DHCEs for participants of the Chronic Disease Co-care Pilot Scheme which was launched on 13 November 2023.

(3)

The Government set up 7 DHCs and 11 smaller interim DHCEs in rented properties across the territory by 2022, thereby attaining the interim goal of covering all 18 districts of Hong Kong. The Government will upgrade the 3 DHCEs in the Central and Western District, Eastern District, and Yau Tsim Mong District to DHCs within 2025. In April 2024, the Health Bureau (HHB) launched a tender exercise for the operation of the Central and Western DHC and 3 women's health service points named Women Wellness Satellites located in Chai Wan, Lam Tin and Tuen Mun. A three-year operation service contract with a total value of approximately \$531.7 million was subsequently awarded in January 2025. The Central and Western DHC is expected to commence operation in the third quarter of this year. In July 2024, the HHB conducted tender exercises for the operation of the Eastern and Yau Tsim Mong DHCs. The operation service contracts for these 2 DHCs are expected to be awarded this year.

Upon the upgrading of the 3 DHCEs to DHCs this year, the 11 existing DHCEs will gradually reduce to 8, while the number of DHCs will increase to 10. The estimated expenditure for DHCs and DHCEs (including provisions for service contracts, site maintenance and rental cost) for 2025-26 are \$1.083 billion and \$213 million respectively.

In addition, the funding proposals for the construction projects of Wan Chai, Kwun Tong, Sai Kung and North District DHCs were approved by the Finance Committee of the Legislative Council (LegCo) in January and October 2021, and in April and July 2024 respectively. These projects will be completed gradually in the next few years. To achieve the long-term development goal of having DHCs in all 18 districts as early as possible, the Government is actively taking forward the plan to establish DHCs in the remaining 4 districts and will seek LegCo's funding approval in due course. Before the remaining DHCs are set up, the Government will continue to subsidise non-governmental organisations to operate DHCEs in those districts. The services provided by DHCEs will be migrated as appropriate to DHCs in respective districts at a later stage. The Primary Healthcare Commission will, together with the operators of DHCEs, draw up and implement transition plans for upgrading DHCEs to DHCs to ensure a smooth transition of services.

- End -

CONTROLLING OFFICER'S REPLY**HHB298****(Question Serial No. 3504)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (3) Subvention: Hospital AuthorityControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

As mentioned in Matters Requiring Special Attention this year, the Health Bureau will increase service capacity for cataract surgeries. In this connection, will the Government inform this Committee of:

1. the number of cataract surgeries performed in each hospital cluster and the waiting time of patients to receive cataract surgeries in each of the past 3 years;
2. whether targets have been set for each hospital cluster regarding the increase in service capacity for cataract surgeries; if yes, what are the specific targets?

Asked by: Hon LEUNG Hei, Edward (LegCo internal reference no.: 149)Reply:

1.

Cataract is a common eye disease, the prevalence of which increases with age. With an ageing population, it is expected that the demand for cataract surgery will continue to grow. Having regard to this, the Ophthalmology Specialist Out-patient Clinics under the Hospital Authority (HA) have been performing triage on patients waiting for cataract surgeries according to the urgency of their situations and clinical conditions since 2009 with a view to ensuring those with conditions requiring early intervention are treated with priority. For patients triaged as priority cases, surgeries will be arranged as early as practicable.

The numbers of cataract surgeries completed and the waiting time of patients who have undergone such surgeries in each hospital cluster under the HA from 2022-23 to 2024-25 (up to 31 December 2024) are set out in the tables below ⁽¹⁾⁽²⁾:

Year	Hospital cluster	Number of cataract surgeries completed
2022-23	HKEC	2 309
	HKWC	2 664
	KCC	5 621
	KEC	2 699

	KWC	1 809
	NTEC	4 595
	NTWC	3 169
	HA overall	22 866
2023-24	HKEC	3 417
	HKWC	3 115
	KCC	6 186
	KEC	2 821
	KWC	2 703
	NTEC	4 643
	NTWC	3 594
	HA overall	26 479
2024-25 (up to 31 December 2024)	HKEC	2 353
	HKWC	2 320
	KCC	5 007
	KEC	2 472
	KWC	1 738
	NTEC	3 511
	NTWC	2 741
	HA overall	20 142

Median waiting time (month) of patients who have their operations completed in the preceding 12 months			
Hospital cluster	2022-23	2023-24	2024-25 (up to 31 December 2024)
HKEC	15	20	11
HKWC	13	11	10
KCC	12	31	27
KEC	17	14	25
KWC	13	14	14
NTEC	20	11	11
NTWC	12	13	14
HA overall	14	14	13

The 90th percentile waiting time (month) of patients who have their operations completed in the preceding 12 months			
Hospital Cluster	2022-23	2023-24	2024-25 (up to 31 December 2024)
HKEC	38	39	35
HKWC	19	18	13
KCC	38	36	33
KEC	23	28	30
KWC	47	52	52
NTEC	25	26	28
NTWC	56	57	54
HA overall	37	40	37

Note:

- (1) In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA adjusted its services to cope with the outbreak. This should be taken into consideration when comparing the service capacity of the HA in relevant years. With the cessation of anti-epidemic measures in early 2023, the services of the HA have gradually returned to normal.
- (2) The waiting time for cataract surgery is the median waiting time and the 90th percentile waiting time of patients who have their operations completed in the preceding 12 months.

2.

As set out in the Chief Executive's 2024 Policy Address, the service capacity for cataract surgeries will be increased to meet the continuous demand from the public. The HA will provide 5 000 additional cataract surgeries in 2025-26 through the following means. Details of the plan are as follows:

- (i) The high-flow cataract surgery centre of Alice Ho Miu Ling Nethersole Hospital commenced trial run in November 2024 and gradual increase in operation sessions in 2025 is planned. Currently, the HA is proactively reviewing related services and workflow, including exploring the establishment of more high-flow cataract surgery centres or increasing operation sessions, further streamlining workflow, assessing manpower requirements, and developing clinical guidelines for high-flow cataract surgery services;
- (ii) Consolidating the current scheduling of cataract surgeries, allocating dedicated sessions for cataract surgeries and setting targets on the number of cataract surgeries to be completed. The dashboard launched in December 2024 facilitates monitoring of the service capacity for cataract surgeries and the HA regularly reviews the improvements in efficiency and progress of surgery scheduling across hospital clusters; and
- (iii) In the 2025-26 work plan, the manpower for the ophthalmic services of KCC, KEC and NTEC will be enhanced to provide additional service capacity for cataract surgeries. The HA will also continue to explore increasing the service capacity for cataract surgeries by providing subsidies to serving doctors for performing surgeries on patients outside working hours through the Cataract Surgery Special Scheme.

Abbreviations:

HKEC – Hong Kong East Cluster
HKWC – Hong Kong West Cluster
KCC – Kowloon Central Cluster
KEC – Kowloon East Cluster
KWC – Kowloon West Cluster
NTEC – New Territories East Cluster
NTWC – New Territories West Cluster

- End -

CONTROLLING OFFICER'S REPLY**HHB299****(Question Serial No. 3505)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (3) Subvention: Hospital AuthorityControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

It is mentioned in Matters Requiring Special Attention this year that the Health Bureau will continue to strengthen mental health services. In this connection, will the Government inform this Committee of:

1. the healthcare manpower establishment of the psychiatric services of the Hospital Authority in the past 3 years by hospital cluster;
2. the total number and the median waiting time of new psychiatric outpatient cases of patients in the past 3 years by hospital cluster;
3. the number of new psychiatric outpatient cases of minors under the age of 18 in the past 3 years by hospital cluster; and
4. the expenditure on mental health services in the past 3 years and the estimated expenditure for 2025-26?

Asked by: Hon LEUNG Hei, Edward (LegCo internal reference no.: 150)Reply:

(1)

The numbers of doctors, nurses and allied healthcare professionals working in the psychiatric stream of the Hospital Authority (HA) from 2022-23 to 2024-25 (as at 31 December 2024) are tabulated below:

Year	Psychiatric Doctor ^{1,2,3}	Psychiatric Nurse ^{1,2,4} (including Community Psychiatric Nurse)	Healthcare Professional		
			Clinical Psychologist ^{1,6}	Medical Social Worker ⁵	Occupational Therapist ^{1,6}
2022-23	381	3 015	105	257	287
2023-24	399	3 064	108	257	300
2024-25 (as at 31 December 2024)	414	3 147	116	257	338

Note:

1. The manpower figures above are calculated on full-time equivalent (FTE) basis including permanent, contract and temporary staff in all HA clusters, but excluding those in the HA Head Office.
2. FTE for temporary part-time staff is calculated based on their actual working hours starting from January 2024. The relevant figures prior to that month are for reference only and cannot be directly compared with the current revised calculation.
3. Psychiatric doctors refer to all those doctors working for the specialty of psychiatry except interns.
4. Psychiatric nurses include those nurses working in psychiatric hospitals, namely Kwai Chung Hospital, Castle Peak Hospital and Siu Lam Hospital, those working in psychiatric departments of other non-psychiatric hospitals, as well as all those working in the psychiatric stream.
5. Information on the number of medical social workers supporting psychiatric services in the HA is provided by the Social Welfare Department.
6. Clinical psychologists and occupational therapists working in the psychiatric stream include those working in psychiatric hospitals, namely Kwai Chung Hospital, Castle Peak Hospital and Siu Lam Hospital, those working in psychiatric departments of other non-psychiatric hospitals, as well as all those engaging in psychiatric-related work.

(2)

The numbers of psychiatric specialist outpatient (SOP) new cases triaged as Priority 1 (urgent), Priority 2 (semi-urgent) and Routine (stable) cases and their respective median (50th percentile) waiting time in each hospital cluster of the HA from 2022-23 to 2024-25 (as at 31 December 2024) are tabulated below:

2022-23

Hospital Cluster	Priority 1		Priority 2		Routine	
	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)
HKEC	302	<1	897	3	3 296	19
HKWC	363	1	687	4	1 920	41
KCC	195	<1	1 318	4	2 347	18
KEC	265	1	2 322	3	5 238	52
KWC	232	<1	909	4	13 129	29
NTEC	828	1	2 427	4	6 342	64
NTWC	377	1	1 459	3	6 027	55

2023-24

Hospital Cluster	Priority 1		Priority 2		Routine	
	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)
HKEC	240	1	766	3	3 655	26
HKWC	348	1	811	4	1 914	40
KCC	271	<1	1 204	3	2 394	20

KEC	272	1	2 066	3	5 455	47
KWC	256	<1	795	3	12 947	26
NTEC	829	1	2 310	4	6 701	73
NTWC	390	1	1 597	3	5 873	34

2024-25 (as at 31 December 2024)

Hospital Cluster	Priority 1		Priority 2		Routine	
	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)
HKEC	106	1	437	3	3 037	39
HKWC	230	1	569	3	1 522	42
KCC	212	<1	925	3	1 813	21
KEC	197	1	1 353	3	4 520	45
KWC	158	<1	395	2	10 266	25
NTEC	482	1	1 858	4	5 531	78
NTWC	291	<1	1 398	2	4 566	39

Note:

With effect from 1 October 2022, the waiting time for new case bookings at integrated clinics has been incorporated in that at psychiatric specialist outpatient clinics (SOPCs).

(3)

The numbers of child and adolescent psychiatric SOP new cases triaged as Priority 1 (urgent), Priority 2 (semi-urgent) and Routine (stable) cases and their respective median (50th percentile) waiting time in each hospital cluster of the HA from 2022-23 to 2024-25 (as at 31 December 2024) are tabulated below:

2022-23

Hospital Cluster	Priority 1		Priority 2		Routine	
	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)
HKEC	16	1	60	4	903	49
HKWC	7	1	96	6	812	61
KCC	11	<1	77	6	1 072	30
KEC	32	1	206	1	1 729	89
KWC	8	<1	194	4	4 037	86
NTEC	52	1	142	4	2 266	86
NTWC	80	1	184	2	2 270	76

2023-24

Hospital Cluster	Priority 1		Priority 2		Routine	
	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)
HKEC	9	<1	44	3	1 060	76
HKWC	39	1	84	4	906	63
KCC	10	1	152	5	1 024	65
KEC	24	1	311	1	1 495	74
KWC	10	<1	214	2	3 858	87
NTEC	20	2	71	3	2 480	87
NTWC	78	1	231	1	2 255	60

2024-25 (as at 31 December 2024)

Hospital Cluster	Priority 1		Priority 2		Routine	
	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)	Number of new cases	Median waiting time (weeks)
HKEC	0	Not applicable	11	2	804	67
HKWC	11	1	45	3	695	70
KCC	5	1	122	4	745	78
KEC	33	1	273	2	1 244	77
KWC	11	<1	155	2	3 090	80
NTEC	7	1	44	4	1 981	96
NTWC	68	<1	181	1	1 788	72

Note:

With effect from 1 October 2022, the waiting time for new case bookings at integrated clinics has been incorporated in that at SOPCs.

(4)

The HA's expenditures on mental health services from 2022-23 to 2025-26 are tabulated below:

Year	Expenditure on Mental Health Services (\$ million)
2022-23	6,145
2023-24	6,585
2024-25 (revised estimate)	7,042
2025-26 (estimate)	7,321

The expenditures on mental health services include direct staff costs (such as doctors, nurses and allied health staff) for providing services to patients; expenses incurred in providing various clinical support services (such as pharmacy); and other operating costs (such as meals for patients, utility expenses and repair and maintenance of medical equipment).

Remark:

In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA adjusted its services to cope with the outbreak. This should be taken into consideration when comparing the service capacity of the HA in the respective years. With the subsiding of local COVID-19 epidemic situation and cessation of anti-epidemic measures in early 2023, the HA has been gradually resuming provision of all of its public healthcare services to tie in with the Government's normalcy measures. As the costing information for 2022-23 has reflected the impact of the epidemic outbreak on costs, the costing information across years may not be directly comparable.

Abbreviations:

HKEC – Hong Kong East Cluster

HKWC – Hong Kong West Cluster

KCC – Kowloon Central Cluster

KEC – Kowloon East Cluster

KWC – Kowloon West Cluster

NTEC – New Territories East Cluster

NTWC – New Territories West Cluster

- End -

CONTROLLING OFFICER'S REPLY

HHB300

(Question Serial No. 3507)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Under Matters Requiring Special Attention in 2025-26, it is stated that the Health Bureau will continue to take forward and implement the five-year plan of eHealth+ to transform eHealth from a health record sharing system into a comprehensive healthcare information infrastructure that integrates multiple functions of healthcare data sharing, service delivery and care journey management. In this connection, will the Government inform this Committee of:

1. the number of members of the public who have registered with eHealth; its proportion to the total population of Hong Kong;
2. the expenditure and staffing establishment involved in the operation of eHealth in the past 3 years; and
3. the estimated expenditure and staffing establishment involved in taking forward the development and implementation of eHealth+ in 2025-26?

Asked by: Hon LEUNG Hei, Edward (LegCo internal reference no.: 153)

Reply:

eHealth is a territory-wide electronic health record sharing system launched by the Government in 2016 that enables citizens to authorise healthcare providers (HCPs) in the public and private sectors to view and share their electronic health records (eHRs) for healthcare purposes. Building on the strengths of the existing infrastructure of eHealth, the Government announced in the 2023 Policy Address the initiative to roll out a five-year development plan of eHealth+ to transform eHealth into a comprehensive healthcare information infrastructure that integrates multiple functions of data sharing, service delivery and care journey management. eHealth+ aims to facilitate care coordination, cross-sector collaboration, as well as active health management and surveillance, thereby better serving our citizens in obtaining optimal healthcare services, and supporting the healthcare reform and various healthcare policies more effectively, such as primary healthcare and cross-boundary healthcare services. The Government is taking forward the eHealth+ development in phases in accordance with the patient-centric principle and four strategic directions,

namely, “One Health Record”, “One Care Journey”, “One Digital Front Door to Empowering Tool” and “One Health Data Repository”.

The reply to the questions raised by the Hon LEUNG Hei, Edward is as follows:

(1) As of end-February 2025, more than 6.1 million citizens have registered with eHealth, accounting for over 80% of the Hong Kong population.

(2) The Hospital Authority (HA) is the technical agency for the development and operation of eHealth. The operational expenditure and the manpower incurred by HA’s dedicated team (including health informatics staff, information technology (IT) staff and project management staff involved in overseeing and operating eHealth) in the past 3 years are as follows:

Financial Year	Operational Expenditure (\$ million)	Manpower (number of posts in HA)
2022-23(Actual)	243.2	223
2023-24 (Actual)	265.8	223
2024-25(Revised Estimate)	312.6	223

As for the Health Bureau, eHealth-related work is only part of the relevant staff’s duties. We do not maintain a breakdown on the relevant expenditure and manpower.

(3) In July 2024, the Finance Committee of the Legislative Council approved a commitment of \$1,395.8 million for the eHealth+ development from 2024-25 to 2028-29. eHealth+ is a highly complex and large-scale comprehensive healthcare information infrastructure programme and its development work requires extensive clinical expertise and experience in operating clinical management systems. Therefore, the HA will engage specialists with relevant qualifications to co-ordinate the five-year plan for eHealth+, particularly for developing and implementing the core projects. The estimated expenditure on the development team for 2025-26 is \$86 million. The team comprises 58 HA staff members, which include health informatics staff, IT staff and project management staff, covering different professions.

- End -

CONTROLLING OFFICER'S REPLY

HHB301

(Question Serial No. 3508)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

In its vigorous pursuit of the Smart Hospital strategy in recent years, the Hospital Authority has adopted innovative technologies to enhance services and treatment quality in various hospitals. In this connection, please advise this Committee on the Government's funding earmarked for upgrading or replacing smart medical devices and equipment of public hospitals in 2025-26.

Asked by: Hon LEUNG Hei, Edward (LegCo internal reference no.: 156)

Reply:

"Developing Smart Hospitals" is put forward in the Hospital Authority (HA) Strategic Plan 2022-2027 entitled "Towards Sustainable Healthcare" as one of the major development strategies for public hospital services. The strategic goal of developing Smart Hospitals is to integrate medical equipment, digital technologies and devices, information technology (IT) and systems to jointly promote clinical excellence, operational efficiency and patient-centred services. Alongside data-driven care empowered by artificial intelligence, technology-enabled healthcare facilities like smart wards, smart clinics and smart pharmacies have been incorporated into the Smart Hospital projects.

To tie in with the development needs of Smart Hospitals and to enhance patient safety and service quality, the HA acquires and replaces a wide variety of medical equipment from time to time. Cluster management makes plans for medical equipment by deliberating and formulating annual medical equipment requirement plan in the relevant committees, based on factors such as risk assessment (e.g. risk of equipment obsolescence, service lifespan of equipment, as well as patient and staff safety), impact on patient care, operational needs and additional equipment essential for the provision of new or enhanced services.

The HA upgrades and acquires medical equipment and information systems with the designated funding, recurrent funding and other relevant funding provided by the Government. In 2025-26, the Government will allocate a designated funding of \$1.2 billion to the HA for the upgrading and acquisition of major and essential medical equipment and information systems, including medical equipment for Smart Hospitals. The HA will also

make use of the recurrent funding for upgrading and acquiring minor smart medical equipment and IT systems. Moreover, the HA has earmarked funding to meet the future needs for upgrading of medical and IT equipment.

- End –

CONTROLLING OFFICER'S REPLY

HHB302

(Question Serial No. 3819)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Regarding haemophilia management and treatment, will the Government inform this Committee of:

1. the numbers of child and adult patients with haemophilia A or B followed up at public hospitals in the past 3 years (by type of haemophilia, including numbers of specialist outpatient attendances and admissions to hospitals);
2. the numbers of child and adult patients with haemophilia A or B having received medication treatment at public hospitals and the expenditure involved in the past 3 years (by medication and clinical indication); and
3. whether the Government has examined for any discrepancy between existing treatments and international standards, and conducted timely reviews; if so, the details; if not, the reasons?

Asked by: Hon LEUNG Hei, Edward (LegCo internal reference no.: 161)

Reply:

(1) and (2)

Haemophilia is a genetic bleeding disorder that affects the body's ability to form blood clots. This condition is caused by a deficiency in certain clotting factors, which are proteins in the blood that help stop bleeding. Individuals with haemophilia have a reduced ability to form clots and their symptoms typically include prolonged bleeding after an injury or surgery, spontaneous bleeding into joints and muscles, easy bruising and an increased risk of internal bleeding. There are 2 main types of haemophilia: haemophilia A and haemophilia B, which are caused by a deficiency in clotting factor VIII and clotting factor IX respectively. Both types of haemophilia are inherited in an X-linked recessive pattern, which means that the gene responsible is located on the X chromosome. It is a rare condition that primarily affects males, although females can also be carriers of the gene without symptoms. The severity of haemophilia can vary from mild to severe, depending on the level of clotting factor present in the blood. The higher the level of clotting factor, the less severe the symptoms of haemophilia.

Treatment for haemophilia involves factor replacement therapy to infuse the missing clotting factor. These clotting factor concentrates are made from human blood plasma or genetically engineered cells. The frequency and dosage of clotting factor infusions depend on the severity of haemophilia. This can be done on a regular basis to serve as prophylaxis to prevent bleeding episodes or on an as-needed basis to treat bleeding episodes as they occur.

The Hospital Authority (HA) does not maintain precise statistics on the number of patients with haemophilia receiving follow-up treatment at public hospitals. The number of HA patients prescribed with the main types of drugs for treating haemophilia and the drug expenditures involved in 2022-23, 2023-24 and 2024-25 (as at 31 December 2024) are set out in the table below. As a drug may have more than one therapeutic use, the number of patients and the amount of drug expenditure include all patients prescribed with these drugs for treatment of related diseases and for other therapeutic uses.

Drug Name/Class	Number of Patients Prescribed with the Drug			Amount of Drug Expenditure Involved (\$ million)		
	2022-23	2023-24	2024-25*	2022-23	2023-24	2024-25*
i) Emicizumab - uses include treatment of haemophilia A	26	28	31	24.46	25.11	20.33
ii) Anti-Inhibitor - Coagulant Complex - uses include treatment of haemophilia A or haemophilia B	9	15	19	7.08	12.38	11.19
iii) Clotting factor IX - uses include treatment of haemophilia B	45	48	42	13.84	20.80	19.24
iv) Clotting factor VIII - uses include treatment of haemophilia A	215	222	216	65.49	82.93	63.58

* Figures up to 31 December 2024

The above 4 main types of drugs for treating haemophilia have been listed in the “Special Drug” category of the HA Drug Formulary (HADF). Patients prescribed with these drugs under specified clinical indications are only required to pay the standard fees which are highly subsidised by the Government.

(3)

As the major provider of publicly funded public healthcare services, the HA strives to provide appropriate treatment for all patients (including haemophiliacs) while ensuring patients have equitable access to cost-effective drugs of proven safety and efficacy under the highly subsidised public healthcare system.

At present, the treatment plans for hemophiliacs in Hong Kong are formulated with reference to the guidelines issued by internationally recognised organisations such as the World Federation of Haemophilia and in compliance with international standards. The HA's medical teams also actively participate in meetings of international organisations on a regular basis to ensure that the efficiency and quality of treatment continue to meet international standards.

Moreover, the HA has mechanisms in place to regularly appraise new drugs as well as review the HADF and the coverage of the safety net (including the Samaritan Fund and the Community Care Fund Medical Assistance Programmes). The review process follows an evidence-based approach, having regard to the principles of safety, efficacy and cost-effectiveness and other relevant factors including international recommendations and practices as well as views from professionals and patient groups, etc. Evaluation of drugs is an on-going process driven by evolving medical evidence, the latest clinical developments and market dynamics. The HA will continue to keep abreast of the latest development of haemophilia drugs and treatments and review clinical services through established mechanisms, with a view to ensuring that patients are provided with cost-effective drugs of proven safety and efficacy as well as optimal care on a continuous basis.

The Government and the HA will press ahead with the implementation of the fees and charges reform for public healthcare announced recently, which aims to guide the public to make optimal use of healthcare resources through 3 aspects, namely reforming the subsidisation structure, reducing wastage and abuse, and enhancing healthcare protection. It also seeks to strengthen the healthcare protection on all fronts for patients who are "poor, acute, serious or critical". Such measures include enhancing the protection in terms of drugs and medical devices for critically ill patients through accelerating the introduction of more effective innovative drugs and devices to the HADF and the coverage of the safety net, with a view to ensuring that the limited healthcare resources can be directed in a more targeted manner to assist those patients most in need. This will thereby enhance the sustainability of the healthcare system so as to serve as a safety net for all.

- End -

CONTROLLING OFFICER'S REPLY**HHB303****(Question Serial No. 3820)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (3) Subvention: Hospital AuthorityControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

Regarding diabetes monitoring, will the Government inform this Committee of the following:

1. What is the estimated number of diabetic patients requiring long-term regular monitoring of blood glucose levels in each of the past 3 years; how many of them require financial subsidy from the Government for the purchase of blood glucose testing equipment and consumables (such as blood glucose testing strips); and what is the estimated annual expenditure involved for subsidising such tests;
2. Whether the Government has considered introducing new testing equipment in response to technological development; if so, what are the details; if not, what are the reasons;
3. How effective is the diabetes monitoring services provided at District Health Centres and through public-private partnerships;
4. How effective is the Government's public education on diabetes prevention?

Asked by: Hon LEUNG Hei, Edward (LegCo internal reference no.: 162)Reply:

1. In general, all patients with diabetes mellitus (DM) have to regularly monitor their blood glucose levels.

The numbers of DM patients who used services of the Hospital Authority (HA) from 2022 to 2024 (last updated in January 2025) are tabulated below.

	2022	2023	2024 ⁵
Numbers of DM ² patients ^{3,4} who used services ¹ of the HA	594 600	625 100	640 200

Note:

1. This refers to patients who used HA's services in the year, but the services may not necessarily be targeted at treating diseases related to DM.

2. The HA estimated the numbers of DM patients through diagnosis coding, information on drug dispensing and/or laboratory results.
3. Figures are rounded to the nearest hundred.
4. In view of the COVID-19 epidemic in Hong Kong in early 2020, the HA adjusted its services in response to the epidemic. This should be taken into account when comparing the throughput of services provided by the HA across the years. With the cessation of anti-epidemic measures in early 2023, the HA's services have gradually resumed normal.
5. The figures for 2024 are based on estimation.

The HA deploys multi-disciplinary teams across various departments to treat patients with chronic diseases, including those diagnosed with DM. Such patients may suffer from multiple chronic diseases, and doctors will arrange different examinations and treatment options for them having regard to their individual conditions. The HA does not maintain information on the number of DM patients who purchase subsidised blood glucose testing equipment and consumables and the estimated expenditure so involved.

2.

The HA has an established mechanism for close monitoring of medical technology developments, with experts regularly studying and reviewing treatment options for patients and the latest developments in clinical and scientific evidence of related technologies, while taking into account healthcare professionals' advice and overseas developments to plan for the introduction of medical technologies. Meanwhile, the availability of relevant expertise, manpower and facilities will also be taken into account.

The HA will continue to closely monitor the latest medical developments. Adhering to the principle of optimising the use of limited public resources, the HA will review clinical services through the established mechanism to benefit more patients with keen needs.

3.

The Government has launched the three-year Chronic Disease Co-Care Pilot Scheme (CDCC Pilot Scheme) since 13 November 2023, the first major initiative following the announcement of the Primary Healthcare Blueprint (the Blueprint) at the end of 2022. The Scheme provides subsidised DM and hypertension (HT) screening services in the private healthcare sector to Hong Kong residents aged 45 or above with no known medical history of DM or HT, with a view to encouraging citizens to gain a better understanding of their own health status as early as possible through screening, so as to achieve the goals of “early prevention, early identification and early treatment”. The Government aims to establish a family doctor regime and position District Health Centres (DHC) and DHC Expresses as hubs to foster expansion of the community healthcare network, so as to properly manage chronic diseases in the community under a multi-disciplinary approach, thereby alleviating the pressure on secondary and tertiary healthcare services, in particular the Specialist Out-patient Clinics (SOPCs) of the HA.

The Government expects that 200 000 people will participate in the CDCC Pilot Scheme within the three-year pilot period. The Scheme has been well received since its launch. As at 27 March 2025 [provisional figures], about 114 200 citizens and over 600 family doctors have joined the Scheme, of which 65 000 participants (i.e. nearly 60%) have completed the screenings for DM and HT, and around 25 230 of which (i.e. nearly 40%) have been diagnosed

with prediabetes^{Note}, or with DM or HT. The latter patients can proceed to the treatment phase and will be subsidised by the Government to continue their treatment with self-selected family doctors, and subject to health conditions, be prescribed medication, or referred to follow-up care at nurse clinics and allied health services. In addition, the Government has established a bi-directional referral mechanism with the HA under the CDCC Pilot Scheme. Family doctors can refer participants with clinical needs to receive a one-off specialist consultation at a designated Medicine SOPC of the HA according to clinical diagnosis and pre-defined criteria and guidelines; 50 participants have received one-off specialist consultation at the HA under the mechanism.

With regard to the promotion of multidisciplinary care, as announced earlier by the Government, the dedicated nurse clinic and allied health services (including optometrists, physiotherapists and dietitians) have been introduced to devise more comprehensive chronic disease management programmes for the CDCC Pilot Scheme participants since 20 January 2025. Since the launch of the relevant services, as at 27 March 2025 (provisional figures), 504 appointments have been made and 417 attendances have been recorded. From 28 March 2025, the CDCC Pilot Scheme has been further expanded to cover blood lipid testing for eligible participants, allowing a more comprehensive approach to the assessment and proper management of cardiovascular disease risk factors, including the “three highs” (high blood pressure, high blood sugar and high cholesterol). Starting from the same day, the CDCC Pilot Scheme has also been expanded in phases to cover the GOPCs of the HA to strengthen preventive screening and care services for the underprivileged. The 2025-26 estimates cover the medical service expenditures required for such expansion, including doctor consultations, laboratory tests, medications, nurse clinics, and allied health services.

As mentioned in the Blueprint, local studies have shown that the healthcare system can achieve savings in healthcare expenses and reduce the burden of disease through the provision of subsidised screening and management services for DM management to suitable patients. The CDCC Pilot Scheme is a pilot scheme that encourages eligible citizens to undergo screening for DM and HT, two common chronic diseases, so that hidden patients can be detected at an early stages and their complications can be treated and prevented as early as possible, thereby reducing the need for hospitalisation. To further examine the effectiveness of the CDCC Pilot Scheme, the Government commissioned a local university in the first quarter of 2024 to conduct a study to assess the extent to which the objectives of the Scheme are met and the overall performance, including the service quality and effectiveness, as well as the cost-effectiveness. In addition, the Government will review the service model and operational details of the CDCC Pilot Scheme in a timely manner and make enhancements as necessary to ensure its effectiveness.

^{Note} Prediabetes with glycated haemoglobin level of 6.0 to 6.4 per cent or fasting plasma glucose level of 6.1 to 6.9 mmol/L.

4.

Type 2 diabetes, a common chronic disease, is closely associated with unhealthy lifestyles including unhealthy diet, physical inactivity and tobacco use. The Government released “Towards 2025: Strategy and Action Plan to Prevent and Control Non-communicable Diseases in Hong Kong” in 2018, focusing on 4 non-communicable diseases, including DM, and 4 shared behavioural risk factors, namely unhealthy diet, physical inactivity, tobacco use and harmful use of alcohol.

As the Government's public health adviser and regulatory authority responsible for territory-wide health promotion, the Department of Health (DH) has taken forward a series of health promotion programmes targeting various age groups with a life-course approach. It has also been promoting a healthy lifestyle, including physical activity and a balanced diet, in settings such as schools, workplaces and the community, as well as different health service points, including Maternal and Child Health Centres, Student Health Service Centres and Elderly Health Centres.

The DH promotes public awareness of how to prevent non-communicable diseases by various means and channels, including posters, leaflets, health education materials published on websites or in print, social media platforms and media interviews. It also encourages members of the public to adopt a healthy lifestyle, including avoidance of smoking and alcohol, healthy diet, regular physical activity and maintenance of a healthy body weight and waist circumference, with a view to reducing the risk of non-communicable diseases including DM.

Meanwhile, the DH also promotes, in collaboration with other government departments and community partners, a healthy lifestyle for prevention of non-communicable diseases by organising activities such as the EatSmart Restaurant Star+ campaign, the StartSmart@school.hk campaign, the EatSmart@school.hk campaign, and the 10,000 Steps a Day campaign. In addition, it was announced in the Chief Executive's 2024 Policy Address that health promotion strategies would be devised by adopting a life-course framework and the Whole School Health Programme of the DH would be strengthened. Such work would contribute to educating the public about the prevention of DM. The DH will continue to monitor the prevalence of DM and its risk factors in Hong Kong.

The Primary Healthcare Commission, on the other hand, focuses on health empowerment and promotion at the individual level, and promotes the Life Course Preventive Care Plan (LCPC Plan) through various DHCs. Based on the core principles of preventive-oriented and whole-person care, and with reference to the latest evidence, the LCPC Plan formulates personalised health plans for people at different life stages. In addition to giving advice on healthy diet and prescribing exercise, it also covers the prevention and management of chronic diseases such as DM, in order to enhance self-care awareness and improve personal health. The LCPC Plan recommends DM screening for persons aged 45 or above, and for others based on individual risk factors.

- End -

CONTROLLING OFFICER'S REPLY**HHB304****(Question Serial No. 3821)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (3) Subvention: Hospital AuthorityControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

Regarding the treatment of liver cancer, will the Government inform this Committee:

1. of the numbers of liver cancer patients diagnosed with hepatocellular carcinoma (HCC) and the numbers of patients who died of HCC in each of the past 3 years;
2. given that some of the drugs currently available in the Drug Formulary for treating liver cancer require gastro-intestinal endoscopy before their use due to bleeding risk, of the number of patients currently waiting for gastro-intestinal endoscopy, the median waiting time and the longest waiting time for it; and
3. whether it has assessed the cost-effectiveness of the latest treatment approach and studied its introduction; if yes, of the details; if not, the reasons for that.

Asked by: Hon LEUNG Hei, Edward (LegCo internal reference no.: 163)Reply:

1.

According to the information of the Hong Kong Cancer Registry, the numbers of cases diagnosed with hepatocellular carcinoma (HCC) from 2020 to 2022 are set out below:

Year	Number of new cases ^{Note 1}
2020	1 439
2021	1 439
2022	1 286

Note 1: The numbers of new cases for 2023 and 2024 are not yet available.

According to the information of the Centre for Health Protection of the Department of Health, the numbers of deaths from HCC from 2021 to 2023 are set out below:

Year	Number of deaths ^{Note 2}
2021	868
2022	849
2023	836

Note 2: The number of deaths for 2024 is not yet available.

2.

The Hospital Authority (HA) currently provides oesophago-gastro-duodenoscopy (commonly known as gastroscopy) and treatment as necessary and appropriate to liver cancer patients with clinical needs. In this regard, the HA generally arranges gastroscopy for liver cancer patients who need to receive drug treatment with Atezolizumab and Bevacizumab to reduce the risk of complications when receiving the relevant drug treatment. The HA does not maintain statistics on the waiting time and number of patients who are arranged to undergo gastroscopy for this reason. At present, the HA will arrange the relevant examination as soon as possible according to the patient's treatment need and schedule, and will, subject to the patient's condition, start treatment early during the waiting period for diagnosis to avoid delay.

3.

As the major provider of publicly funded public healthcare services, the HA is committed to providing appropriate treatment to all patients (including cancer patients) while ensuring patients have equitable access to cost-effective drugs of proven safety and efficacy under the highly subsidised public healthcare system.

On medical technology, the HA has in place an established mechanism to follow closely the development of medical technology under which experts regularly study and review treatment options for patients, as well as the latest development of clinical and scientific evidence of relevant technology. Moreover, the HA will consider the views of healthcare professionals and overseas development in planning for the introduction of medical technology. At the same time, the HA will take into account the availability of expertise, manpower and facilities. On drug management, the HA has mechanisms in place to regularly appraise new drugs and review the HA Drug Formulary (HADF) and the coverage of the safety net (including the Samaritan Fund and the Community Care Fund Medical Assistance Programmes). The review process follows an evidence-based approach, having regard to the principles of safety, efficacy and cost-effectiveness and other relevant factors including international recommendations and practices as well as views from professionals and patient groups. Evaluation of drugs is an on-going process which has to be driven by evolving medical evidence, the latest clinical developments and market dynamics.

The HA will continue to keep abreast of the latest development of cancer drugs and treatments, and review the clinical services through the established mechanisms, with a view

to ensuring that patients are provided with cost-effective drugs of proven safety and efficacy as well as optimal care on a continuous basis.

Besides, the Government and the HA will press ahead with the implementation of the fees and charges reform for public healthcare announced recently, which aims to guide the public to make optimal use of healthcare resources through 3 aspects, namely reforming the subsidisation structure, reducing wastage and abuse, and enhancing healthcare protection. It also seeks to strengthen the healthcare protection on all fronts for patients who are “poor, acute, serious or critical”. Such measures include enhancing the protection in terms of drugs and medical devices for critically ill patients (including cancer patients) through accelerating the introduction of more effective innovative drugs and devices to the HADF and the coverage of the safety net, with a view to ensuring that the limited healthcare resources can be directed in a more targeted manner to assist those patients most in need. This will thereby enhance the sustainability of the healthcare system and serve as a safety net for all.

- End -

CONTROLLING OFFICER'S REPLY

HHB305

(Question Serial No. 3524)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

In 2024/25, the Hospital Authority (HA) was staffed with over 93 000 employees, with 7 140 doctors, 13 dentists, 28 580 nurses and 10 050 allied health professionals. Regarding the establishment of nurses, will the Government inform this Committee of the following:

- (a) What is the distribution of nurses by ranks, including enrolled nurses, senior nurses, nursing officers and ward managers?
- (b) Has the HA set reference indicators/ratios for doctors and nurses in caring for in-patients? If so, what are the figures?
- (c) In what ways will the HA ensure that there will be sufficient nursing staff to care for in-patients in the future?
- (d) Apart from raising the salaries of existing nursing staff, does the HA have plans to consolidate overlapping job duties among different nursing ranks so as to release more nurses to provide frontline patient care?
- (e) Given the growth of establishment in the HA, has the Government considered increasing the financial provision for the HA to ensure that hospitals have sufficient financial support to cope with growing manpower demand? If yes, what is the additional provision involved?

Asked by: Hon LEUNG Tsz-wing, Dennis (LegCo internal reference no.: 53)

Reply:

(a)

The numbers of nursing staff on a full-time equivalent basis by rank group in 2024-25 (as at 31 December 2024) are set out in the table below⁽¹⁾⁽²⁾:

Rank Group	2024-25 (as at 31 December 2024)
DOM/NC/SNO and above ⁽³⁾	539
APN/NS/NO/WM/ANC ⁽⁴⁾	7 325
RN	18 867
EN/Others	2 807
Total	29 538

Note:

- (1) The above manpower figures are calculated on a full-time equivalent basis including permanent, contract and temporary staff in the Hospital Authority (HA). Individual figures may not add up to the total due to rounding.
- (2) Starting from January 2024, the full-time equivalent for temporary part-time staff is calculated based on their actual working hours. Relevant figures prior to that month are estimates for reference only and cannot be directly compared with the data under the revised compilation method.
- (3) Since August 2022, the “DMO/SNO and above” rank group has been revised to “DMO/NC/SNO and above”.
- (4) After the creation of the rank of Associate Nurse Consultant, the “APN/NS/NO/WM” rank group was revised to “APN/NS/NO/WM/ANC” in August 2022.

(b)

The HA adopts an integrated and multi-disciplinary approach in service provision which allows flexible deployment of staff to cope with service needs and operational requirements. As healthcare professionals supporting in-patient services in the HA also provide support for other services such as specialist out-patient services, the ratio of staff supporting in-patient services to in-patients cannot be separately quantified.

(c), (d) and (e)

Over the years, the HA has been closely monitoring its manpower situation and introduced a series of measures to attract, develop and retain talents. The HA has implemented ongoing measures within its overall budget including increasing the number of Resident Trainee posts to recruit local medical graduates, recruiting non-locally trained doctors to supplement local recruitment, improving promotion prospects to retain staff, hiring part-time healthcare staff (e.g. recruitment of locum staff), offering flexible full-time work arrangements, extending employment to suitable staff beyond retirement, enhancing the Home Loan Interest Subsidy Scheme, and providing better training opportunities for various grades by establishment of the HA Academy. The above measures have begun to bear fruits, as evidenced by an increase in the number of the HA’s healthcare staff in the past 2 years and a fall in attrition rate from the peak over the past 2 years.

In December 2019, the HA established the Task Group (TG) on Sustainability to review strategies including those for retaining staff. In line with the key directions recommended

by the TG, the HA gradually rolled out further staff retention measures in 2023-24 and will continue with the relevant work in 2025-26, including:

- (a) creating opportunities for Associate Consultants (AC) to be promoted to Consultant rank, with 400 AC posts upgraded to Consultant posts as at December 2024, so as to retain experienced medical personnel to address the service, manpower and training needs in the HA;
- (b) providing Specialty Nurse Allowance to eligible registered nurses, with around 4 800 nurses receiving the allowance as at December 2024, so as to retain manpower and encourage professional development of nurses through recognising their specialty qualifications;
- (c) enhancing promotion opportunities of allied health professionals and offering Specialist Allied Health Professionals Allowance to eligible resident physiotherapists, occupational therapists and radiographers, with about 66 applications received as at December 2024, so as to retain manpower and support specialist service needs and development; and
- (d) continuing to implement the policy of Extending Employment Beyond Retirement to attract more retired staff who wish to stay after retirement. As at December 2024, there were 181 doctors, 565 nurses, 113 allied health professionals and 3 020 supporting/other grades staff working at the HA after retirement. Among all doctors/nurses/allied health professionals retiring from 2024-25 to 2028-29, at least 338 doctors, 880 nurses and 200 allied health professionals had indicated interest/agreed to take up full-time or part-time employment after retirement.

The additional financial provision for the above 4 measures is around \$161 million in 2025-26. The HA will continue to closely monitor the manpower situation and actively adopt measures to attract, develop and retain talents for supporting the overall service demand and development in the HA.

Abbreviations

DMO/NC/SNO – Department Operations Managers/Nurse Consultants/Senior Nursing Officers

APN/NS/NO/WM/ANC – Advanced Practice Nurses/Nurse Specialists/Nursing Officers/Ward Managers/Associate Nurse Consultants

RN – Registered Nurses

EN – Enrolled Nurses

- End -

CONTROLLING OFFICER'S REPLY**HHB306****(Question Serial No. 3657)**Head: (140) Government Secretariat: Health BureauSubhead (No. & title): ()Programme: (2) HealthControlling Officer: Permanent Secretary for Health (Thomas CHAN)Director of Bureau: Secretary for HealthQuestion:

The Government had compiled statistics and published figures on dementia in the past. However, no such surveys were conducted and published in recent years. Therefore, an enquiry about the figures on the people with dementia in the past 5 years is made as follows: Please provide the numbers of patients with dementia and their age distribution in the past 5 years.

Asked by: Hon TIK Chi-yuen (LegCo internal reference no.: 185)Reply:

The table below sets out the numbers of dementia patients receiving treatment under the Hospital Authority (HA) by age group from 2020 to 2024.

Year	Total ^{1,3}	Age Group ²	
		Below 65 ¹	65 or above ¹
2020	79 400	7 400	72 100
2021	82 200	8 000	74 200
2022	84 100	8 400	75 700
2023	83 900	8 700	75 100
2024 ⁴	85 500	8 600	77 000

Figures updated in January 2025

Note:

- Figures are rounded to the nearest hundred.
- Referring to the age of the patient as of 30 June of the respective year.
- Individual figures may not add up to the total due to rounding and the inclusion of patients of unknown age.
- Figures for 2024 are estimates.

Remark:

In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA adjusted its services to cope with the outbreak. This should therefore be taken into consideration

when comparing the service capacity of the HA in the respective years. With the subsiding of local COVID-19 epidemic situation and cessation of anti-epidemic measures in early 2023, the HA has been gradually resuming provision of all of its public healthcare services to tie in with the Government's normalcy measures.

- End -

CONTROLLING OFFICER'S REPLY

HHB307

(Question Serial No. 3673)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Please provide the following figures in respect of Siu Lam Hospital for the past 3 years:

1. the number of new applicants and the total number of applicants on the waiting list by gender and district of residence;
2. the number of inpatients, their average waiting time and the current longest waiting time by gender;
3. the staffing establishment and the unit cost per patient;
4. the number of people who applied to have their placements put on hold and the number of those who declined offers by gender; and
5. the numbers of rejected applicants and users of respite service by quarter, age (with each age group covering 10 years starting from the age of 16) and district of residence.

Asked by: Hon TIK Chi-yuen (LegCo internal reference no.: 201)

Reply:

Siu Lam Hospital (SLH) of the Hospital Authority (HA) provides territory-wide infirmary and rehabilitation inpatient services for adults with severe and profound intellectual disability.

(1), (2) & (4)

The table below sets out the number of patients with severe and profound intellectual disability on the central waiting list (active cases), the number of new applications and number of withdrawals/ineligible applications, the number of patients with severe and profound intellectual disability on the central waiting list (inactive cases), the number of admissions, and the median and 90th percentile waiting time for the infirmary and rehabilitation inpatient services in SLH for the past 3 financial years.

	2022-23		2023-24		2024-25 (up to 31 December 2024) [Provisional figures]	
	Male	Female	Male	Female	Male	Female
Number of patients on central waiting list (active cases)	8	9	2	1	0	0
Number of new applications	10	6	14	5	10	13
Number of withdrawals/ineligible applications	2	1	3	0	0	1
Number of patients on central waiting list (inactive cases)	19	7	21	7	22	9
Number of admissions*	277	199	344	252	224	159
Median waiting time (months)	6.3		4.7		0	
90th percentile waiting time (months)#	15.67		15.50		0.06	

Note:

* Including patients admitted from other non-psychiatric hospitals after treatment of physical problems.

The HA uses the 90th percentile to denote the longest waiting time.

The HA does not maintain statistics on the applicants' districts of residence.

(3)

SLH, which is part of the New Territories West Cluster (NTWC) of the HA, provides infirmary and rehabilitation services for adult patients with severe and profound intellectual disability through an integrated and multi-professional approach involving psychiatric doctors, psychiatric nurses, clinical psychologists, occupational therapists and medical social workers, etc. The adoption of a multi-professional team approach allows flexible deployment of manpower to cope with service needs and operational requirements. As the healthcare professionals usually provide support for a variety of psychiatric services within the cluster, the breakdown on the manpower for supporting psychiatric services of SLH cannot be separately quantified.

The table below sets out the number of psychiatric doctors, psychiatric nurses, clinical psychologists and occupational therapists working in the psychiatric stream in the NTWC in the past 3 financial years.

Financial Year	Psychiatric Doctors ^{1,2,3}	Psychiatric Nurses ^{1,2,4} (including Community Psychiatric Nurses)	Allied Health Professionals	
			Clinical Psychologists ^{1,5}	Occupational Therapists ^{1,5}

2022-23	81	763	17	51
2023-24	88	772	17	58
2024-25 (as of 31 December 2024)	92	788	17	65

Note:

1. The manpower figures above are calculated on full-time equivalent (FTE) basis including permanent, contract and temporary staff in all HA clusters, but excluding those in the HA Head Office.
2. FTE for temporary part-time staff is calculated based on their actual working hours starting from January 2024. The relevant figures prior to that month are for reference only and cannot be directly compared with the current revised calculation.
3. Psychiatric doctors refer to all doctors working for the specialty of psychiatry except interns.
4. Psychiatric nurses include all nurses working in psychiatric hospitals (i.e. Castle Peak Hospital and SLH), nurses working in psychiatric departments of other non-psychiatric hospitals, as well as all nurses in the psychiatric stream.
5. Clinical psychologists and occupational therapists working in the psychiatric stream include those working in psychiatric hospitals (i.e. Castle Peak Hospital and SLH), those working in psychiatric departments of other non-psychiatric hospitals, as well as those engaging in psychiatric-related work.

The table below sets out the average cost of each inpatient per patient day in the mentally handicapped service in SLH from 2022-23 to 2023-24. Since the 2024-25 financial year has yet to end and related costing report is not yet completed, the corresponding cost information is not available.

	2022-23	2023-24
Average cost of each inpatient per patient day (\$)	2,270	2,250

The cost of inpatient services includes direct staff costs (such as doctors, nurses and allied health staff) for providing services to patients, expenditure incurred for various clinical support services (such as pharmacy), and other operating costs (such as meals for patients, utility expenses, as well as repair and maintenance of medical equipment). The average cost per patient day represents an average of the total cost of the respective inpatient services and the corresponding activities (in terms of patient days) provided.

(5)

The table below sets out the number of patients on the central waiting list who have received time-limited respite services in SLH in the past 3 financial years. The HA does not have a breakdown by district of residence.

	2022-23	2023-24	2024-25 (up to 31 December 2024) [Provisional figures]

Age group/gender	0	Aged above 18/ female	Aged above 18/ male
Number of patients who have received respite care		1	3

No patient application for respite services in SLH was rejected in the past 3 financial years.

Remark:

In view of the COVID-19 epidemic outbreak in Hong Kong in early 2020, the HA adjusted its services to cope with the outbreak. This should be taken into consideration when comparing the service capacity of the HA in the respective years. With the subsiding of local COVID-19 epidemic situation and cessation of anti-epidemic measures in early 2023, the HA has been gradually resuming provision of all of its public healthcare services to tie in with the Government's normalcy measures. As the costing information for 2022-23 has reflected the impact of the epidemic outbreak on unit costs (if any), the costing information for different years may not be directly comparable.

- End -

CONTROLLING OFFICER'S REPLY

HHB308

(Question Serial No. 3674)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Please provide this Committee with the following information for the past 3 years:

- (1) the numbers of vehicles used for Non-emergency Ambulance Transfer Service (NEATS) in each hospital and cluster under the Hospital Authority, and the staff establishment and staff vacancy situation of NEATS; and
- (2) the respective numbers of patients in each hospital who used NEATS for follow-up appointments or for discharge from hospital, the usage rates of NEATS and the number of people whose requests for NEATS were rejected.

Asked by: Hon TIK Chi-yuen (LegCo internal reference no.: 202)

Reply:

(1)

The non-emergency ambulance transfer service (NEATS) of the Hospital Authority (HA) provides point-to-point transfer service primarily for patients who are unable to use public transport (such as bus, taxi and Rehabus) due to mobility disability or mental/sensory impairment. The clinical conditions of the patients using this service should meet certain criteria, such as being bed-ridden or requiring constant oxygen supply. Patients who are assessed by clinical staff to be eligible for the service may use it for hospital admission, transfer, discharge, medical follow-ups, etc, and generally such requests will not be rejected. Eligible patients can make booking for the NEATS on a first-come-first-served basis. The HA will schedule the vehicles and make appropriate arrangements to meet patients' needs as far as possible.

The HA all along assesses its manpower and vehicle requirements from time to time, and flexibly deploys its resources having regard to the service and operational needs. The numbers of non-emergency ambulances and staff involved in the HA's NEATS calculated on a full-time equivalent basis ⁽¹⁾ from 2022-23 to 2024-25 (as at 31 December 2024) are set out in the table below.

Financial year	No. of non-emergency ambulances	No. of staff calculated on a full-time equivalent basis
2022-23	276	981
2023-24 ⁽²⁾	284	1 041
2024-25 ⁽²⁾ (as at 31 December 2024)	294	1 107

Note:

- (1) The manpower figures above are calculated on a full-time equivalent basis including permanent, contract and temporary staff in the HA.
- (2) Starting from January 2024, the full-time equivalent for temporary part-time staff is calculated based on their actual working hours. Relevant figures prior to that month are estimates for reference only, and cannot be directly compared with the data under the revised compilation method.

(2)

The usage rates of the NEATS vary among clusters and hospitals. The table below sets out the numbers of patient trips served by the NEATS for out-patients attending appointments (including those for specialist out-patient clinics and day rehabilitation services) and discharged patients in the past 3 years:

Year	No. of patient trips served for out-patients	No. of patient trips served for discharged patients
2022-23 (Note)	181 180	224 690
2023-24	250 618	250 086
2024-25	265 555 (Projection as at 31 December 2024)	262 300 (Projection as at 31 December 2024)

Note:

In view of the emergence of the COVID-19 epidemic in Hong Kong in early 2020, the HA adjusted its services in response to the epidemic. This should be taken into account when comparing the throughput of services provided by the HA across the years. With the cessation of anti-epidemic measures in early 2023, the HA's services have gradually returned to normalcy.

- End -

CONTROLLING OFFICER'S REPLY

HHB309

(Question Serial No. 3676)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (2) Health

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Please set out in table form the actual number of appointment, attrition and vacancies in each cluster under the Hospital Authority in each of the past 3 years for the following:

- 1) doctors;
- 2) nurses;
- 3) occupational therapists;
- 4) physiotherapists;
- 5) speech therapists;
- 6) pharmacists;
- 7) medical social workers;
- 8) health care assistants;
- 9) ward attendants;
- 10) patient care assistants;
- 11) radiographers; and
- 12) medical technologists/medical laboratory technicians.

Asked by: Hon TIK Chi-yuen (LegCo internal reference no.: 204)

Reply:

The Hospital Authority (HA) delivers healthcare services through a multi-disciplinary team approach involving doctors, nursing staff, allied health professionals and care-related support staff. The HA Head Office works together with human resources departments of various clusters to co-ordinate the recruitment and selection of healthcare professionals, and regularly monitors the manpower situation in various clusters to flexibly deploy its staff in order to meet service and operational needs.

The table below sets out the intake and attrition (wastage) numbers of doctors, nursing staff, allied health professionals and care-related support staff from 2021-22 to 2024-25 (April – December 2024) ⁽¹⁾⁽²⁾⁽³⁾:

Staff Group / Major Grade		2021-22			2022-23			2023-24 ⁽⁴⁾⁽⁵⁾			2024-25 (April to December 2024) ⁽⁴⁾⁽⁵⁾		
		Intake Number	Attrition (Wastage) Number		Intake Number	Attrition (Wastage) Number		Intake Number	Attrition (Wastage) Number		Intake Number	Attrition (Wastage) Number	
			FT	PT		FT	PT		FT	PT		FT	PT
Doctors ⁽⁶⁾		555	510	67	582	436	50	663	340	43	672	244	34
Nurses		2 559	2 573	82	2 506	2 940	51	2 534	2 190	36	2 374	1 502	35
Allied Health Professionals	Medical Laboratory Technologist	175	113	1	164	151	2	162	107	1	152	66	2
	Radiographer (Diagnostic Radiographer & Radiation Therapist)	77	107	1	95	96	1	74	61	1	87	39	0
	Social Worker	56	39	4	53	35	9	69	39	3	26	27	0
	Occupational Therapist	123	107	1	134	119	3	139	96	1	109	62	2
	Physiotherapist	125	169	1	186	152	1	217	142	3	226	92	1
	Pharmacist ⁽⁷⁾	54	37	0	79	37	0	64	36	1	59	27	0
	Speech Therapist	20	11	1	14	11	0	11	10	1	22	16	0
Care-related Support Staff ⁽⁸⁾		3 052	2 539	13	2 663	2 630	15	2 646	2 366	16	2 057	1 663	12

Note:

- (1) Intake refers to the total number of permanent and contract staff joining the HA on headcount basis during the period. Transfer, promotion and staff movement within the HA are not regarded as Intake.
- (2) Intake number of Doctors includes number of Interns appointed as Residents.
- (3) Attrition (Wastage) on headcount basis includes all types of cessation of service from the HA (including retirement) for permanent and contract staff. Temporary staff such as Pharmacy Interns and Trainee Nurses are not included.
- (4) Attrition (wastage) excludes the number of staff under the arrangement of Extending Employment Beyond Retirement (EER) starting from January 2024. The figures prior to this month are for reference only and cannot be directly compared with those under the current revised compilation method.
- (5) Intake excludes the number of staff under the arrangement of EER starting from January 2024. The figures prior to this month are for reference only and cannot be directly compared with those under the current revised compilation method.
- (6) Doctors exclude Interns and Dental Officers.
- (7) The number of Pharmacists includes Resident Pharmacists.
- (8) "Care-related support staff" include health care assistants, ward attendants and patient care assistants, etc. Supporting jobs in the HA are generally grouped into 3 job streams, namely Patient Support, Operation Support and Executive Support, and the job incumbents are mainly hired as patient care assistants, operation assistants and executive assistants respectively.

The number of doctors, nurses, allied health professionals and care-related support staff on full-time equivalent (FTE) basis in various clusters from 2021-22 to 2024-25 (as at 31 December 2024) is tabulated as follows:

Cluster	Staff Group / Major Grade		2021-22 (As at 31.3.2022)	2022-23 (As at 31.3.2023)	2023-24 (As at 31.3.2024) (2)	2024-25 (As at 31.12.2024) (2)
HKEC	Doctors ⁽³⁾		653	651	683	735
	Nurses ⁽⁴⁾		3 045	3 018	3 031	3 067
	Allied Health Professionals	Medical Laboratory Technologist	143	143	145	154
		Radiographer (Diagnostic Radiographer & Radiation Therapist)	125	126	133	147
		Social Worker	49	50	56	58
		Occupational Therapist	98	98	109	112
		Physiotherapist	128	144	153	163
		Pharmacist ⁽⁵⁾	87	89	90	96
		Speech Therapist	17	17	17	18
	Care-related Support Staff ⁽⁶⁾		1 852	1 833	1 795	1 862
HKWC	Doctors ⁽³⁾		662	666	687	749
	Nurses ⁽⁴⁾		2 974	2 899	2 869	2 924
	Allied Health Professionals	Medical Laboratory Technologist	263	262	269	283
		Radiographer (Diagnostic Radiographer & Radiation Therapist)	133	130	135	137
		Social Worker	55	55	62	59
		Occupational Therapist	94	93	97	95
		Physiotherapist	116	119	126	134
		Pharmacist ⁽⁵⁾	76	82	88	91
		Speech Therapist	17	18	19	19
	Care-related Support Staff ⁽⁶⁾		1 417	1 398	1 391	1 406
KCC	Doctors ⁽³⁾		1 351	1 383	1 461	1 522
	Nurses ⁽⁴⁾		6 228	6 184	5 725	5 970
	Allied Health Professionals	Medical Laboratory Technologist	466	467	492	504
		Radiographer (Diagnostic Radiographer & Radiation Therapist)	252	248	245	255
		Social Worker	89	93	97	95
		Occupational Therapist	165	176	175	181
		Physiotherapist	259	259	274	297
		Pharmacist ⁽⁵⁾	151	158	164	169
		Speech Therapist	24	26	24	26
	Care-related Support Staff ⁽⁶⁾		3 655	3 710	3 753	3 839
KEC	Doctors ⁽³⁾		767	796	815	857
	Nurses ⁽⁴⁾		3 505	3 562	3 548	3 599
	Allied Health Professionals	Medical Laboratory Technologist	179	177	190	196
		Radiographer (Diagnostic Radiographer & Radiation Therapist)	112	112	113	117

Cluster	Staff Group / Major Grade		2021-22 (As at 31.3.2022)	2022-23 (As at 31.3.2023)	2023-24 (As at 31.3.2024) (2)	2024-25 (As at 31.12.2024) (2)
		Social Worker	58	57	65	67
		Occupational Therapist	113	115	119	123
		Physiotherapist	160	165	173	190
		Pharmacist ⁽⁵⁾	79	85	90	94
		Speech Therapist	17	16	17	18
		Care-related Support Staff ⁽⁶⁾		2 058	2 101	2 183
KWC	Doctors ⁽³⁾		1 099	1 110	1 146	1 190
	Nurses ⁽⁴⁾		5 044	5 038	4 838	4 994
	Allied Health Professionals	Medical Laboratory Technologist	249	253	259	273
		Radiographer (Diagnostic Radiographer & Radiation Therapist)	192	196	197	201
		Social Worker	67	72	69	68
		Occupational Therapist	205	200	214	224
		Physiotherapist	171	181	201	213
		Pharmacist ⁽⁵⁾	132	140	145	152
		Speech Therapist	21	21	22	23
		Care-related Support Staff ⁽⁶⁾		2 848	2 818	2 934
NTEC	Doctors ⁽³⁾		1 039	1 045	1 072	1 139
	Nurses ⁽⁴⁾		4 863	4 865	4 744	4 808
	Allied Health Professionals	Medical Laboratory Technologist	294	300	308	322
		Radiographer (Diagnostic Radiographer & Radiation Therapist)	208	210	214	237
		Social Worker	39	42	47	48
		Occupational Therapist	166	171	181	191
		Physiotherapist	215	211	241	262
		Pharmacist ⁽⁵⁾	117	119	123	129
		Speech Therapist	22	22	22	24
		Care-related Support Staff ⁽⁶⁾		3 068	3 107	3 240
NTWC	Doctors ⁽³⁾		874	881	928	977
	Nurses ⁽⁴⁾		4 029	3 992	4 071	4 138
	Allied Health Professionals	Medical Laboratory Technologist	199	203	216	224
		Radiographer (Diagnostic Radiographer & Radiation Therapist)	166	173	178	177
		Social Worker	42	42	48	49
		Occupational Therapist	141	142	148	157
		Physiotherapist	153	162	173	194
		Pharmacist ⁽⁵⁾	98	101	107	111
		Speech Therapist	25	26	23	24
	Care-related Support Staff ⁽⁶⁾		2 989	3 026	3 080	3 124

Note:

- (1) The manpower figures are calculated on FTE basis including permanent, contract and temporary staff in the HA.
- (2) Starting from January 2024, FTE for temporary part-time staff is calculated based on their actual working hours. The related figures before January 2024 are for reference only and cannot be directly compared with those under the revised compilation method.
- (3) Doctors exclude Interns and Dental Officers.
- (4) The number of nurses includes senior nursing officers, department operations managers, nurse consultants, associate nurse consultants, ward managers, nursing officers, advanced practice nurses, registered nurses, enrolled nurses and nursing trainees, etc.
- (5) The number of Pharmacists includes Resident Pharmacists.
- (6) “Care-related support staff” include health care assistants, ward attendants, patient care assistants. Supporting jobs in the HA are generally grouped into 3 job streams, namely Patient Support, Operation Support and Executive Support, and the job incumbents are mainly hired as patient care assistants, operation assistants and executive assistants respectively.

Abbreviations

HKEC – Hong Kong East Cluster
HKWC – Hong Kong West Cluster
KCC – Kowloon Central Cluster
KEC – Kowloon East Cluster
KWC – Kowloon West Cluster
NTEC – New Territories East Cluster
NTWC – New Territories West Cluster
FT – Full-time
PT – Part-time

- End -

CONTROLLING OFFICER'S REPLY

HHB310

(Question Serial No. 3750)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

Sexual violence causes severe physical and psychological harm to victims, and traditional procedures for handling sexual violence cases often require victims to recount the experience repeatedly at different locations, which may result in secondary trauma. The Legislative Council (LegCo) passed a motion at its meeting on 12 December 2018 urging the Government to allocate additional resources for the Hospital Authority (HA) to set up a crisis support centre in a public hospital on Hong Kong Island, in Kowloon and in the New Territories respectively. Please provide the following information:

- (1) the respective number of persons, who claimed to have been raped or indecently assaulted, receiving diagnosis and treatment at the accident and emergency departments of public hospitals each year during the period from 2019 to 2024; among such persons, the number of those who had their statements taken and who underwent forensic examinations in the same hospital, as well as the number of those who went through only one of these two procedures and the reasons for that; if such information is unavailable, whether it will compile the statistics;
- (2) the respective number of persons, who claimed to have been raped or indecently assaulted, receiving diagnosis and treatment, having their statements taken and undergoing forensic examinations in (i) the designated rooms and (ii) other places of public hospitals each year during the period from 2019 to 2024, and the reasons why these procedures were not conducted in the designated rooms; if such information is unavailable, whether it will compile the statistics; and
- (3) given that the LegCo passed a motion at its meeting on 12 December 2018 urging the Government to allocate additional resources for the HA to set up a crisis support centre in a public hospital on Hong Kong Island, in Kowloon and in the New Territories respectively, the details and the latest progress of the follow-up work, including site selection, funding arrangements and the timetable for public consultation.

Asked by: Hon TIK Chi-yuen (LegCo internal reference no.: 42)

Reply:

(1) to (3)

Currently, the Hospital Authority (HA) has set up designated multi-purpose rooms in each of the 18 public hospitals providing Accident and Emergency (A&E) services across the territory for timely provision of “one-stop” service to victims of sexual violence in a safe, confidential and supportive manner. To ensure that relevant healthcare and professional staff are familiar with the procedures of the “one-stop” service for better co-ordination, the Social Welfare Department, the HA and relevant departments such as the Hong Kong Police Force would co-organise drills on a regular basis to enhance the capabilities of frontline healthcare staff in handling cases of sexual violence through practice and scenario sharing. These training exercises include not only experience sharing but also emphasise on scenario simulation to ensure that healthcare staff can make appropriate responses in a prompt and effective manner when faced with real cases, thereby enhancing their ability and sensitivity in handling such cases. Under the “one-stop” service model, and with the victim’s consent, the Police would as far as practicable arrange for statement-taking and forensic examination to be conducted in the same public hospital where the victim receives treatment to prevent long travel journeys and to expedite the investigation process. The victim may also choose to be accompanied by other person(s) of their personal preference when attending interviews by the Police and forensic examination.

The A&E departments provide timely and appropriate emergency services to patients who require urgent medical attention for different reasons. At present, the A&E departments do not collect data on the use of designated rooms for individual purposes or by patients/persons of different categories. While the HA has been co-operating with other professions and law enforcement departments, it does not keep statistics on the number of rape and indecent assault cases in which the victims were treated or examined at the A&E departments of public hospitals, and the number of statements taken and forensic examinations conducted by the Police. The HA also does not keep statistics on cases of sexual violence or other cases in its medical system.

The HA will continue to dovetail with the Government’s policy direction on crisis support for sexual violence victims as appropriate, and explore measures, including their feasibility, to provide them with more optimal support in public hospitals. If needed, the HA could actively study the provision and enhancement of relevant rooms or facilities in newly constructed or renovated hospitals for patients in need, including sexual violence victims, in its long-term planning.

- End -

CONTROLLING OFFICER'S REPLY

HHB311

(Question Serial No. 3860)

Head: (140) Government Secretariat: Health Bureau

Subhead (No. & title): ()

Programme: (3) Subvention: Hospital Authority

Controlling Officer: Permanent Secretary for Health (Thomas CHAN)

Director of Bureau: Secretary for Health

Question:

It is stated in the Budget that a third medical school will be built. What is the breakdown of the estimated expenditure for each medical graduate (including but not limited to the spending on internship and course, etc.)?

Asked by: Hon TIK Chi-yuen (LegCo internal reference no.: 256)

Reply:

The Task Group on New Medical School (Task Group) has received a total of 3 proposals for the establishment of the third medical school before the submission deadline of 17 March 2025, which are submitted by Hong Kong Baptist University, the Hong Kong Polytechnic University, and the Hong Kong University of Science and Technology. The Task Group will proceed to the next stage of work to evaluate proposals according to the devised parameters. The Task Group will adopt a holistic and comprehensive approach for evaluating the proposals submitted by universities from various perspectives, in accordance with the 10 key parameters set.

The 2025-26 Budget announced that the Government will set aside resources to support universities in the development of the new medical school on a matching basis. The Government will assess the public expenditure involved in the introduction of new medical programmes, taking into account the specific proposals in the recommended proposal and the advice of the Task Group. The 2025-26 Estimates does not include the expenditure for the introduction of new medical programmes.

- End -

CONTROLLING OFFICER'S REPLY

HHB312

(Question Serial No. 3397)

Head: (37) Department of Health

Subhead (No. & title): (000) Operational Expenses

Programme: (1) Statutory Functions

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Regarding tobacco and alcohol control in Hong Kong, will the Government advise this Committee on:

1. the manpower of the Tobacco and Alcohol Control Office (TACO) of the Department of Health (DH) responsible for prosecution against smoking offences and the expenditure incurred in the past 5 years;
2. the number of fixed penalty notices issued by the DH's TACO in respect of smoking offences in each of the past 5 years; and
3. whether the Government has reviewed the effectiveness of prosecution against smoking offences; and the ways to enhance its prosecution efficiency?

Asked by: Hon CHAN Hak-kan (LegCo internal reference no.: 61)

Reply:

1.

The Tobacco and Alcohol Control Office (TACO) of the Department of Health (DH) is the principal enforcement agency for the Smoking (Public Health) Ordinance (Cap. 371) and the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600). The TACO will conduct inspections and investigation in response to smoking and related complaints. In general, the TACO will issue fixed penalty notices (FPNs) to smoking offenders without warning. Apart from smoking offences, the TACO also issued summonses for offences under Cap. 371 (including aiding and abetting smoking offences, offences relating to smoking product advertisements, the promotion, manufacture, sale, or possession for commercial purposes of alternative smoking products (ASPs), obstruction of inspectors, etc.), and for the offence of importing ASPs under the Import and Export Ordinance (Cap. 60).

The expenditure on and provision/revised estimate for tobacco control initiatives taken forward by the TACO, as well as the approved establishment of the TACO from 2020-21 to 2024-25 are at **Annex 1 and Annex 2** respectively.

2. & 3.

Under the Smoking (Public Health) Ordinance (Cap. 371) and the Fixed Penalty (Smoking Offences) Ordinance (Cap. 600), any person who does a smoking act in a statutory no smoking area commits an offence and is subject to a fixed penalty of \$1,500. The TACO issued 6 587, 7 703, 6 296, 10 261 and 13 488 FPNs in each of the years between 2020 and 2024 to smoking offenders. To effectively mitigate the impact of passive smoking on the public and enhance the deterrent effect against illegal smoking, new enforcement strategies have been adopted since 2023, including extension of the time of surveillance and inspections in no smoking areas, deploying plain-clothes officers to take proactive enforcement actions, strengthening enforcement action in venues (such as bars and food premises) where waterpipes were offered for smoking, as well as prosecuting people aiding and abetting illegal smoking. The number of prosecutions against illegal smoking has surged due to the new enforcement strategies, reflecting their enhanced effectiveness.

The Government will continue to step up its work on smoking cessation and explore various tobacco control measures in the medium and long term in order to eliminate the social hazards posed by tobacco products in all aspects and safeguard the health of the community with a progressive and multi-pronged approach.

Expenditure on/provision for
the Department of Health's Tobacco and Alcohol Control Office

	2020-21 (\$ million)	2021-22 (\$ million)	2022-23 (\$ million)	2023-24 (\$ million)	2024-25 Revised Estimate (\$ million)
<u>Enforcement</u>					
Programme 1: Statutory Functions	102.2	101.3	100.4	123.3	167.4
<u>Health Education and Smoking Cessation</u>					
Programme 3: Health Promotion	141.2	138.9	149.0	151.4	170.5
<u>(a) General Health Education and Promotion of Smoking Cessation</u>					
TACO	64.5	62.8	73.0	83.7	88.2
Subvention to Hong Kong Council on Smoking and Health (COSH)	26.0	26.2	26.8	26.6	27.9
<i>Sub-total</i>	<u>90.5</u>	<u>89.0</u>	<u>99.8</u>	<u>110.3</u>	<u>116.1</u>
<u>(b) Expenditure on/Provision for Smoking Cessation and Related Services by Non-Governmental Organisations</u>					
Subvention to Tung Wah Group of Hospitals	30.6	30.8	29.4	10.2	14.0
Subvention to Pok Oi Hospital	7.4	7.5	7.6	14.8	17.9
Subvention to Po Leung Kuk	1.7	0.7	-	-	-
Subvention to Lok Sin Tong	3.0	3.2	3.3	3.6	3.6
Subvention to United Christian Nethersole Community Health Service	4.4	4.9	5.8	6.1	8.9
Subvention to Life Education Activity Programme	2.7	2.8	2.8	2.9	3.0
Subvention to Christian Family Service Centre	-	-	-	3.5	7.0
Subvention to The University of Hong Kong	0.9	-	0.3	-	-
<i>Sub-total</i>	<u>50.7</u>	<u>49.9</u>	<u>49.2</u>	<u>41.1</u>	<u>54.4</u>
Total	<u>243.4</u>	<u>240.2</u>	<u>249.4</u>	<u>274.7</u>	<u>337.9</u>

Approved Establishment of
the Department of Health's Tobacco and Alcohol Control Office

Rank	No. of staff from 2020-2021 to 2024-25
<u>Head, TACO</u>	
Consultant	1
<u>Enforcement</u>	
Senior Medical & Health Officer	1
Medical & Health Officer	1
Scientific Officer (Medical)	1
Land Surveyor	1
Police Officer	5
Overseer/Senior Foreman/Foreman	125
Senior Executive Officer/Executive Officer	13
<i>Sub-total</i>	<u>147</u>
<u>Health Education and Smoking Cessation</u>	
Senior Medical & Health Officer	1
Medical & Health Officer	1
Scientific Officer (Medical)	2
Nursing Officer/Registered Nurse	3
Hospital Administrator II	4
<i>Sub-total</i>	<u>11</u>
<u>Administrative and General Support</u>	
Senior Executive Officer/Executive Officer	4
Clerical and support staff	19
Motor Driver	1
<i>Sub-total</i>	<u>24</u>
Total	<u>183</u>

- End -

CONTROLLING OFFICER'S REPLY

HHB313

(Question Serial No. 3940)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Regarding the School Dental Care Service, will the Government please inform this Committee of:

1. the manpower figures of the school dental clinics, the expenditure involved, and the number of students benefiting from the programme in each of the past 3 years?

Asked by: Hon CHAN Hak-kan (LegCo internal reference no.: 55)

Reply:

To safeguard the oral health of the public, the Chief Executive announced in the 2022 Policy Address to conduct a comprehensive review of the dental services provided or subsidised by the Government. The Working Group on Oral Health and Dental Care (Working Group) was subsequently established in end-2022. The Working Group published a final report in end-2024, recommending that the future development of dental services should make reference to the direction of the Primary Healthcare Blueprint emphasising prevention, early identification and timely intervention, with the goal of retention of natural teeth and enhancing the overall level of citizens' oral health.

The Government concurs with the views of the Working Group that providing or subsidising comprehensive curative dental services from public purse to all Hong Kong citizens regardless of their financial means does not align with the policy objectives of developing a prevention-oriented oral health and dental care system and encouraging citizens to take responsibility for their own oral health. This would exacerbate the current shortcomings of the treatment-oriented system, and would be neither cost-effective nor sustainable in terms of utilisation of public resources. It would be financially untenable for the Government and would thin out the resources that could otherwise be used for other healthcare services.

In response to the final report of the Working Group, the Government has adopted the oral health policy that: (1) Oral health is an integral component of general health. The Government's oral health policy aims to enable all Hong Kong citizens to improve their oral hygiene and lifestyle conducive to both oral and overall health levels; (2) Through publicity, education, promotion and development of primary oral health and dental care, the

Government facilitates citizens to manage their oral health, and put prevention, early identification and timely intervention of dental diseases into action with the objective of tooth retention; and (3) The Government provides appropriate oral health and dental care services targeting underprivileged groups with financial difficulties and special needs, ensuring these groups have access to essential dental care services.

In the Oral Health Action Plan formulated based on the Working Group's strategic recommendations, the School Dental Care Service (SDCS) is rolled out to actively develop prevention-oriented primary oral healthcare according to the strategy of community-wide preventive primary oral health care. The service scope and expenditure of the DH's SDCS are outlined below.

The Government focuses particularly on nurturing good oral hygiene habits from an early age including providing the SDCS to children. Primary school students in Hong Kong, as well as students aged under 18 with intellectual disability and/or physical disability studying in special schools, can join the SDCS of the DH to receive annual check-ups at designated school dental clinics, which cover oral examination as well as basic restorative and preventive treatment.

The staff establishment and expenditure of the SDCS and the number of students benefitting from the SDCS in 2022-23, 2023-24 and 2024-25 are set out below:

Grade	2022-23	2023-24	2024-25 (as at 1 February 2025)
Dental Officer	32	32	32
Dental Therapist	269	269	269
Dental Surgery Assistant	42	42	42
Administrative and Clerical Staff	57	57	57
Supporting Staff	27	27	27
Total:	427	427	427

Financial Year	2022-23 (Actual)	2023-24 (Actual)	2024-25 (Revised Estimate)
Annual Expenditure (\$ million)	276.2	281.6	281.1

Service Year [@]	2022-23	2023-24	2024-25
Number of Primary School Students	313 500	313 700	307 600

Participating in the SDCS			
Percentage of the Total Number of Primary School Students in Hong Kong	94%	98%	97%

@ A service year refers to the period from 1 November of the current year to 31 October of the following year.

- End -

CONTROLLING OFFICER'S REPLY

HHB314

(Question Serial No. 3419)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (1) Statutory Functions, (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

It is learnt that the Department of Health (DH) prevents and controls importation and spread of infectious diseases through port health measures. Please then advise on:

1. the staff establishment, actual number of staff and expenditure of the DH for setting up quarantine clearance at boundary various control points (BCPs) in the past 3 years, with a detailed breakdown by each BCP; and
2. the number of inbound travellers identified to be suffering from statutorily notifiable infectious diseases by the staff of the DH's Port Health Division during quarantine clearance at various BCPs in the past 3 years, with a detailed breakdown by type and number of infectious diseases at each BCP.

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 28)

Reply:

In accordance with the power conferred by the Prevention and Control of Disease Ordinance of Hong Kong and with regard to the guidelines of the International Health Regulations, the Department of Health (DH) enforces various preventive measures at boundary control points (BCPs) to prevent the introduction or spreading of infectious diseases into or out of Hong Kong. The Port Health Division under the DH carries out health screening work at each BCP (including conducting regular body temperature screening for arrivals and setting up health stations). Taking into account the design of each BCP and its traveller and vehicle flow, the DH deploys manpower as appropriate to conduct body temperature screening for all arrivals; and performs, in accordance with the mechanism, further health assessments for travellers with fever or in need (such as travellers who self-reported being unwell) to understand their symptoms, travel history, contact history, etc., in order to make appropriate referrals and follow-up, including compulsory referral of persons with suspected infection of major infectious diseases to Hong Kong public hospitals for checking, advising other travellers with fever or in need to seek medical treatment at medical institutions with issuance of referral letters, and assisting persons in need to call for ambulance service for further treatment at Accident and Emergency Department.

The Hong Kong Special Administrative Region (HKSAR) Government has been maintaining close co-operation with entry-exit health inspection and quarantine authorities of the Mainland to safeguard the well-being and safety of residents and travellers of the 2 places. The Health Bureau and the General Administration of Customs of the People's Republic of China (GACC) signed the Co-operation Arrangement for Entry-exit Health Inspection and Quarantine between the GACC and the Health Bureau of the HKSAR Government in 2023. Under the normalisation arrangements for epidemic prevention and control, the 2 parties agreed to focus on the health inspection and quarantine of their respective inbound personnel travelling between the HKSAR and the Mainland BCPs.

The HKSAR Government will maintain close liaison with the relevant Mainland authorities and, taking into account factors such as cost-effectiveness and appropriateness, actively review the entry health inspection and quarantine arrangements (including temperature screening) from the public health perspective.

(1)

From 2020 to 2024, the average number of health screening shifts of the DH per day at various BCPs (some health screening posts involve more than 1 shift according to the operation of BCPs) is as follows:

	2022	2023	2024
Airport	226	125	122
Lo Wu	0	40	40
Lok Ma Chau Spur Line	0	30	30
Lok Ma Chau	111	94	94
Man Kam To	41	36	36
Sha Tau Kok	20	8	0
Shenzhen Bay	182	116	94
Hong Kong-Zhuhai-Macao Bridge	178	116	130
Heung Yuen Wai	28	68	58
Express Rail Link West Kowloon	31	51	51
Hung Hom	18	0	0
Macau Ferry Terminal	45	45	45
China Ferry Terminal	0	22	22
Total	880	751	722

Note:

The DH redeploys health screening posts in view of the actual circumstances. Some of the posts at BCPs where operation has been suspended would be redeployed to other BCPs. Health screening service of Kai Tak Cruise Terminal and Ocean Terminal was not included as it was only provided during stopover of cruises.

The expenditure incurred by health screening shifts listed in the table above is set out below:

	Financial Year		
	2022-23	2023-24	2024-25
Expenditure (\$ million)	239	240	205

(2)

From 2022 to 2024, the number of inbound travellers compulsorily referred to public hospitals at BCPs upon fulfilling the reporting criteria of any major infectious disease is set out as follows:

		2022	2023	2024
Suspected Infection of Coronavirus Disease 2019 (COVID-19)*	Airport	168	2	0
	Shenzhen Bay	78	48	0
	Hong Kong-Zhuhai-Macao Bridge	3	1	0
	Express Rail Link West Kowloon	1	0	0
	Man Kam To	0	8	0
Suspected Infection of Avian Influenza	Airport	0	0	2
	Express Rail Link West Kowloon	0	1	0
Suspected Infection of Middle East Respiratory Syndrome	Airport	0	0	2
	Macau Ferry Terminal	0	1	0
Suspected Infection of Measles	Kai Tak Cruise Terminal	0	0	1
Suspected Infection of Malaria	Airport	0	0	1

*The compulsory isolation arrangement imposed on persons infected with COVID-19 has been rescinded since 30 January 2023.

- End -

CONTROLLING OFFICER'S REPLY

HHB315

(Question Serial No. 3420)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The Government has included 7 medical institutions in the Guangdong-Hong Kong-Macao Greater Bay Area (GBA) in the Elderly Health Care Voucher Greater Bay Area Pilot Scheme (Pilot Scheme) last year. In this connection, please advise on the following:

1. the number of voucher claim transactions and the amount claimed for each medical institution since the implementation of the Pilot Scheme, with a breakdown by designated department of each medical institution; and
2. in the wake of the Government's plan to enhance the Elderly Health Care Voucher Scheme (EHVS) including the Pilot Scheme, the enhancement details, timetable and expenditure involved.

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 32)

Reply:

1.

The Government launched the Elderly Health Care Voucher Greater Bay Area Pilot Scheme (Pilot Scheme) in 2024 to extend the coverage of Elderly Health Care Vouchers (EHCVs) to suitable medical institutions in the Guangdong-Hong Kong-Macao Greater Bay Area (GBA). As at September 2024, the coverage of the EHCVs has been extended to 7 integrated medical/dental institutions in the GBA. Together with the 2 existing service points operated by the University of Hong Kong – Shenzhen Hospital, eligible elderly persons can use EHCVs to pay for outpatient healthcare services provided by the designated departments at 9 service points in the GBA, located at Guangzhou, Zhongshan, Dongguan and Shenzhen, offering more convenience and flexibility for eligible Hong Kong elderly persons residing in Mainland cities in the GBA by providing more service points for them to better use their EHCVs on primary healthcare services for improving their health.

As at 31 December 2024, there were a total of 15 468 EHCV claim transactions at the 7 medical institutions under the Pilot Scheme, with the amount claimed totalling about \$19.78 million. The number of voucher claim transactions and the amount of vouchers claimed at each of the pilot medical institutions, broken down by service type, are tabulated below:

Pilot Medical Institutions	Preventive Care		Follow-up/Monitoring of Long Term Conditions		Management of Acute Episodic Conditions		Rehabilitative Care		Total	
	Number of Voucher Claims	Amount of Vouchers Claimed (\$'000)	Number of Voucher Claims	Amount of Vouchers Claimed (\$'000)	Number of Voucher Claims	Amount of Vouchers Claimed (\$'000)	Number of Voucher Claims	Amount of Vouchers Claimed (\$'000)	Number of Voucher Claims	Amount of Vouchers Claimed (\$'000)
The First Affiliated Hospital, Sun Yat-sen University (Since 28 June 2024)	158	191	1 254	103	305	500	148	137	1 865	931
Zhongshan Chen Xinghai Hospital of Integrated Traditional Chinese and Western Medicine (Since 18 July 2024)	289	305	969	125	505	450	289	115	2 052	995
Shenzhen New Frontier United Family Hospital (Since 14 August 2024)	572	762	599	269	229	562	2	1	1 402	1,594
Nansha Division of The First Affiliated Hospital, Sun Yat-sen University (since 6 September 2024) Note: The Department of Stomatology pending commencement	17	24	188	13	33	56	8	2	246	95
Dongguan Tungwah Hospital (since 6 September 2024)	313	221	335	45	125	174	17	11	790	451
Shenzhen C.K.J Stomatological Hospital (since 14 August 2024)	2 266	362	4 180	200	87	7,082	2 370	7,620	8 903	15,264
Dental Bauhinia Specialty Service Center (Shenzhen)/ Dental Bauhinia General Care Center (Shenzhen) (since 14 August 2024)	69	65	93	56	17	199	31	132	210	452

2.

The Chief Executive's 2024 Policy Address announced the extension of the Pilot Scheme to cover 9 Mainland cities in the GBA. The Health Bureau and the DH are actively taking forward the related work. The initial plan is to commence the relevant arrangements under the Pilot Scheme at the locations concerned by the 4th quarter of 2025.

The expenditure on the Pilot Scheme is subsumed under the overall provision for the Elderly Health Care Voucher Scheme (EHVS) and will not be separately identified. The estimated expenditure for 2025-26 on the EHVS is \$4.15 billion, which includes the possible claim amount relating to the Pilot Scheme.

- End -

CONTROLLING OFFICER'S REPLY

HHB316

(Question Serial No. 3422)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (3) Health Promotion

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

It is learnt that the Department of Health (DH) will continue to strengthen the publicity and education programme and adopt a community approach on smoking prevention and cessation. Please then advise on:

1. the DH's work on smoking prevention and cessation, along with the manpower and expenditure involved in the past 3 years, with a detailed breakdown by type and frequency; and
2. the activities launched under the Quit in June campaign in each of the past 3 years; the expenditure involved and the effectiveness of such activities.

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 46)

Reply:

(1) & (2)

Over the years, the Government has been actively promoting a tobacco-free environment through publicity for smoking prevention and cessation services. To leverage community effort, the Department of Health (DH) collaborates with the Hong Kong Council on Smoking and Health (COSH), non-governmental organisations (NGOs) and healthcare professionals to promote smoking cessation, provide smoking cessation services and organise publicity programmes on smoking prevention.

At present, the DH is responsible for coordinating the provision of smoking cessation services in Hong Kong. Apart from operating an integrated Smoking Cessation Hotline (Quitline) to handle general enquiries and provide professional counselling on smoking cessation, the DH arranges referrals to various smoking cessation services in the territory, including those provided by public clinics under the Hospital Authority (HA) (helping patients, especially for those with chronic diseases, to quit smoking), and community-based cessation programmes operated by NGOs. There are a total of 15 full-time and 55 part-time centres operated by the HA which have been providing smoking cessation services to the general public since 2002, and there are 5 smoking cessation clinics for civil servants operated by the DH. Furthermore, the DH also collaborates with NGOs to provide a range of community-based smoking cessation services including counselling, consultations by doctors (including free

postal delivery of smoking cessation drugs) or Chinese medicine practitioners, and designated services for smokers from different ethnicities, immigrant smokers and workplace smokers. For young smokers, the DH collaborates with local universities to operate a hotline to provide them with dedicated counselling services over the phone. Besides, the DH has subvented 2 more service providers (from 2 to 4 in total) since 2023 to operate smoking cessation clinics with a focus on counselling and pharmacotherapy, and 3 more Chinese medicine smoking cessation service providers (from 1 to 4 in total) starting from this year to operate smoking cessation clinics with an emphasis on counselling and acupuncture. It is expected that the number of service users of the former type of clinics will increase by about 40% and the number regarding the latter type will double.

The DH subvents the COSH to organise publicity and education programmes in schools, such as health talks, training programmes and theatre programmes, to raise students' awareness of smoking hazards, including hazards from alternative smoking products. To prevent youngsters from picking up smoking, the DH collaborates with the NGOs to organise health promotional activities at schools. By using interactive teaching materials and setting up mobile classrooms, the programmes enlighten students in respect of the tactics used by the tobacco industry to market tobacco products, and equip them with the skills to resist picking up smoking due to peer pressure. The DH has also launched publicity campaigns through mass media to spread the message that smoking brings risks of serious illnesses. To encourage and help all healthcare professionals to provide support and treatment for smokers who are quitting, the DH organises online and face-to-face training courses, compiles the Practical Handbook for Smoking Cessation Treatments and a clinical guide on smoking cessation with Chinese medicine and acupuncture, and provides related resources, among other initiatives.

Since 2021, the DH has launched the "Quit in June" campaign to promote smoking cessation services and one-week nicotine replacement therapy (NRT) trial packs have been distributed for free at more than 250 designated community pharmacies, smoking cessation clinics and District Health Centres (DHC)/ DHC Expresses with a view to encouraging smokers to attempt quitting. Last year, the DH introduced a trial programme on the use of Chinese medicine ear-point patches for smoking cessation. So far, more than 3 500 NRT trial packs and more than 300 Chinese medicine ear-point patches have been distributed, and most of the smokers who tried the ear-point patches found them helpful in alleviating withdrawal symptoms and the response has been very positive. In addition, the number of enquiries received by Quitline during the annual "Quit in June" campaign increased by nearly 30% to 50%, reflecting its effectiveness in boosting smokers' desire to quit. The resources required for the campaign mainly involve promotional work and manpower, and the related expenses cannot be separately identified.

Smoking cessation services and counselling for smokers are currently available at all DHCs and DHC Expresses in the 18 districts, which collaborate with smoking cessation service providers in their respective districts to provide information or arrange referrals for smokers in need.

In 2022, 2023 and 2024, the quitlines operated by the DH and local universities handled 9 216, 11 051 and 10 875 enquiries respectively. During these 3 years, there were 20 406, 27 715 and 28 512 smokers receiving smoking cessation services via quitlines, at cessation clinics under the HA and through community-based programmes operated by NGOs.

Smokers who receive smoking cessation treatment receive 52-week follow-up services to assess their quit status. For smokers who receive smoking cessation services via quitlines, at cessation clinics under the HA and through community-based programmes operated by NGOs, their 52-week quit rates, which refer to the percentage of service users self-reporting to have stayed quit in the past 7 days, range from 20% to 60%, which are comparable to those in overseas countries. Discrepancies in the quit rates concerning different smoking cessation programmes are due to differences in terms of their target groups and treatment methods (which include counselling, pharmacotherapy, and Chinese medicine with acupuncture). To become a successful quitter, smokers are encouraged to choose the cessation service that best caters for their personal needs.

The expenditure on and provision/revised estimate for tobacco control initiatives taken forward by the Tobacco and Alcohol Control Office (TACO) of the DH, broken down by type of activity, as well as the approved establishment of the TACO from 2020-21 to 2024-25 are set out in **Annex 1 and Annex 2** respectively. The expenditure on individual publicity and promotional activities cannot be separately identified.

The Government will continue to step up its work on smoking cessation and explore various tobacco control measures in the medium and long term in order to eliminate the social hazards posed by tobacco products in all aspects and safeguard the health of the community with a progressive and multi-pronged approach.

Expenditure on/Provision for
the Department of Health's Tobacco and Alcohol Control Office

	2020-21 (\$ million)	2021-22 (\$ million)	2022-23 (\$ million)	2023-24 (\$ million)	2024-25 Revised Estimate (\$ million)
<u>Enforcement</u>					
Programme 1: Statutory Functions	102.2	101.3	100.4	123.3	167.4
<u>Health Education and Smoking Cessation</u>					
Programme 3: Health Promotion	141.2	138.9	149.0	151.4	170.5
<u>(a) General Health Education and Promotion of Smoking Cessation</u>					
TACO	64.5	62.8	73.0	83.7	88.2
Subvention to Hong Kong Council on Smoking and Health (COSH)	26.0	26.2	26.8	26.6	27.9
<i>Sub-total</i>	<u>90.5</u>	<u>89.0</u>	<u>99.8</u>	<u>110.3</u>	<u>116.1</u>
<u>(b) Expenditure on/Provision for Smoking Cessation and Related Services by Non-Governmental Organisations</u>					
Subvention to Tung Wah Group of Hospitals	30.6	30.8	29.4	10.2	14.0
Subvention to Pok Oi Hospital	7.4	7.5	7.6	14.8	17.9
Subvention to Po Leung Kuk	1.7	0.7	-	-	-
Subvention to Lok Sin Tong	3.0	3.2	3.3	3.6	3.6
Subvention to United Christian Nethersole Community Health Service	4.4	4.9	5.8	6.1	8.9
Subvention to Life Education Activity Programme	2.7	2.8	2.8	2.9	3.0
Subvention to Christian Family Service Centre	-	-	-	3.5	7.0

<i>Subvention to The University of Hong Kong</i>	0.9	-	0.3	-	-
<i>Sub-total</i>	<u>50.7</u>	<u>49.9</u>	<u>49.2</u>	<u>41.1</u>	<u>54.4</u>
Total	<u>243.4</u>	<u>240.2</u>	<u>249.4</u>	<u>274.7</u>	<u>337.9</u>

Approved Establishment of
the Department of Health's Tobacco and Alcohol Control Office

Rank	Number of Staff from 2020-21 to 2024-25
<u>Head, TACO</u>	
Consultant	1
<u>Enforcement</u>	
Senior Medical & Health Officer	1
Medical & Health Officer	1
Scientific Officer (Medical)	1
Land Surveyor	1
Police Officer	5
Overseer/ Senior Foreman/ Foreman	125
Senior Executive Officer/ Executive Officer	13
<i>Sub-total</i>	<u>147</u>
<u>Health Education and Smoking Cessation</u>	
Senior Medical & Health Officer	1
Medical & Health Officer	1
Scientific Officer (Medical)	2
Nursing Officer/ Registered Nurse	3
Hospital Administrator II	4
<i>Sub-total</i>	<u>11</u>
<u>Administrative and General Support</u>	
Senior Executive Officer/ Executive Officer	4
Clerical and support staff	19
Motor Driver	1
<i>Sub-total</i>	<u>24</u>
Total	<u>183</u>

- End -

CONTROLLING OFFICER'S REPLY**HHB317****(Question Serial No. 3423)**Head: (37) Department of HealthSubhead (No. & title): (-) Not SpecifiedProgramme: (1) Statutory FunctionsControlling Officer: Director of Health (Dr. Ronald LAM)Director of Bureau: Secretary for HealthQuestion:

In connection with supporting the functioning of the various boards and councils responsible for the registration and regulation of healthcare professionals, please advise on:

1. the establishment and actual number of staff at the Secretariat of the Medical Council of Hong Kong in the past 3 years;
2. whether the Government has considered deploying more personnel to expedite the processing of complaints and disciplinary inquiries to enhance efficiency.

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 47)Reply:

1.

The Boards and Councils Office (B&C Office) of the Department of Health (DH) provides secretariat support to 15 healthcare-related boards and councils, including the Medical Council of Hong Kong (MCHK). The Head of the B&C Office also serves as the Secretary of the MCHK. The Secretariat staff of the MCHK, mainly composed of the Executive Officer and Clerical Officer grades, assist the MCHK in the execution of its decisions and statutory functions, which include registration, organising Licensing Examinations, formulating code of conduct for the profession, as well as handling complaints and conducting disciplinary inquiries. The civil service establishment and actual number of staff providing secretariat support for the MCHK in the past 3 years are tabulated below:

	As at 31 March 2023	As at 31 March 2024	As at 1 February 2025
Establishment	24 Note (1)	24 Note (1)	26 Note (2)

Actual Number of Staff	21	21	23

Note:

(1) Including 7 time-limited posts.

(2) Including 9 time-limited posts.

2.

The DH enhances the operational efficiency of the Secretariat through flexible deployment of staff and different measures (such as streamlining administrative procedures, increasing the use of information technology and optimising the organisational structure) and will review the manpower of the Secretariat of the MCHK from time to time. Upon commencement of the Medical Registration (Amendment) Ordinance 2018, the MCHK has introduced various improvement measures in regard to its complaint investigation and disciplinary inquiry mechanism. The Government has also provided additional resources, including the creation in 2018 and 2024 of a total of 17 related posts (of which 9 are time-limited posts) for the Secretariat to support the MCHK in discharging its statutory functions and handling related work.

- End -

CONTROLLING OFFICER'S REPLY

HHB318

(Question Serial No. 3424)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Regarding the arrangements for seasonal influenza vaccination, please advise on:

1. the estimated and actual numbers of vaccine recipients, the uptake rate and the expenditure incurred in respect of the subsidy schemes under which influenza vaccination is administered, broken down by target group, in the past 3 years;
2. the numbers of nasal influenza vaccines procured for and actually administered in the above subsidy schemes as well as the respective uptake rates in the past 3 years; and
3. whether the Government will consider sending influenza vaccination vans in the 18 districts to facilitate vaccination for mobility-impaired persons or those with busy work schedules to further boost the uptake rate.

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 55)

Reply:

1.

The Scientific Committee on Vaccine Preventable Diseases (SCVPD) under the Centre for Health Protection (CHP) of the Department of Health (DH) issues recommendations on the seasonal influenza (SI) vaccines to be used and the priority groups for receiving vaccination in regard to the influenza season in Hong Kong on an annual basis after reviewing scientific evidence, local data, latest recommendations of the World Health Organization and overseas practices.

Based on the recommendations of the SCVPD, the DH has been administering the following vaccination programmes/schemes to provide free/subsidised seasonal influenza (SI) vaccination to eligible persons:

- Government Vaccination Programme (GVP), which provides free SI vaccination to eligible children, elderly and other target groups at clinics of the DH and the Hospital Authority (HA);

- Seasonal Influenza Vaccination School Outreach Programme (SIVSOP), which provides free or subsidised SI vaccination to eligible schoolchildren through the public-private partnership outreach teams or the DH's outreach team; and
- Vaccination Subsidy Scheme (VSS), which provides subsidised SI vaccination to eligible persons, including persons aged 50 or above, pregnant women and children aged between 6 months and below 18 years of age through private doctors participating in the VSS.

The target population, the number of vaccine recipients, the uptake rate and the expenditure on subsidy for the eligible groups under each vaccination programme/scheme in the past 3 seasons are detailed at **Annex**. As some target group members may have, at their own expense, received SI vaccination at private clinics outside the Government's vaccination programmes/schemes, they are not included in the statistics concerned.

As at 23 March this year, with the concerted efforts of the Government and all sectors of the community such as the medical sector, schools, parents and residential care homes, a record high number of about 2.07 million doses of SI vaccine have been administered under various vaccination programmes/schemes in 2024/25, representing an increase of about 12.2% over the same period of the last influenza vaccination season and exceeding the total number of doses (about 1.87 million doses) administered last season.

As at 23 March 2025, about 1 020 kindergartens/child care centres (97%), about 640 primary schools (98%) and about 490 secondary schools (98%) have completed or will conduct SI vaccination school outreach activities, which is higher than last year's participation rates (80% of kindergartens/child care centres, 95% of primary schools and 70% of secondary schools), reflecting the schools' strong support for the SIVSOP.

2.

The quantities of nasal live attenuated influenza vaccines (LAIV) procured by the Government for the SIVSOP and the number of doses administered in the past 3 years are as follows:

Vaccine	2022/23		2023/24		2024/25	
	Number of doses procured (Actual)	Number of doses administered	Number of doses procured (Actual)	Number of doses administered	Number of doses procured (Estimate)	Number of doses administered (Provisional figure)
LAIV (nasal spray)	22 500	17 400	25 700	21 400	37 000	26 800

The overall uptake rates of children and adolescents and the SIVSOP in the past 3 seasons are set out at **Annex**.

3.

Under the SI vaccination programmes, eligible persons may receive free SI vaccination at public venues or subsidised SI vaccination at private clinics participating in the VSS. Apart from the public venues located in the 18 Districts, such as HA's General Outpatient Clinics and Specialist Outpatient Clinics and DH's clinics, over 1 900 doctors have enrolled in the VSS, providing vaccination services to eligible persons at over 3 000 clinic locations. Institutions and community groups can also arrange SI vaccination activities for eligible persons at non-clinic settings (such as elderly centres, community halls, institutions serving persons with intellectual disabilities, schools, etc.) through the Vaccination Subsidy Scheme (Outreach).

In addition, the Government this year has introduced several new vaccination venues, including opening up the DH's Maternal and Child Health Centres to all children aged between 6 months and under 2 years for vaccination, and 18 District Health Centres (DHCs)/DHC Expresses, so as to provide more vaccination venues for the public.

The Government will continue to explore the feasibility of introducing other vaccination venues to improve the accessibility so as to further increase the uptake rate of SI vaccination.

Annex

Target group	Programmes /schemes for provision of SI vaccination	2022/23				2023/24				2024/25 (as at 23 March 2025)			
		Target Population*	No. of SI vaccine recipients under each vaccination programme/scheme	The uptake rate within the age group	Subsidy@ claimed (\$ million)	Target Population*	No. of SI vaccine recipients under each vaccination programme/scheme	The uptake rate within the age group	Subsidy@ claimed (\$ million)	Target Population*	No. of SI vaccine recipients under each vaccination programme/scheme	The uptake rate within the age group	Subsidy@ claimed (\$ million)
Elderly aged 65 or above	GVP	1 520 100	452 900	48.3%	Not applicable	1 637 600	513 100	51.5%	Not applicable	1 715 400	515 500	51.3%	Not applicable
	VSS		281 300		73.1		329 700		85.7		364 400		94.7
Persons aged between 50 and 64	GVP	1 796 700	49 200	17.8%	Not applicable	1 824 900	6 100	19.2%	Not applicable	1 815 300	115 700	25.3%	Not applicable
	VSS		271 000		70.5		343 400		89.3		343 300		89.3
Children aged between 6 months and under 18	GVP	917 900	1 400	39.8%	Not applicable	929 600	800	53.0%	Not applicable	911 400	6 900	62.1 %	Not applicable
	VSS		104 700		30.3		169 500		50.5		189 900		53.3
	SIVSOP		259 200		28.8		322 000		36.1		369 100		40.6
Others ^	GVP/VSS	#	112 300	#	1.5	#	140 200	#	1.7	#	126 900	#	1.6
Total			1 532 000		204.2		1 824 800		263.3		2 031 700		279.5

* Provisional figures for the relevant population group at mid-year as estimated by the Census and Statistics Department.

@ Refers to the subsidy for private doctors participating in the SIVSOP and the VSS. As vaccination services under the GVP are provided free of charge by public hospitals/clinics etc., the related expenses cannot be separately identified.

^ Others include healthcare workers; poultry workers; pig farmers or pig slaughtering industry personnel; persons with intellectual disabilities; Disability Allowance recipients; and pregnant women, etc.

There are no accurate population statistics for this group.

- End -

CONTROLLING OFFICER'S REPLY

HHB319

(Question Serial No. 3895)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (4) Curative Care

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Regarding the dental services provided by the Department of Health, please advise on:

1. the total number of discs available, service sessions, attendances and utilisation rates in relation to the General Public Sessions at government dental clinics in each of the past 5 years; and
2. the administrative expenses incurred and manpower involved in implementing the Online Registration System for Dental General Public Session launched in December 2024.

Asked by: Hon CHAN Hoi-yan (LegCo internal reference no.: 24)

Reply:

To safeguard the oral health of the public, the Chief Executive announced in the 2022 Policy Address to conduct a comprehensive review of the dental services provided or subsidised by the Government. The Working Group on Oral Health and Dental Care (Working Group) was subsequently established in end-2022. The Working Group published a final report in end-2024, recommending that the future development of dental services should make reference to the direction of the Primary Healthcare Blueprint emphasising prevention, early identification and timely intervention, with the goal of retention of natural teeth and enhancing the overall level of citizens' oral health.

The Government concurs with the views of the Working Group that providing or subsidising comprehensive curative dental services from public purse to all Hong Kong citizens regardless of their financial means does not align with the policy objectives of developing a prevention-oriented oral health and dental care system and encouraging citizens to take responsibility for their own oral health. This would exacerbate the current shortcomings of the treatment-oriented system, and would be neither cost-effective nor sustainable in terms of utilisation of public resources. It would be financially untenable for the Government and would thin out the resources that could otherwise be used for other healthcare services.

In response to the final report of the Working Group, the Government has adopted the oral health policy that: (1) Oral health is an integral component of general health. The

Government's oral health policy aims to enable all Hong Kong citizens to improve their oral hygiene and lifestyle conducive to both oral and overall health levels; (2) Through publicity, education, promotion and development of primary oral health and dental care, the Government facilitates citizens to manage their oral health, and put prevention, early identification and timely intervention of dental diseases into action with the objective of tooth retention; and (3) The Government provides appropriate oral health and dental care services targeting underprivileged groups with financial difficulties and special needs, ensuring these groups have access to essential dental care services.

In the Oral Health Action Plan formulated based on the Working Group's strategic recommendations, the emergency dental service (generally referred to as General Public (GP) Sessions) and the Community Dental Support Programme (CDSP) are services focusing on underprivileged groups who have difficulties in accessing dental care under the aforesaid strategy of ensuring these groups have access to essential dental care services.

On top of the existing dental grants under the Comprehensive Social Security Assistance Scheme and the emergency dental service provided through GP Sessions by government dental clinics, the Department of Health (DH) will increase the dental services to underprivileged groups with financial difficulties by launching the CDSP in 2025 and enhancing service capacity, increasing service points and expanding service scope, aiming to additionally offer at least twice the current number of quotas provided by the GP Sessions of government dental clinics (i.e. 40 000 per year). The CDSP leverages the networks of non-governmental organisations and social welfare organisations serving underprivileged groups to provide services to persons with financial difficulties more effectively. In addition to tooth extraction, the CDSP provides dental fillings where dentists consider appropriate to encourage tooth retention.

1. Under Programme (4), the DH provides free GP Sessions through designated sessions each week at 11 government dental clinics. Dental service under the GP Sessions only includes treatment of acute dental diseases, prescriptions for pain relief, treatment of oral abscess and tooth extraction. The dentists will also provide professional advice based on individual needs of patients. Under the civil service terms of appointment, the Government is obliged to provide dental benefits for civil servants/pensioners and their eligible dependents. Dental clinics under the DH are established primarily for fulfilling this obligation. That said, the Government uses only a small fraction of the service capacity of the dental clinics to provide supplementary emergency dental service to the general public.

The numbers of discs available and service sessions at each dental clinic with GP Sessions in 2020-21, 2021-22, 2022-23, 2023-24 and 2024-25 (up to 31 January 2025) are tabulated as follows:

Dental clinic with GP Sessions	Number of discs available (Number of service sessions)				
	2020-21	2021-22	2022-23	2023-24	2024-25 (up to 31 January 2025)
Kowloon City Dental Clinic	3 652 (98)	4 292 (100)	3 213 (97)	2 877 (94)	2 562 (81)
Kwun Tong Dental Clinic	2 520 (45)	2 751 (47)	2 142 (52)	2 143 (51)	1 596 (38)
Kennedy Town Community Complex Dental Clinic	4 620 (92)	5 733 (99)	3 990 (95)	3 822 (91)	3 444 (82)
Fanling Health Centre Dental Clinic	1 509 (50)	1 757 (51)	1 200 (48)	1 250 (50)	1 075 (43)
Mona Fong Dental Clinic	1 216 (49)	1 457 (50)	1 092 (52)	1 071 (51)	861 (41)
Tai Po Wong Siu Ching Dental Clinic	1 216 (49)	1 457 (50)	1 071 (52)	1 071 (51)	840 (40)
Tsuen Wan Dental Clinic	4 888 (97)	5 850 (100)	4 116 (98)	4 074 (97)	3 528 (84)
Yan Oi Dental Clinic	1 269 (51)	1 404 (48)	1 071 (51)	1 071 (51)	798 (38)
Yuen Long Government Offices Dental Clinic	2 433 (97)	2 947 (100)	2 058 (98)	2 037 (97)	1 743 (83)
Tai O Dental Clinic	232 (12)	261 (12)	192 (12)	192 (12)	144 (9)
Cheung Chau Dental Clinic	232 (12)	192 (12)	192 (12)	176 (11)	144 (9)
Total	23 787 (652)	28 101 (669)	20 337 (667)	19 784 (656)	16 735 (548)

The numbers of attendances at each dental clinic in 2020-21, 2021-22, 2022-23, 2023-24 and 2024-25 (up to 31 January 2025) are tabulated as follows:

Dental clinic with GP Sessions	Number of attendances				
	2020-21	2021-22	2022-23	2023-24	2024-25 (up to 31 January 2025)
Kowloon City Dental Clinic	3 601	4 133	3 157	2 787	2 469
Kwun Tong Dental Clinic	2 513	2 655	2 136	2 089	1 574
Kennedy Town Community Complex Dental Clinic	4 482	5 420	3 909	3 670	3 332
Fanling Health Centre Dental Clinic	1 508	1 727	1 192	1 175	1 014
Mona Fong Dental Clinic	1 196	1 420	1 065	929	729
Tai Po Wong Siu Ching Dental Clinic	1 191	1 420	1 071	1 014	804
Tsuen Wan Dental Clinic	4 838	5 746	4 104	3 970	3 476
Yan Oi Dental Clinic	1 265	1 373	1 062	984	779
Yuen Long Government Offices Dental Clinic	2 397	2 872	2 041	1 919	1 678
Tai O Dental Clinic	121	137	130	122	100
Cheung Chau Dental Clinic	205	164	168	153	127
Total	23 317	27 067	20 035	18 812	16 082

The overall utilisation rates of each dental clinic in 2020-21, 2021-22, 2022-23, 2023-24 and 2024-25 (up to 31 January 2025) are tabulated as follows:

Dental clinic with GP Sessions	Overall utilisation rate in %				
	2020-21	2021-22	2022-23	2023-24	2024-25 (up to 31 January 2025)
Kowloon City Dental Clinic	99.3	96.8	99.5	97.7	98.2
Kwun Tong Dental Clinic	99.7	96.7	100.0	97.9	99.8
Kennedy Town Community Complex Dental Clinic	98.0	96.8	99.7	97.1	98.6
Fanling Health Centre Dental Clinic	99.9	98.5	99.5	95.0	95.9
Mona Fong Dental Clinic	98.7	97.9	98.0	88.1	86.6
Tai Po Wong Siu Ching Dental Clinic	99.3	98.0	100.0	95.3	97.7
Tsuen Wan Dental Clinic	99.4	99.2	99.9	98.8	99.6
Yan Oi Dental Clinic	99.8	97.9	99.8	92.3	98.1
Yuen Long Government Offices Dental Clinic	99.4	97.8	99.2	94.7	97.8
Tai O Dental Clinic	52.2	52.9	67.7	64.1	70.8
Cheung Chau Dental Clinic	89.7	85.4	88.0	88.1	90.3

2. The Online Registration System for Dental General Public Session (ORDGP) has commenced service since 30 December 2024. The DH set up a temporary enquiry hotline in early January this year to assist the public on online registration, provide technical support and handle public enquiries, the expenditure of which is absorbed within the DH's overall provision for dental services under Programme (4) and Programme (7) and a breakdown of the expenditure is not available. The ORDGP requires no additional manpower.

- End -

CONTROLLING OFFICER'S REPLY

HHB320

(Question Serial No. 3481)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

As stated in this year's Matters Requiring Special Attention, the Government will formulate risk-based screening programmes for prevalent cancers. In this connection, please inform this Committee of:

1. the expenditure involved in implementing the Cervical Screening Programme, Colorectal Cancer Screening Programme, and the risk-based Breast Cancer Screening Pilot Programme already in place; whether the effectiveness of the programmes has been evaluated; if yes, the details; if no, the reasons;
2. the expenditure and staff establishment in respect of the pilot programme in subsidising hepatitis B screening scheduled for launch by the end of this year as announced earlier; and
3. other than those already implemented or announced for launch soon, whether the Government has any plans to launch screening programmes for other cancers, including the second phase of breast cancer screening; if yes, the details; if no, the reasons.

Asked by: Hon LEUNG Hei, Edward (LegCo internal reference no.: 107)

Reply:

The Cancer Expert Working Group on Cancer Prevention and Screening (CEWG) under the Cancer Coordinating Committee chaired by the Secretary for Health regularly reviews local and international scientific evidence, with a view to making recommendations to the Government on suitable evidence-based measures for cancer prevention and screening for the local population. Based on the CEWG's recommendations on cancer screening, the Government has rolled out the Cervical Screening Programme (CSP), the Colorectal Cancer Screening Programme (CRCSP) and the Breast Cancer Screening Pilot Programme (BCSPP).

When considering recommendations for any disease screening, the Government will refer to the evidence-based risk assessment and views of relevant experts from the perspective of public health. A number of factors will be carefully assessed, such as local prevalence of the cancer, accuracy and safety of the screening tests, effectiveness in reducing incidence and mortality rates as well as feasibility of implementation of a screening programme. The

perspective of good utilisation of medical resources will be taken into account to determine the priority. Excessive screening under public health programmes not only wastes resources for the overall public health, but also runs out of resources that can be invested on other projects in greater need, and may pose unnecessary health risks to individuals, often causing more harm than good.

Primary prevention (i.e. reducing exposure to cancer risk factors) is the most important strategy for reducing the risk of developing cancer. The Department of Health (DH) has all along been encouraging members of the public to adopt a healthy lifestyle, including avoidance of smoking and alcohol, healthy diet, regular physical activity and maintenance of a healthy body weight and waist circumference, in order to reduce the risk of non-communicable diseases including cancer.

(1) to (3)

The CSP

Acting on the CEWG's recommendation that women aged 25 to 64 who have had sexual experience should have regular cervical screening, the Government launched the CSP in collaboration with the healthcare sector in 2004 to encourage local women aged 25 to 64 who have had sexual experience to undergo regular cervical screening for prevention of cervical cancer. Early identification and timely treatment of cervical abnormalities, including precancerous changes, can help reduce the incidence and mortality rates of cervical cancer. Major service providers under the CSP include the Maternal and Child Health Centres (MCHCs) of the DH and non-governmental organisations (NGOs). The DH's Family Health Service (FHS) provides subsidised cervical screening for the public. In 2022, 2023 and 2024, the numbers of attendance for cervical screening service at the MCHCs were 65 003, 52 859 and 62 516 respectively. Among the women having cervical screening at the MCHCs in 2022, 2023 and 2024, 4 248 were referred to relevant specialties for follow-up of abnormal cervical screening results, including suspected precancerous changes or cervical cancer.

The expenditure involved in the CSP is absorbed within the overall provision for the DH's FHS and cannot be separately identified.

The Cervical Screening Information System is a central computerised registry for keeping and processing screening details to facilitate sharing of information among healthcare providers and remind women who have registered as users of the system to undergo regular screening. As at 31 December 2024, more than 540 000 women aged 25 to 64 have registered as users of the system.

The Woman Health Service (WHS) under the DH will be integrated into the district health network of the Health Bureau Primary Healthcare Commission (PHC Commission) within 2025. The service points, to be named Women Wellness Satellites (WWSs), will form a network with District Health Centres (DHCs)/DHC Expresses in all 18 districts across Hong Kong to provide eligible women with prevention-based and more personalised primary healthcare services, including cervical cancer and breast cancer screening. The WWSs will also explore introducing self-sampling for Human Papilloma Virus (HPV) testing to enhance prevention-oriented women's health services. In parallel, the DHCs/DHC Expresses

actively promote the “Life Course Preventive Care Plan”. In line with the core principles of prevention-oriented and whole-person care, a personalised preventive care plan will be formulated based on the most updated evidence and the health needs of citizens across different life stages. Family doctors and primary healthcare professionals will collaborate to promote healthy lifestyles and disease prevention, including providing education and vaccination for cancer prevention, and advising on cancer screening services according to personal risk factors.

The CRCSP

Based on the recommendations of the CEWG, the Government launched and fully implemented the CRCSP in September 2016 and 2020 respectively to subsidise asymptomatic Hong Kong residents aged between 50 and 75 to undergo regular screening. As at end-December 2024, more than 510 000 eligible persons have participated in the CRCSP. Among those participants who had undergone colonoscopy examination, about 40 000 were diagnosed to have colorectal adenomas and about 3 400 were diagnosed with colorectal cancer. A preliminary analysis of about 2 400 colorectal cancer cases revealed that about 56% belonged to early-stage (stage II or below) with a more favourable prognosis. For other colorectal cancer cases recorded by the Hong Kong Cancer Registry of the Hospital Authority, less than 40% of them belonged to early-stage, which demonstrates that participation in the CRCSP allows early detection and treatment of colorectal cancer, thereby leading to a more favourable prognosis. Such screenings can help in the early identification of those who have colorectal cancer before they present with symptoms, or those with higher risk of colorectal cancer, enabling them to receive early treatment, thus significantly improving the prognosis. The removal of colorectal adenomas in the course of colonoscopy also prevents them from turning into cancer.

A breakdown of the number of new participants by year from 2022 to 2024 is appended below:

Year	Number of New Participants
2022	72 600
2023	71 900
2024	86 000

The actual expenditure of the CRCSP in 2022-23 and 2023-24 and its revised estimate in 2024-25 are as follows:

Financial Year	Annual Expenditure (\$ million)
2022-23 (Actual)	151.6
2023-24 (Actual)	175.6
2024-25 (Revised Estimate)	222.7

The BCSP

Based on the recommendations of the CEWG, the Government adopts a risk-based approach for breast cancer screening and launched Phase I of the BCSP in 2021. Women aged between 44 and 69 with certain combinations of personalised risk factors (including presence of history of breast cancer among first-degree relatives, a prior diagnosis of benign breast

disease, nulliparity or late age of first live birth, early age of menarche, high body mass index and physical inactivity) putting them at increased risk of breast cancer are recommended to consider mammography (MMG) screening every 2 years.

In the two-year Phase I of the BCSPP (which ran from September 2021 to December 2023), a total of 27 807 women aged between 44 and 69 have received breast cancer risk assessment in Woman Health Centres (WHCs), 4 MCHCs and 18 Elderly Health Centres (EHCs). 7 785 (about 28%) of them underwent the MMG screening on referral based on the risk assessment. Among the women with abnormal MMG results who had been referred to specialists for treatment, 409 cases were followed up in public hospitals, among which 68 were confirmed to have breast cancer. The breast cancer detection rate per 1 000 MMG screenings was 8.7, which was comparable to the international standard of about 5 cases per 1 000 MMG screenings. Of the 68 breast cancer cases identified through the MMG screening, 97% were at stage II or below. Following the review of Phase I of the BCSPP, the breast cancer risk assessment and screening have been included as part of the regular services provided by the WHS and the Elderly Health Service.

The expenditure of Phase I of the BCSPP is subsumed under the overall provision for WHCs and EHCs, thus a breakdown of such expenditure is not available.

The Government is now preparing for Phase II of the BCSPP to provide subsidised breast cancer screening services for women at high risk of developing breast cancer (i.e. carriers of certain gene mutations and/or with strong family history of breast cancer or ovarian cancer) through Public-Private Partnership programmes in collaboration with the NGOs. Phase II of the BCSPP, of which details will be announced in due course, is expected to be launched around the second quarter of 2025.

Hepatitis B screening

As for liver cancer screening, the CEWG currently does not recommend routine screening for liver cancer for asymptomatic persons at average risk.

The major risk factor leading to liver cancer is chronic hepatitis B (CHB) infection. As stated in the Chief Executive's 2024 Policy Address, the Government will implement a hepatitis B screening programme this year for early identification and continuous management and treatment of individuals with CHB infection. This will help reduce the risk of developing serious liver diseases such as cirrhosis and liver cancer associated with CHB infection, thereby minimising the incidence and mortality of liver cancer cases. The PHC Commission would roll out a new programme to subsidise hepatitis B screening to prevent liver cancer, under which DHCs and family doctors provide risk-based hepatitis B screening and management through strategic purchasing.

- End -

CONTROLLING OFFICER'S REPLY

HHB321

(Question Serial No. 3506)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (4) Curative Care

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

The Department of Health mentioned in the Matters Requiring Special Attention in 2025-26 that it would continue to provide specialised curative services to the public and dental service to patients with special oral healthcare needs or emergency, as well as to collaborate with non-governmental organisations to launch the Community Dental Support Programme for enhancing dental services for underprivileged groups. In this connection, will the Government please inform this Committee of:

1. its expenditure on public or subsidised dental services over the past 3 years and the estimated expenditure in this respect for 2025-26; and
2. the current quotas on general public sessions, along with the attendances and overall utilisation rates of public dental clinics over the past 3 years?

Asked by: Hon LEUNG Hei, Edward (LegCo internal reference no.: 151)

Reply:

To safeguard the oral health of the public, the Chief Executive announced in the 2022 Policy Address to conduct a comprehensive review of the dental services provided or subsidised by the Government. The Working Group on Oral Health and Dental Care (Working Group) was subsequently established in end-2022. The Working Group published a final report in end-2024, recommending that the future development of dental services should make reference to the direction of the Primary Healthcare Blueprint emphasising prevention, early identification and timely intervention, with the goal of retention of natural teeth and enhancing the overall level of citizens' oral health.

The Government concurs with the views of the Working Group that providing or subsidising comprehensive curative dental services from public purse to all Hong Kong citizens regardless of their financial means does not align with the policy objectives of developing a prevention-oriented oral health and dental care system and encouraging citizens to take responsibility for their own oral health. This would exacerbate the current shortcomings of the treatment-oriented system, and would be neither cost-effective nor sustainable in terms of

utilisation of public resources. It would be financially untenable for the Government and would thin out the resources that could otherwise be used for other healthcare services.

In response to the final report of the Working Group, the Government has adopted the oral health policy that: (1) Oral health is an integral component of general health. The Government's oral health policy aims to enable all Hong Kong citizens to improve their oral hygiene and lifestyle conducive to both oral and overall health levels; (2) Through publicity, education, promotion and development of primary oral health and dental care, the Government facilitates citizens to manage their oral health, and put prevention, early identification and timely intervention of dental diseases into action with the objective of tooth retention; and (3) The Government provides appropriate oral health and dental care services targeting underprivileged groups with financial difficulties and special needs, ensuring these groups have access to essential dental care services.

In the Oral Health Action Plan formulated based on the Working Group's strategic recommendations, the School Dental Care Service (SDCS), the Primary Dental Co-care Pilot Scheme for Adolescents (PDCC), and the dental services provided under the Elderly Health Care Voucher Scheme (EHVS) are rolled out to actively develop prevention-oriented primary oral healthcare according to the strategy of community-wide preventive primary oral health care, while the Hospital Dental Service, the Emergency Dental Service, the Special Oral Care Service (SOCS), the Healthy Teeth Collaboration (HTC), the Outreach Dental Care Programme for the Elderly (ODCP) and the Community Dental Support Programme (CDSP) are services focusing on underprivileged who have difficulties in accessing dental care under the aforesaid strategy of ensuring these groups have access to essential dental care services.

1.

The public dental services provided by the Department of Health (DH) and the expenditures involved are set out below:

(A) The SDCS

The Government focuses particularly on nurturing good oral hygiene habits from an early age including providing the SDCS to children. Primary school students in Hong Kong, as well as students aged under 18 with intellectual disability and/or physical disability studying in special schools, can join the SDCS of the DH to receive annual check-ups at designated school dental clinics, which cover oral examination as well as basic restorative and preventive treatment. The actual expenditures for the SDCS in 2022-23 and 2023-24, the revised estimate for 2024-25 and the estimate for 2025-26 are as follows:

SDCS	2022-23 (Actual)	2023-24 (Actual)	2024-25 (Revised Estimate)	2025-26 (Estimate)
Annual Expenditure (\$ million)	276.2	281.6	281.1	287.7

(B) Hospital Dental Service, Emergency Dental Service and the SOCS

The DH provides free emergency dental service (generally referred to as General Public (GP) Sessions) to the public through designated sessions each week at 11 government dental

clinics. Such services cover treatment of acute dental problems, prescriptions for pain relief, treatment of oral abscess and tooth extraction. The dentists will also provide professional advice based on individual needs of patients. Under the civil service terms of appointment, the Government is obliged to provide dental benefits for civil servants/pensioners and their eligible dependents. Dental clinics under the DH are established primarily for fulfilling this obligation. That said, the Government uses only a small fraction of the service capacity of the dental clinics to provide supplementary emergency dental service to the general public.

In addition, oral maxillofacial surgery and specialist dental treatment are provided by the DH's Oral Maxillofacial Surgery and Dental Clinics in 7 public hospitals for hospital in-patients, and patients with special oral health care needs and dental emergency needs. To improve the oral health of children with intellectual disability, the DH also provides the SOCS for pre-school children under 6 years old with intellectual disability for early intervention and prevention of common oral diseases in collaboration with the Hospital Authority since September 2019.

The expenditures for Hospital Dental Service, Emergency Dental Service and the SOCS in 2022-23 and 2023-24 are absorbed within the DH's overall provision for dental services under Programme (4) and Programme (7) and there is no breakdown available.

The revised estimate for 2024-25 and the estimate for 2025-26 in respect of the Hospital Dental Service are as follows:

Hospital Dental Service	2024-25 (Revised Estimate)	2025-26 (Estimate)
Annual Expenditure (\$ million)	80.41	80.55

The revised estimate for 2024-25 and the estimate for 2025-26 in respect of the Emergency Dental Service are as follows:

Emergency Dental Service	2024-25 (Revised Estimate)	2025-26 (Estimate)
Annual Expenditure (\$ million)	9.60	9.62

The revised estimate for 2024-25 and the estimate for 2025-26 in respect of the SOCS are as follows:

SOCS	2024-25 (Revised Estimate)	2025-26 (Estimate)
Annual Expenditure (\$ million)	4.80	4.81

(C) Dental Care Support for Adult Persons with Intellectual Disability

The Government launched a three-year programme named the HTC in July 2018 to provide free oral check-ups, dental treatments and oral health education for adult persons aged 18 or above with intellectual disability. The HTC was further extended from 16 July 2024 to March 2027 with 900 additional quotas for new cases every year and its scope extended to cover persons aged 18 or above with autistic spectrum disorder. The actual expenditures for implementing the HTC in 2022-23 and 2023-24, the revised estimate for 2024-25 and the estimate for 2025-26 are as follows:

HTC	2022-23 (Actual)	2023-24 (Actual)	2024-25 (Revised Estimate)	2025-26 (Estimate)
Annual Expenditure (\$ million)	22.8	33.4	46.4	46.4

(D) Dental Care Support for Elderly Persons in Residential Care Homes for the Elderly (RCHEs) and Day Care Centres for the Elderly (DEs)

The ODCP has been implemented since October 2014 to provide free on-site oral check-ups for elderly persons and oral care training to caregivers of RCHEs, DEs and similar facilities in the 18 districts of Hong Kong through outreach dental teams set up by non-governmental organisations (NGOs). Free dental treatment will be provided on-site or at a dental clinic if the elderly person is considered suitable for further curative treatments. The outreach dental teams will also design personalised oral care plans for the elderly persons to suit their oral care needs and self-care abilities. The actual expenditures for implementing the ODCP in 2022-23 and 2023-24, the revised estimate for 2024-25 and the estimate for 2025-26 are as follows:

ODCP	2022-23 (Actual)	2023-24 (Actual)	2024-25 (Revised Estimate)	2025-26 (Estimate)
Annual Expenditure (\$ million)	48.6	55.8	63.7	64.4

(E) Dental Care Support for Financially Disadvantaged Underprivileged Groups

On top of the existing dental grants under the Comprehensive Social Security Assistance (CSSA) Scheme and the emergency dental service provided through the GP Sessions by government dental clinics, the DH will increase the dental services to underprivileged groups with financial difficulties by launching the CDSP in 2025 and enhancing service capacity, increasing service points and expanding service scope, aiming to additionally offer at least twice the current number of quotas provided by the GP Sessions of government dental clinics (i.e. 40 000 per year). The CDSP leverages the networks of NGOs and social welfare organisations serving underprivileged groups to provide services to persons with financial difficulties more effectively. In addition to tooth extraction, the CDSP provides dental fillings where dentists consider appropriate to encourage tooth retention.

(F) Dental Care Support for Adolescents

The DH launched the PDCC on 20 March this year as an interface with the SDCS by providing partial subsidies for private dental check-up services for adolescents aged between 13 and 17 on a co-payment basis to foster their partnership with dentists and maintain the good life-long habit of regular oral check-ups for prevention of dental diseases. Adolescents from age 13 to 17 (or will turn 13 in the calendar year when applying to join the PDCC) who hold a valid Hong Kong Identity Card and have registered in the Electronic Health Record Sharing System (eHealth) are eligible to join the PDCC. About 370 000 adolescents are eligible to join each year. While the Government will provide a subsidy of \$200 each time, participants have to pay a co-payment fee as determined by their selected dentists. The co-payment for the subsidised services each time as recommended by the Government is \$200. As at 18 March, there are around 270 registered dentists whose application to participate in the PDCC has been accepted by the DH, providing services at over 370 service locations. Among these dentists, over 67% charge a co-payment amount of \$200 or less while the minimum co-payment amount is \$50. The DH has publicised the PDCC in collaboration with the Education Bureau to all secondary school students and their parents in the territory. The final number of participants will depend on the response from adolescents and their parents.

The total revised estimate for implementing the PDCC and the CDSP for 2024-25 is \$38.4 million, while the total financial provision for 2025-26 is \$136.3 million.

Apart from the above public dental services provided by the DH, the EHVS subsidises eligible Hong Kong elderly persons aged 65 or above with an annual Elderly Health Care Voucher (EHCV) amount of \$2,000 (with an accumulation limit of \$8,000) to use private primary healthcare services, including dental services. The amount of vouchers claimed by dentists/for dental (stomatology) services under the EHVS in the past 3 years are as follows:

Amount of Vouchers Claimed (\$'000)			
	2022	2023	2024
Dentists in Hong Kong	343,327	413,222	402,347
Dental/Stomatology Department of the medical institutions in the Greater Bay Area (GBA) ^{Note}	170	462	17,408

Note : The medical institutions in the GBA cover two service points operated by the University of Hong Kong-Shenzhen Hospital and 7 pilot medical institutions under the Elderly Health Care Voucher Greater Bay Area Pilot Scheme. The Department of Stomatology at the Nansha Division of the First Affiliated Hospital, Sun Yat-sen University is pending service launch.

The estimated expenditure on the EHVS for 2025-26 is \$4.15 billion, which has already included the claim amount in respect of dental services. The expenditure related to EHCVs for dental services is subsumed under the overall provision for the EHVS and will not be separately identified.

Based on the actual expenditures provided above, as well as the expenditure separately under the “Elderly Dental Assistance Programme” funded by the Community Care Fund and the

dental grants under the CSSA Scheme of the Social Welfare Department, the expenditures on dental services provided or subsidised by the Government was close to \$1.3 billion in 2023-24.

2.

The current number of discs for allocation per GP Session under normal circumstances for each dental clinic with GP Sessions are tabulated as follows:

Dental Clinic with GP Sessions	Service Session	Number of Discs for Allocation per Session
Kowloon City Dental Clinic	Monday (AM)	42
	Thursday (AM)	21
Kwun Tong Dental Clinic	Wednesday (AM)	42
Kennedy Town Community Complex Dental Clinic	Monday (AM)	42
	Friday (AM)	42
Fanling Health Centre Dental Clinic	Tuesday (AM)	25
Mona Fong Dental Clinic	Thursday (AM)*	21
Tai Po Wong Siu Ching Dental Clinic	Thursday (AM)	21
Tsuen Wan Dental Clinic	Tuesday (AM)	42
	Friday (AM)	42
Yan Oi Dental Clinic	Wednesday (AM)	21
Yuen Long Government Offices Dental Clinic	Tuesday (AM)	21
	Friday (AM)	21
Tai O Dental Clinic	2 nd Thursday (AM) of each month	16
Cheung Chau Dental Clinic	1 st Friday (AM) of each month	16

* Changed from Thursday afternoons to Thursday mornings with effect from 2 January 2025

The numbers of attendances at each dental clinic in 2022-23, 2023-24 and 2024-25 (up to 31 January 2025) are tabulated as follows:

Dental Clinic with GP Sessions	Number of Attendances		
	2022-23	2023-24	2024-25 (up to 31 January 2025)
Kowloon City Dental Clinic	3 157	2 787	2 469
Kwun Tong Dental Clinic	2 136	2 089	1 574
Kennedy Town Community Complex Dental Clinic	3 909	3 670	3 332
Fanling Health Centre Dental Clinic	1 192	1 175	1 014
Mona Fong Dental Clinic	1 065	929	729
Tai Po Wong Siu Ching Dental Clinic	1 071	1 014	804
Tsuen Wan Dental Clinic	4 104	3 970	3 476
Yan Oi Dental Clinic	1 062	984	779
Yuen Long Government Offices Dental Clinic	2 041	1 919	1 678
Tai O Dental Clinic	130	122	100
Cheung Chau Dental Clinic	168	153	127
Total	20 035	18 812	16 082

The overall utilisation rates of each dental clinic in 2022-23, 2023-24 and 2024-25 (up to 31 January 2025) are tabulated as follows:

Dental Clinic with GP Sessions	Overall Utilisation Rate in %		
	2022-23	2023-24	2024-25 (up to 31 January 2025)
Kowloon City Dental Clinic	99.5	97.7	98.2
Kwun Tong Dental Clinic	100.0	97.9	99.8
Kennedy Town Community Complex Dental Clinic	99.7	97.1	98.6
Fanling Health Centre Dental Clinic	99.5	95.0	95.9
Mona Fong Dental Clinic	98.0	88.1	86.6
Tai Po Wong Siu Ching Dental Clinic	100.0	95.3	97.7

Dental Clinic with GP Sessions	Overall Utilisation Rate in %		
	2022-23	2023-24	2024-25 (up to 31 January 2025)
Tsuen Wan Dental Clinic	99.9	98.8	99.6
Yan Oi Dental Clinic	99.8	92.3	98.1
Yuen Long Government Offices Dental Clinic	99.2	94.7	97.8
Tai O Dental Clinic	67.7	64.1	70.8
Cheung Chau Dental Clinic	88.0	88.1	90.3

- End -

CONTROLLING OFFICER'S REPLY

HHB322

(Question Serial No. 4001)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (3) Health Promotion

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Please advise on:

- (1) the changes in the number of smokers in Hong Kong following the last 2 tobacco-duty increases, along with the current proportion of smokers in the population according to the Government's statistics; and
- (2) whether there has been any increase in the number of enquiries and requests for assistance in relation to smoking cessation services received by government hospitals and government-subvented organisations following the tobacco-duty increases.

Asked by: Hon MA Fung-kwok (LegCo internal reference no.: 10)

Reply:

(1)

After the Government increased the tobacco duty in February 2023, the result of the Thematic Household Survey (THS) on smoking pattern conducted by the Census and Statistics Department (C&SD) from May to August that year showed that the smoking prevalence dropped from 10.2% in 2019 and 9.5% in 2021 to 9.1% in 2023. The average number of cigarettes smoke per day by smokers also decreased from 12.7 sticks in 2019 and 2021 to 12.1 sticks in 2023. The Government further increased the tobacco duty in 2024. In this connection, a THS will be conducted later and it is expected that the reduction in the demand for tobacco products will be reflected in the survey. The C&SD conducted and completed 2 rounds of THS on the pattern of smoking in the past 5 years, with a breakdown of the smoking prevalence and the number of cigarettes consumed by smokers daily (by age group and sex) set out at Annex.

(2)

Increasing tobacco duty is recognised internationally as the most effective means of reducing tobacco use. Through raising the costs of smoking, it provides a greater incentive for smokers to quit smoking, and dampens the eagerness of non-smokers, the youth in particular, to smoke. Past experience in increasing tobacco duty indicated that increasing tobacco duty

is conducive to reducing smoking prevalence. The greater the tax hike, the greater the drop in smoking prevalence. The number of calls to the Department of Health (DH)'s Quitline immediately after the increase in tobacco duty is also a sensitive indicator of smokers' response (i.e. their intention to quit smoking) to the duty increase. In the first month after the duty increase was announced in the 2023-2024 and 2024-25 Budget, the number of calls to the Quitline increased by about three times respectively when compared to the monthly number of calls received in the previous three months, reflecting the strong intention of smokers to quit smoking as a result of the duty increase. The number of calls received by the DH's Quitline increased from about 7 400 in 2022 to about 9 300 in 2024, representing an increase of more than 20%.

At present, the DH is responsible for coordinating the provision of smoking cessation services in Hong Kong. Apart from operating an integrated Smoking Cessation Hotline to handle general enquiries and provide professional counselling on smoking cessation, the DH arranges referrals to various smoking cessation services in the territory, including those provided by public clinics under the Hospital Authority (HA) (helping patient, especially for those with chronic diseases, to quit smoking), and community-based cessation programmes operated by non-governmental organisations (NGOs). There are a total of 15 full-time and 55 part-time centres operated by the HA which have been providing smoking cessation services to the general public since 2002, and there are 5 smoking cessation clinics for civil servants operated by the DH. Furthermore, the DH also collaborates with NGOs to provide a range of community-based smoking cessation services including counselling, consultations by doctors (including free postal delivery of smoking cessation drugs) or Chinese medicine practitioners, and designated services for smokers from different ethnicities, immigrant smokers and workplace smokers. For young smokers, the DH collaborates with local universities to operate a hotline to provide them with dedicated counselling services over the phone. Besides, the DH has subvented 2 more service providers (from 2 to 4 in total) since 2023 to operate smoking cessation clinics with a focus on counselling and pharmacotherapy, and 3 more Chinese medicine smoking cessation service providers (from 1 to 4 in total) starting from this year to operate smoking cessation clinics with an emphasis on counselling and acupuncture. It is expected that the number of service users of the former type of clinics will increase by about 40% and the number regarding the latter type will double.

In 2022, 2023 and 2024, there were 20 406, 27 715 and 28 512 smokers receiving smoking cessation services via quitlines, at cessation clinics under the HA and through community-based programmes operated by NGOs.

Smokers who receive smoking cessation treatment receive 52-week follow-up services to assess their quit status. For smokers who receive smoking cessation services via quitlines, at cessation clinics under the HA and through community-based programmes operated by NGOs, their 52-week quit rates, which refer to the percentage of service users self-reporting to have stayed quit in the past 7 days, range from 20% to 60%, which are comparable to those in overseas countries. Discrepancies in the quit rates concerning different smoking cessation programmes are due to differences in terms of their target groups and treatment methods (which include counselling, pharmacotherapy, and Chinese medicine with acupuncture). To become a successful quitter, smokers are encouraged to choose the cessation service that best caters for their personal needs.

The Government will continue to step up its work on smoking cessation and explore various tobacco control measures in the medium and long term in order to eliminate the social hazards posed by tobacco products in all aspects and safeguard the health of the community with a progressive and multi-pronged approach.

Prevalence of daily cigarette smokers by age group and sex in 2021 and 2023*

Age group	Male		Female		Overall	
	2021	2023	2021	2023	2021	2023
15 - 19	#	#	#	#	#	#
20 - 29	9.6%	9.3%	2.1%	1.7%	5.9%	5.5%
30 - 39	15.3%	16.2%	4.5%	3.6%	9.5%	9.7%
40 - 49	24.6%	21.9%	5.8%	5.0%	14.2%	12.6%
50 - 59	22.0%	23.5%	3.2%	4.1%	11.7%	12.7%
≥ 60	15.7%	15.3%	1.2%	0.9%	8.2%	7.7%
Overall	16.7%	16.4%	3.0%	2.7%	9.5%	9.1%

* As a percentage of all persons in the respective age group. For example, among all males aged 20 to 29, 9.6% were daily cigarette smokers based on the survey conducted in 2021.

The figures are not released due to the large sampling error.

Source: Thematic Household Survey Report Nos. 75 and 79, Census and Statistics Department.

Average Daily Consumption of Cigarettes (number of sticks of cigarettes)
by Age Group and Sex in 2021 and 2023

	2021	2023
Age group		
15 - 19	#	#
20 - 29	11.2	11.2
30 - 39	11.5	11.5
40 - 49	12.7	11.8
50 - 59	13.7	12.6
≥ 60	13.0	12.5
Sex		
Male	13.2	12.6
Female	10.5	9.3
Overall	12.7	12.1

The figures are not released due to the large sampling error.

Source: Thematic Household Survey Report Nos. 75 and 79, Census and Statistics Department.

- End -

CONTROLLING OFFICER'S REPLY

HHB323

(Question Serial No. 4023)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Have the Government and its subvented groups/organisations strengthened services for alcohol prevention and treatment since the reduction in duty for liquor? Has there been an increase in the number of cases seeking such services?

Asked by: Hon MA Fung-kwok (LegCo internal reference no.: 9)

Reply:

The Government adopts a multi-pronged approach, comprising publicity and education, law enforcement, promotion of alcohol screening, etc., to reduce alcohol-related harm. The relevant initiatives include:

- (i) The Department of Health (DH) has launched a publicity and education campaign named “Understanding Alcohol Harm” since 2022 to enhance the public’s understanding of the health risks associated with alcohol consumption through various channels. Through a website, the DH disseminates information on alcohol-related harm to the public, and provides online risk assessment of drinking behaviour, personalised health advice, self-help tools, health education resources, etc. to encourage drinkers to change their drinking behaviour for the sake of their health.
- (ii) District Health Centres (DHCs) and District Health Centre Expresses (DHC Expresses) provide primary healthcare services to citizens, including the Life Course Preventive Care which is an evidence-based and comprehensive health strategy that emphasises prevention and personalised needs. It provides guidance on the health needs of citizens across different life stages and assists citizens in developing a healthy lifestyle, including early identification and intervention of high-risk drinking behaviours through the Health Risk Factors Assessment and providing alcohol abuse prevention advice, with a view to enhancing the overall health of the Hong Kong citizens.
- (iii) The DH recommends the Alcohol Screening and Brief Intervention (A-SBI) tool to primary healthcare service providers, including organisation of online training for the staff of the DHCs and DHC Expresses to encourage regular use of the A-SBI tool for

early identification and management of at-risk drinkers, as well as referral of those with probable alcohol dependence to the relevant services.

- (iv) The DH has also launched the Pilot Alcohol Cessation Counselling Service (Pilot Programme) through subvention to a non-governmental organisation. The Pilot Programme was launched on 8 April 2024 and will last for 2 years to provide free counselling service for Hong Kong residents identified to have probable alcohol dependence. The service comprises 3 components, namely initial assessment, evidence-based individual counselling intervention, and subsequent evaluation follow-up. As at the end of December 2024, a total of 124 eligible individuals have enrolled for and started receiving the service provided under the Pilot Programme.
- (v) Since 2018, the DH has been enforcing the Dutiable Commodities (Amendment) Regulation 2018 to prevent youth access to alcohol. The sale and supply of intoxicating liquor to minors in the course of business are prohibited under Part 5 of the Dutiable Commodities (Liquor) Regulations (Cap. 109B). It also requires vendors which sell or supply intoxicating liquor in face-to-face distributions to display a prescribed notice in a prominent position at the premises in the course of business. The DH conducts inspections and carries out enforcement actions upon receipt of intelligence or complaints. It may conduct inspections, either randomly or targeted, to check whether vendors have complied with the relevant requirements.

The DH will continue to reduce alcohol-related harm through various means and will closely monitor local alcohol consumption through periodic surveys, including the situation following the reduction in the duty for certain types of liquor.

- End -

CONTROLLING OFFICER'S REPLY

HHB324

(Question Serial No. 3934)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (4) Curative Care

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

1. While the Government is currently collaborating with non-governmental organisations to launch the Community Dental Support Programme (CDSP) for providing dental services for underprivileged groups, the number of people benefiting from the programme is limited. In this connection, will the Government consider setting up a mechanism for middle-income or low-income families, so that they can apply for financial assistance from relevant departments, where necessary, to cover the high costs of dental treatment?
2. As the CDSP will in 2026 supplant the Community Care Fund Elderly Dental Assistance Programme, under which participating elderly can receive dental services provided by the private sector, will the Government consider continuing the practice of the Community Care Fund Elderly Dental Assistance Programme by inviting dentists in the private sector to participate in the new programme to optimise the resources of the dentist profession in Hong Kong?

Asked by: Hon SHANG Hailong (LegCo internal reference no.: 11)

Reply:

1&2.

To safeguard the oral health of the public, the Chief Executive announced in the 2022 Policy Address to conduct a comprehensive review of the dental services provided or subsidised by the Government. The Working Group on Oral Health and Dental Care (Working Group) was subsequently established in end-2022. The Working Group published a final report in end-2024, recommending that the future development of dental services should make reference to the direction of the Primary Healthcare Blueprint emphasising prevention, early identification and timely intervention, with the goal of retention of natural teeth and enhancing the overall level of citizens' oral health.

The Government concurs with the views of the Working Group that providing or subsidising comprehensive curative dental services from public purse to all Hong Kong citizens regardless of their financial means does not align with the policy objectives of developing a prevention-oriented oral health and dental care system and encouraging citizens to take responsibility for their own oral health. This would exacerbate the current shortcomings of

the treatment-oriented system, and would be neither cost-effective nor sustainable in terms of utilisation of public resources. It would be financially untenable for the Government and would thin out the resources that could otherwise be used for other healthcare services.

In response to the final report of the Working Group, the Government has adopted the oral health policy that: (1) Oral health is an integral component of general health. The Government's oral health policy aims to enable all Hong Kong citizens to improve their oral hygiene and lifestyle conducive to both oral and overall health levels; (2) Through publicity, education, promotion and development of primary oral health and dental care, the Government facilitates citizens to manage their oral health, and put prevention, early identification and timely intervention of dental diseases into action with the objective of tooth retention; and (3) The Government provides appropriate oral health and dental care services targeting underprivileged groups with financial difficulties and special needs, ensuring these groups have access to essential dental care services.

In the Oral Health Action Plan formulated based on the Working Group's strategic recommendations, the Community Dental Support Programme (CDSP) is a service focusing on underprivileged groups who have difficulties in accessing dental care under the aforesaid strategy of ensuring these groups have access to essential dental care services.

On top of the existing dental grants under the Comprehensive Social Security Assistance Scheme and the emergency dental service provided through General Public Sessions by government dental clinics, the Department of Health (DH) will increase the dental services to underprivileged groups with financial difficulties by launching the CDSP in 2025 and enhancing service capacity, increasing service points and expanding service scope, aiming to additionally offer at least twice the current number of quotas provided by the General Public Sessions of government dental clinics (i.e. 40 000 per year). The CDSP leverages the networks of non-governmental organisations and social welfare organisations serving underprivileged groups to provide services to persons with financial difficulties more effectively. In addition to tooth extraction, the CDSP provides dental fillings where dentists consider appropriate to encourage tooth retention. The DH will continuously monitor the utilisation rates of the service and gather feedback from service users regarding their needs, as well as the data on their oral health conditions to review the effectiveness of the CDSP in due course.

- End -

CONTROLLING OFFICER'S REPLY**HHB325****(Question Serial No. 3645)**Head: (37) Department of HealthSubhead (No. & title): (-) Not SpecifiedProgramme: (2) Disease Prevention, (3) Health PromotionControlling Officer: Director of Health (Dr. Ronald LAM)Director of Bureau: Secretary for HealthQuestion:

Please provide a breakdown of the number of people from most-at-risk populations for HIV requesting post-exposure prophylaxis (PEP), the number of PEP recipients and the expenditure involved in the past 5 years.

Asked by: Hon TIK Chi-yuen (LegCo internal reference no.: 173)Reply:

The Government attaches great importance to the prevention and control of HIV infection. With global medical advances and effective implementation of HIV prevention and control strategies in Hong Kong over the past 4 decades, HIV infection has transformed from a fatal illness to a manageable chronic disease. According to the latest data published by the Department of Health (DH), the number of new cases of HIV infection in Hong Kong has been declining for 9 consecutive years, and the local prevalence of HIV infection remained at 0.1%, which is far below the global average. This demonstrates the effectiveness of Hong Kong's efforts in HIV prevention and control. Looking ahead, the Government will continue to scale up HIV testing and enhance treatment and care, and will keep strengthening the co-operation with various sectors of society towards the de-stigmatisation of HIV infection.

The number of clients prescribed with HIV post-exposure prophylaxis (PEP) by the Integrated Treatment Centre of the DH, including but not limited to those with post-sexual exposure, is as follows:

Financial year	Number of clients prescribed with PEP
2020-21	155
2021-22	140
2022-23	172
2023-24	187
2024-25*	175

* Figure as at 28 February 2025

Subsumed into the HIV care services provided by the DH, the expenditure involved cannot be separately identified.

- End -

CONTROLLING OFFICER'S REPLY

HHB326

(Question Serial No. 3646)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention, (3) Health Promotion

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Please provide a breakdown of the research expenditure on HIV pre-exposure prophylaxis (PrEP) in the past 5 years.

Asked by: Hon TIK Chi-yuen (LegCo internal reference no.: 174)

Reply:

The Government attaches great importance to the prevention and control of HIV infection. With global medical advances and effective implementation of HIV prevention and control strategies in Hong Kong over the past 4 decades, HIV infection has transformed from a fatal illness to a manageable chronic disease. According to the latest data published by the Department of Health, the number of new cases of HIV infection in Hong Kong has been declining for 9 consecutive years, and the local prevalence of HIV infection remained at 0.1%, which is far below the global average. This demonstrates the effectiveness of Hong Kong's efforts in HIV prevention and control. Looking ahead, the Government will continue to scale up HIV testing and enhance treatment and care, and will keep strengthening the co-operation with various sectors of society towards the de-stigmatisation of HIV infection.

No research projects on pre-exposure prophylaxis of HIV have been approved under the AIDS Trust Fund from 2020-21 to 2024-25.

- End -

CONTROLLING OFFICER'S REPLY

HHB327

(Question Serial No. 3647)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention, (3) Health Promotion

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Please advise on the estimated expenditure if the Government proposes the introduction of pre-exposure prophylaxis (PrEP) drugs to the Drug Formulary to subsidise the prevention of HIV infection among the most-at-risk populations.

Asked by: Hon TIK Chi-yuen (LegCo internal reference no.: 175)

Reply:

The Government attaches great importance to the prevention and control of HIV infection. With global medical advances and effective implementation of HIV prevention and control strategies in Hong Kong over the past 4 decades, HIV infection has transformed from a fatal illness to a manageable chronic disease. According to the latest data published by the Department of Health (DH), the number of new cases of HIV infection in Hong Kong has been declining for 9 consecutive years, and the local prevalence of HIV infection remained at 0.1%, which is far below the global average. This demonstrates the effectiveness of Hong Kong's efforts in HIV prevention and control. Looking ahead, the Government will continue to scale up HIV testing and enhance treatment and care, and will keep strengthening the co-operation with various sectors of society towards the de-stigmatisation of HIV infection.

The DH has implemented a programme called "The Commons" since 5 February 2024 to provide one-stop sexual health service for sexual minorities such as men who have sex with men with risk behaviours. The services provided under the programme include test for HIV and viral hepatitis, viral hepatitis vaccination, sexual health assessment, test and treatment for sexually transmitted infection and counselling. The programme further provides monitoring and counselling services for PrEP users to ensure that they receive medication in an appropriate and safe manner. A bundle of individualised preventive measures is also offered to optimise the effectiveness of PrEP use.

The DH will continue to examine and study the demand for PrEP and the need for related services through “The Commons”, with a view to establishing an appropriate mode of service provision and operation.

Subsumed into the DH’s overall provision for disease prevention, the expenditure of the resources involved in the implementation of “The Commons”, the one-stop sexual health service programme mentioned above, cannot be separately identified.

- End -

CONTROLLING OFFICER'S REPLY**HHB328****(Question Serial No. 3648)**Head: (37) Department of HealthSubhead (No. & title): (-) Not SpecifiedProgramme: (2) Disease Prevention, (3) Health PromotionControlling Officer: Director of Health (Dr. Ronald LAM)Director of Bureau: Secretary for HealthQuestion:

Please advise on the number of people requesting and obtaining post-exposure prophylaxis (PEP) and the expenditure and financial provision for the past 5 years in this respect.

Asked by: Hon TIK Chi-yuen (LegCo internal reference no.: 176)Reply:

The Government attaches great importance to the prevention and control of HIV infection. With global medical advances and effective implementation of HIV prevention and control strategies in Hong Kong over the past 4 decades, HIV infection has transformed from a fatal illness to a manageable chronic disease. According to the latest data published by the Department of Health (DH), the number of new cases of HIV infection in Hong Kong has been declining for 9 consecutive years, and the local prevalence of HIV infection remained at 0.1%, which is far below the global average. This demonstrates the effectiveness of Hong Kong's efforts in HIV prevention and control. Looking ahead, the Government will continue to scale up HIV testing and enhance treatment and care, and will keep strengthening the co-operation with various sectors of society towards the de-stigmatisation of HIV infection.

The number of clients prescribed with HIV post-exposure prophylaxis (PEP) by the Integrated Treatment Centre of the DH, including but not limited to those with post-sexual exposure, is as follows:

Financial year	Number of clients prescribed with PEP
2020-21	155
2021-22	140
2022-23	172
2023-24	187
2024-25*	175

* Figure as at 28 February 2025

Subsumed into the HIV care services provided by the DH, the expenditure involved cannot be separately identified.

- End -

CONTROLLING OFFICER'S REPLY

HHB329

(Question Serial No. 3649)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention, (3) Health Promotion

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Please provide a breakdown of the expenditure per head on the prevention of HIV infection in the most-at-risk populations in the past 5 years.

Asked by: Hon TIK Chi-yuen (LegCo internal reference no.: 177)

Reply:

The Government attaches great importance to the prevention and control of HIV infection. With global medical advances and effective implementation of HIV prevention and control strategies in Hong Kong over the past 4 decades, HIV infection has transformed from a fatal illness to a manageable chronic disease. According to the latest data published by the Department of Health (DH), the number of new cases of HIV infection in Hong Kong has been declining for 9 consecutive years, and the local prevalence of HIV infection remained at 0.1%, which is far below the global average. This demonstrates the effectiveness of Hong Kong's efforts in HIV prevention and control. Looking ahead, the Government will continue to scale up HIV testing and enhance treatment and care, and will keep strengthening co-operation with various sectors of society towards the de-stigmatisation of HIV infection.

The Government has been allocating resources for the prevention and control of HIV/AIDS. The initiatives include:

- (a) setting up the Hong Kong Advisory Council on AIDS (ACA) in 1990 to review the local and international trends and development in respect of HIV infection and AIDS; to advise the Government on policies relating to the prevention, care and control of HIV infection and AIDS in Hong Kong; and to provide advice on the co-ordination and monitoring of programmes for prevention of HIV infection and on the services provided for people with HIV/AIDS in Hong Kong;
- (b) setting up the AIDS Trust Fund (ATF) in April 1993 with a commitment of \$350 million approved by the Finance Committee (FC) of the Legislative Council, to provide assistance for HIV infected haemophiliacs; to strengthen medical and support services;

and to enhance public education about AIDS. An additional injection of \$350 million was approved by the FC in 2013-14 to continue supporting the funding applications submitted by non-governmental organisations (NGOs) set up in response to AIDS and other organisations under the ATF.

Based on the “Recommended HIV/AIDS Strategies for Hong Kong” issued by the Hong Kong Advisory Council on AIDS in 2022, the ATF accords higher funding priority to applications for projects targeting 6 high-risk groups, namely men who have sex with men, people living with HIV, female sex workers and their male clients, people who inject drugs, ethnic minorities and transgenders. From 2020-21 to 2024-25, the ATF has allocated a total of \$107.6 million to 52 projects targeting the 6 high-risk groups mentioned above. Upon reviewing the funding applications received in July 2024, the ATF recommended that the DH support 17 projects targeting the 6 high-risk groups, with an allocation of \$22.6 million directly funded by the DH.

A breakdown of project funding by target group is as follows:

High-risk Group	Funding Approved (\$ million)
Men who have sex with men	61.02
People living with HIV	20.50
Female sex workers with their male clients	29.58
People who inject drugs	8.54
Ethnic minorities	8.16
Transgenders	2.39
Total (Note)	130.19

Note: The funding for project applications received in July 2024, directly funded by the DH, has been subsumed into the total amount.

- (c) providing resources for the DH’s services, including the Special Preventive Programme (SPP), the Social Hygiene Service and the Methadone Treatment Programme, for HIV prevention and care. With reference to the recommendation by the World Health Organization and the Joint United Nations Programme on HIV/AIDS, the DH has set up a one-stop sexual health service called “The Commons” under a people-oriented concept on 5 February 2024. The target clientele of this service include sexual minorities such as men who have sex with men with risk behaviours. In addition to the provision of screening for HIV and viral hepatitis, viral hepatitis vaccination, sexual health assessment, testing and treatment for sexually transmitted infection, “The Commons” also proactively identifies people in need, including those who have engaged in high-risk behaviors, to provide personalised HIV prevention service integrated with counselling and support. Meanwhile, “The Commons” is also dedicated to maintaining and fostering close collaborations and mutual support with non-governmental organisations, leveraging the efficiency at the primary healthcare level to maximise its impact on disease prevention.

Subsumed into the DH’s overall provision for disease prevention, the expenditure of the overall resources for prevention of HIV/AIDS for high-risk individuals cannot be separately identified.

- (d) Rather than its previous approach of funding community stakeholders through a designated fund dedicated to a single disease, the Government will implement a multi-faceted and collaborative strategy to support various community stakeholders, including NGOs, in AIDS prevention and control. This new strategy will integrate HIV response into a broader healthcare framework, promoting normalisation of HIV testing, dispelling misconceptions about the infection, and fostering greater acceptance and support for people living with HIV.

- End -

CONTROLLING OFFICER'S REPLY**HHB330****(Question Serial No. 3650)**Head: (37) Department of HealthSubhead (No. & title): (-) Not SpecifiedProgramme: (2) Disease Prevention, (3) Health PromotionControlling Officer: Director of Health (Dr. Ronald LAM)Director of Bureau: Secretary for HealthQuestion:

Please provide a breakdown of the expenditure on HIV prevention research in the past 5 years.

Asked by: Hon TIK Chi-yuen (LegCo internal reference no.: 178)

Reply:

The Government attaches great importance to the prevention and control of HIV infection. With global medical advances and effective implementation of HIV prevention and control strategies in Hong Kong over the past 4 decades, HIV infection has transformed from a fatal illness to a manageable chronic disease. According to the latest data published by the Department of Health (DH), the number of new cases of HIV infection in Hong Kong has been declining for 9 consecutive years, and the local prevalence of HIV infection remained at 0.1%, which is far below the global average. This demonstrates the effectiveness of Hong Kong's efforts in HIV prevention and control. Looking ahead, the Government will continue to scale up HIV testing and enhance treatment and care, and will keep strengthening the co-operation with various sectors of society towards the de-stigmatisation of HIV infection.

From 2020-21 to 2024-25, the AIDS Trust Fund (ATF) has approved a total of \$9.56 million for 17 research projects on HIV prevention. Upon reviewing the funding applications received in July 2024, the ATF recommended that the DH support 1 research project, with an allocation of \$940 000 directly funded by the DH.

A breakdown of the project funding by target group is as follows:

High risk Group	Funding Approved (\$ million)
Men who have sex with men	5.87
People living with HIV	4.63
Total^(Note)	10.50

Note: The funding for project applications received in July 2024, directly funded by the DH, has been subsumed into the total amount.

- End -

CONTROLLING OFFICER'S REPLY

HHB331

(Question Serial No. 3651)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention, (3) Health Promotion

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Please provide a breakdown of the expenditure on the promotion of U=U in the past 5 years.

Asked by: Hon TIK Chi-yuen (LegCo internal reference no.: 179)

Reply:

The Government attaches great importance to the prevention and control of HIV infection. With global medical advances and effective implementation of HIV prevention and control strategies in Hong Kong over the past 4 decades, HIV infection has transformed from a fatal illness to a manageable chronic disease. According to the latest data published by the Department of Health (DH), the number of new cases of HIV infection in Hong Kong has been declining for 9 consecutive years, and the local prevalence of HIV infection remained at 0.1%, which is far below the global average. This demonstrates the effectiveness of Hong Kong's efforts in HIV prevention and control. Looking ahead, the Government will continue to scale up HIV testing and enhance treatment and care, and will keep strengthening co-operation with various sectors of society towards the de-stigmatisation of HIV infection.

The Government has been allocating resources for the prevention and control of HIV/AIDS. The initiatives include:

- (a) setting up the Hong Kong Advisory Council on AIDS (ACA) in 1990 to review the local and international trends and development in respect of HIV infection and AIDS; to advise the Government on policies relating to the prevention, care and control of HIV infection and AIDS in Hong Kong; and to provide advice on the co-ordination and monitoring of programmes for prevention of HIV infection and on the services provided for people with HIV/AIDS in Hong Kong. Promoting the idea of "Undetectable = Untransmittable (U=U)" can reduce the public's stigma and discrimination against people with HIV, alleviate the fear of undergoing HIV test, and enhance treatment adherence of people with HIV. "U=U" has been listed as a key message for promotion in the "Recommended HIV/AIDS Strategies for Hong Kong (2022-2027) released by the ACA in 2022";

- (b) setting up the AIDS Trust Fund (ATF) in April 1993 with a commitment of \$350 million approved by the Finance Committee (FC) of the Legislative Council to provide assistance for HIV infected haemophiliacs; to strengthen medical and support services; and to enhance public education about AIDS. An additional injection of \$350 million was approved by the FC in 2013-14 to continue supporting the funding applications submitted by non-governmental organisations (NGOs) set up in response to AIDS and other organisations under the ATF. The NGOs funded by the Government have been promoting the idea of “U=U”;
- (c) providing resources for the Department of Health’s (DH) services, including the Special Preventive Programme (SPP) and the Social Hygiene Service for HIV prevention and care. The DH has been promoting the idea of “Undetectable = Untransmittable (U=U)” through various means, including life-skill-based education about HIV and sex through the SPP, as well as online resources about sex education. The idea of “U=U” has already been incorporated into the SPP’s publicity work, including online promotion, mass media promotion and health talks. Moreover, the DH has been collaborating with NGOs to organise events for promoting the idea of “U=U” and fostering the public’s acceptance of people with HIV/AIDS; and
- (d) rather than its previous approach of funding community stakeholders through a designated fund dedicated to a single disease, the Government will implement a multi-faceted and collaborative strategy to support various community stakeholders, including NGOs, in AIDS prevention and control. This new strategy will integrate HIV response into a broader healthcare framework, promoting normalisation of HIV testing, dispelling misconceptions about the infection, and fostering greater acceptance and support for people living with HIV.

Resources for the “U=U” promotion have been subsumed into the DH’s overall provision for disease prevention and cannot be separately identified.

The Government will keep in view the service demand in the coming years for resource allocation.

- End -

CONTROLLING OFFICER'S REPLY

HHB332

(Question Serial No. 3652)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention, (3) Health Promotion

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Please advise on the expenditure incurred in preventing HIV infection in the past 5 years broken down into the following groups: heterosexual population, men who have sex with men, ethnic minorities, sex workers and injecting drug users.

Asked by: Hon TIK Chi-yuen (LegCo internal reference no.: 180)

Reply:

The Government attaches great importance to the prevention and control of HIV infection. With global medical advances and effective implementation of HIV prevention and control strategies in Hong Kong over the past 4 decades, HIV infection has transformed from a fatal illness to a manageable chronic disease. According to the latest data published by the Department of Health (DH), the number of new cases of HIV infection in Hong Kong has been declining for 9 consecutive years, and the local prevalence of HIV infection remained at 0.1%, which is far below the global average. This demonstrates the effectiveness of Hong Kong's efforts in HIV prevention and control. Looking ahead, the Government will continue to scale up HIV testing and enhance treatment and care, and will keep strengthening the co-operation with various sectors of society towards the de-stigmatisation of HIV infection.

Based on the "Recommended HIV/AIDS Strategies for Hong Kong" issued by the Hong Kong Advisory Council on AIDS in 2022, the AIDS Trust Fund (ATF) accords higher funding priority to applications for projects targeting 6 high-risk groups, namely men who have sex with men, people living with HIV, female sex workers and their male clients, people who inject drugs, ethnic minorities and transgenders.

From 2020-21 to 2024-25, the ATF has allocated a total of \$107.6 million to 52 projects targeting the 6 high-risk groups mentioned above. Upon reviewing the funding applications received in July 2024, the ATF recommended that the DH support 17 projects targeting these 6 high-risk groups, with an allocation of \$22.6 million directly funded by the DH.

A breakdown of project funding by target group is as follows:

High-risk Group	Funding Approved (\$ million)
Men who have sex with men	61.02
People living with HIV	20.50
Female sex workers with their male clients	29.58
People who inject drugs	8.54
Ethnic minorities	8.16
Transgenders	2.39
Total ^(Note)	130.19

Note: The funding for project applications received in July 2024, directly funded by the DH, has been subsumed into the total amount.

With reference to the recommendation by the World Health Organization and the Joint United Nations Programme on HIV/AIDS, the DH has set up a one-stop sexual health service called “The Commons” under a people-centred care concept on 5 February 2024. The target clientele of this service are sexual minorities such as men who have sex with men with risk behaviours. In addition to the provision of screening for HIV and viral hepatitis, viral hepatitis vaccination, sexual health assessment, test and treatment for sexually transmitted infections, “The Commons” also proactively identifies people in need, including those who have engaged in high-risk behaviors, to provide personalised HIV prevention services integrated with counselling and support. Meanwhile, “The Commons” is also dedicated to maintaining and fostering close collaborations and mutual support with non-governmental organisations, leveraging the efficiency at the primary healthcare level to maximise its impact on disease prevention.

Subsumed into the DH’s overall provision for disease prevention, the expenditure of the resources involved in the implementation of “The Commons”, the one-stop sexual health service programme mentioned above, cannot be separately identified.

Rather than its previous approach of funding community stakeholders through a designated fund dedicated to a single disease, the Government will implement a multi-faceted and collaborative strategy to support various community stakeholders, including non-governmental organisations, in AIDS prevention and control. This new strategy will integrate HIV response into a broader healthcare framework, promoting normalisation of HIV testing, dispelling misconceptions about the infection, and fostering greater acceptance and support for people living with HIV.

- End -

CONTROLLING OFFICER'S REPLY**HHB333****(Question Serial No. 3666)**Head: (37) Department of HealthSubhead (No. & title): (-) Not SpecifiedProgramme: (5) RehabilitationControlling Officer: Director of Health (Dr. Ronald LAM)Director of Bureau: Secretary for HealthQuestion:

Regarding children with special educational needs (SENs), the Government adopts the principle of early identification and intervention for children to receive assessment before they turn 6 (prior to pre-primary education), and to provide relevant training and services. In this connection, please advise on the number of children assessed over the past 5 years by type of SEN (e.g. attention deficit/hyperactivity disorder (ADHD), autism, developmental delay in terms of intellectual ability, learning disorders, etc.).

Asked by: Hon TIK Chi-yuen (LegCo internal reference no.: 194)Reply:

The Child Assessment Service (CAS) of the Department of Health (DH) receives referrals from doctors and psychologists and provides comprehensive assessment and diagnosis for children under the age of 12 who are suspected to have developmental problems. Apart from the DH, assessment services are also provided by the Hospital Authority (HA), the Education Bureau, non-governmental organisations and recognised professionals in the private sector.

The number of children assessed by the CAS in the past 5 years is as follows:

	2020	2021	2022	2023	2024 (Provisional figures)
Number of children assessed by the CAS #	14 507	16 626	14 251	18 637	17 757

The figure includes both newly registered referral cases and follow-up cases.

The DH does not maintain statistics on the number of children assessed with breakdown by the stage of schooling.

The number of newly diagnosed cases of developmental conditions in the CAS in the past 5 years is as follows:

Developmental Conditions	Number of newly diagnosed cases				
	2020	2021	2022	2023	2024 (Provisional figures)
Attention/Hyperactive Problems/Disorders	3 318	2 970	2 422	3 156	2 996
Autism Spectrum Disorder	1 769	1 960	1 861	2 415	2 195
Borderline Developmental Delay	2 512	2 652	2 105	2 479	2 752
Developmental Motor Coordination Problems/Disorders	2 016	2 503	2 256	2 765	3 018
Dyslexia & Mathematics Learning Disorder	477	331	229	359	298
Hearing Loss (Moderate to profound grade)	51	63	50	58	90
Language Delay/Disorders and Speech Problems	4 570	5 401	4 147	5 441	6 974
Physical Impairment (i.e. Cerebral Palsy)	36	38	34	38	45
Significant Developmental Delay/Intellectual Disability	1 482	1 722	1 527	1 914	2 261
Visual Impairment (Blind to Low Vision)	11	11	6	46	46

Note: A child might have been diagnosed with more than 1 developmental condition.

As announced by the Chief Executive in his 2024 Policy Address, to enhance the health of the people of Hong Kong, improve healthcare protection and quality, and capitalise on our healthcare professions' strengths, the Government is conducting a comprehensive review on the positioning and objectives of the healthcare system. The review covers the reform of the functions and division of work among the HA, the DH and the Primary Healthcare Commission (PHC Commission). The relevant initiatives include reforming the HA's governance effectiveness to enhance the standards and efficiency of its specialist and in-patient services. At the same time, the PHC Commission and the DH will strengthen their efforts in health promotion and disease prevention in order to continue to redress the imbalance in the existing system which emphasises on treatment rather than prevention. The DH will also strengthen its role as the Government's adviser and regulatory authority in respect of public health, and will focus on its functions in this aspect. In this connection, the DH is gradually transferring its specialist clinical services and primary healthcare services to the HA and the PHC Commission respectively.

The DH is liaising with the HA on the detailed arrangements for integrating the CAS into the Hong Kong Children's Hospital under the HA, with a view to consolidating the public paediatrics services to facilitate collaboration among various specialities and streamline the procedure for service delivery. In this way, the children suspected of having developmental or behavioural problems can receive the necessary integrated multi-disciplinary assessment, treatment and rehabilitative services in a timely manner, while the referral arrangements and

services for patients can be further enhanced. Relevant details will be announced in due course.

- End -

CONTROLLING OFFICER'S REPLY

HHB334

(Question Serial No. 3675)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (4) Curative Care

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Please advise on the locations of clinics/centres where dental services are provided for persons with disabilities, as well as their service capacity, services provided, number of service users and average cost per user, in the past 3 years.

Asked by: Hon TIK Chi-yuen (LegCo internal reference no.: 203)

Reply:

To safeguard the oral health of the public, the Chief Executive announced in the 2022 Policy Address to conduct a comprehensive review of the dental services provided or subsidised by the Government. The Working Group on Oral Health and Dental Care (Working Group) was subsequently established in end-2022. The Working Group published a final report in end-2024, recommending that the future development of dental services should make reference to the direction of the Primary Healthcare Blueprint emphasising prevention, early identification and timely intervention, with the goal of retention of natural teeth and enhancing the overall level of citizens' oral health.

The Government concurs with the views of the Working Group that providing or subsidising comprehensive curative dental services from public purse to all Hong Kong citizens regardless of their financial means does not align with the policy objectives of developing a prevention-oriented oral health and dental care system and encouraging citizens to take responsibility for their own oral health. This would exacerbate the current shortcomings of the treatment-oriented system, and would be neither cost-effective nor sustainable in terms of utilisation of public resources. It would be financially untenable for the Government and would thin out the resources that could otherwise be used for other healthcare services.

In response to the final report of the Working Group, the Government has adopted the oral health policy that: (1) Oral health is an integral component of general health. The Government's oral health policy aims to enable all Hong Kong citizens to improve their oral hygiene and lifestyle conducive to both oral and overall health levels; (2) Through publicity, education, promotion and development of primary oral health and dental care, the Government facilitates citizens to manage their oral health, and put prevention, early

identification and timely intervention of dental diseases into action with the objective of tooth retention; and (3) The Government provides appropriate oral health and dental care services targeting underprivileged groups with financial difficulties and special needs, ensuring these groups have access to essential dental care services.

The dental services currently provided by the Government to persons with disabilities are outlined below. In the Oral Health Action Plan formulated based on the Working Group's strategic recommendations, these services are focusing on underprivileged groups who have difficulties in accessing dental care under the aforesaid strategy of ensuring these groups have access to essential dental care services.

School Dental Care Service (SDCS)

Primary school students in Hong Kong, as well as students aged under 18 with intellectual disability (ID) and/or physical disability studying in special schools, can join the SDCS of the Department of Health (DH) to receive annual check-ups at 8 designated school dental clinics, which cover oral examination as well as basic restorative and preventive treatment. The 8 designated school dental clinics are Tang Shiu Kin School Dental Clinic, Argyle Street Jockey Club School Dental Clinic (1/F and 3/F), Lam Tin School Dental Clinic, Ha Kwai Chung School Dental Clinic, Pamela Youde School Dental Clinic, Tuen Mun School Dental Clinic and Fanling School Dental Clinic. The number of participating students with ID and/or physical disability studying in special schools in the past 3 years is set out below:

Service Year ^{Note 1}	2022-23	2023-24	2024-25
Number of Participants	6 429	6 907	7 155

Note 1: A service year refers to the period from 1 November of the current year to 31 October of the following year.

Absorbed within the overall provision for dental services under its Programme, the expenditure on providing the SDCS to persons with ID is not available.

Dandelion Oral Care Action

Since 2005, to strengthen concerted efforts from parents and schools to facilitate children with ID to maintain personal oral hygiene, the Oral Health Promotion Division (OHPD) (formerly the Oral Health Education Division) of the DH has been conducting a special oral health promotion programme named the "Dandelion Oral Care Action" (the Dandelion Programme) which adopts a train-the-trainer approach whereby the school nurses, teachers and parents of the participating special schools are trained to equip special tooth cleaning skills. Under the Dandelion Programme, oral care skill has become part of the self-care curriculum of the participating schools. At least 1 school nurse or teacher from each school will be trained by the OHPD to become the Oral Health Trainer (OHT) in school. The OHTs, in turn, will train all the teachers and parents and the long-term goal is to enable the children with ID to brush and floss their teeth competently and independently by the time they leave school. Currently, there are 29 schools in Hong Kong joining the Dandelion Programme.

The number of participants (including school nurses, teachers, parents and students) in the

past 3 school years is set out below:

School Year ^{Note 2} :	2021-2022	2022-2023	2023-2024
Number of Participants	5 288	5 396	5 527

Note 2: A school year refers to the period from 1 September of the current year to 31 August of the following year.

Absorbed within the provision for dental services under its Programme, the expenditure on the Dandelion Programme is not available.

Oral Maxillofacial Surgery & Dental Clinics (OMS&DCs) and Special Oral Care Service (SOCS)

The DH sets up the OMS&DCs in 7 public hospitals (Queen Mary Hospital, Pamela Youde Nethersole Eastern Hospital, Queen Elizabeth Hospital, Princess Margaret Hospital, Prince of Wales Hospital, North District Hospital and Tuen Mun Hospital) to provide oral maxillofacial surgery and specialist dental treatment to in-patients and patients with special oral health care needs and dental emergency.

The number of attendances of patients with ID and/or severe physical disability in the past 3 years is set out below:

Year	2022	2023	2024
Number of Attendances	366	375	383

Absorbed within the provision for dental services under its Programme, the expenditure for providing services to persons with ID and/or severe physical disability under the DH's OMS&DCs is not available.

In order to improve the oral health of children with ID, the DH set up a SOCS in September 2019 in collaboration with the Hospital Authority at the Hong Kong Children's Hospital (HKCH) for pre-school children under 6 years old with ID for early intervention and prevention of common oral diseases. The SOCS has also implemented an outreach dental service since September 2019 to provide free onsite dental check-up and oral health education for eligible children at Special Child Care Centres under the Social Welfare Department. If necessary, children can be referred to the HKCH for follow-up dental treatments, including treatment under sedation/general anaesthesia.

The number of children with ID receiving services over the past 3 service years is as follows:

Service Year ^{Note 3}	2022-23	2023-24	2024-25 (up to January 2025)

Number of Attendances For Dental Check-ups By The SOCS Teams	1 580	1 780	531
Number of Referrals to The HKCH	232	261	86

Note 3: A service year refers to the period from 1 November of the current year to 31 October of the following year.

Absorbed within the provision for dental services under its Programme, the expenditure of services to children with ID under the SOCS in 2022-23 and 2023-24 is not available. The revised estimate for the SOCS in 2024-25 is \$4.8 million.

Dental Service for Adult Patients with ID

The Government has implemented the Healthy Teeth Collaboration (HTC) programme since July 2018, which provides, through non-governmental organisations (NGOs), free dental services including check-ups, treatments and oral health education for adults aged 18 or above with ID. The HTC programme was further extended from 16 July 2024 to March 2027 with 900 additional quotas for new cases every year and its scope expanded to cover persons aged 18 or above with autism spectrum disorder (ASD). There are currently 8 participating NGOs, each with at least 1 dentist and 1 dental surgery assistant. Among them, 2 are located on Hong Kong Island, 5 in Kowloon and the remaining 1 in the New Territories.

The number of attendances over the past 3 service years is set out below:

Service Year ^{Note 4}	2022-23	2023-24	2024-25 ^{Note 5} (up to January 2025)
Number of Attendances	6 121	6 902	5 778

Note 4: A service year refers to the period from 16 July of the current year to 15 July of the following year.

Note 5: The service year 2024-25 runs from 16 July 2024 to 31 March 2025. Starting from 16 July 2024, the HTC programme has been extended to include patients with ASD.

The Government's actual expenditures for implementing the HTC programme in 2022-23 and 2023-24 are \$22.8 million and \$33.4 million respectively, while the revised estimate for 2024-25 is \$46.4 million.

The Government's existing SOCS, SDCS and HTC programme have been providing oral health and dental care services for persons with ID throughout their life course. In addition to persons with ID, the Special Child Care Centres covered by the SOCS and the special schools covered by the SDCS also serve persons with other disabilities. The Government accepts the Working Group's views, and will continue to develop special care dental services in the future and extend such services beyond persons with ID to those with other disabilities, special needs or high-risk groups.

- End -

CONTROLLING OFFICER'S REPLY

HHB335

(Question Serial No. 4009)

Head: (37) Department of Health

Subhead (No. & title): (-) Not Specified

Programme: (2) Disease Prevention

Controlling Officer: Director of Health (Dr. Ronald LAM)

Director of Bureau: Secretary for Health

Question:

Currently, the Hong Kong Childhood Immunisation Programme (HKCIP) in place for newborn babies in the Maternal and Child Health Centres does not include vaccines against certain common or highly lethal infectious diseases (such as Rotavirus, Haemophilus influenzae type b, hepatitis A and meningococcal disease), leaving parents with no choice but to spend thousands of dollars out of pocket to have their children vaccinated at private clinics. In this connection, will the Government consider expanding the range of vaccines available under the HKCIP in the new financial year to ease the burden on parents?

Asked by: Hon TSE Wai-chun, Paul (LegCo internal reference no.: 28)

Reply:

The Government attaches great importance to children's health, and is committed to providing children with quality medical and health services. The 29 Maternal and Child Health Centres in operation under the Department of Health (DH) are set up in all 18 districts in Hong Kong, providing health promotion and disease prevention services for newborn babies, children up to 5 years old and women of reproductive age, including free vaccination services and continuous monitoring of children's growth and development. Data also shows that the overall coverage for relevant vaccines among locally born pre-school children remains at a remarkably high level of over 98%. The DH is discussing the streamlining of maternal health services with the Primary Healthcare Commission and the Hospital Authority to make better use of resources and enhance service efficiency.

The Hong Kong Childhood Immunisation Programme (HKCIP) has been highly effective in keeping the local incidence of relevant communicable diseases at a remarkably low level. As recommended by the Scientific Committee on Vaccine Preventable Diseases (SCVPD) under the Centre for Health Protection of the DH, children from birth to Primary 6 should receive 12 types of vaccines and boosters under the HKCIP for the prevention of a wide range of communicable diseases, namely Tuberculosis, Poliomyelitis, Hepatitis B, Diphtheria, Pertussis, Tetanus, Pneumococcal infection, Varicella, Measles, Mumps, Rubella and Human Papilloma Virus (HPV) infection. The DH provides free vaccination services for eligible

children under the HKCIP for the prevention of the 12 communicable diseases with public health significance.

Regarding vaccines for disease prevention, the DH and the SCVPD regularly review the local epidemiology of diseases, while keeping abreast of the latest recommendations of the World Health Organization on immunisation, the scientific development and application of new vaccines, the updates of vaccine composition, and the studies on cost-benefit of vaccines, in order to examine and update the HKCIP from a public health perspective. In keeping with this strategy, the DH included, for instance, varicella vaccine in the HKCIP in 2014 and advanced the administration of the second dose of measles-containing vaccination to 18 months of age in 2020 to enhance children's immunity against varicella and measles. In 2024, the DH replaced the 13-valent pneumococcal conjugate vaccine with the 15-valent pneumococcal conjugate vaccine to enhance public health protection. Furthermore, the HPV vaccine was included in the HKCIP starting from the 2019/20 school year for the provision of free HPV vaccination to eligible Primary 5 and Primary 6 school girls as part of the public health strategy against HPV infection and cervical cancer.

Apart from the recommendations of the SCVPD, the DH takes into account a number of public health considerations and scientific factors when deciding whether to include a vaccine in the HKCIP, including epidemiology (such as incidence and death rates), disease burden, and the safety, efficacy, side effects, cost-benefit and adequacy of supply of the vaccine. The acceptance of the vaccine by the public, the availability of other preventive measures and the administrative arrangements for vaccination are also important considerations. At present, the vaccines mentioned in the question are not deemed to warrant inclusion in the HKCIP.

For other vaccines that are not included in the HKCIP from the public health perspective, parents are advised to seek professional advice from their family doctors on the benefits and risks of receiving such vaccines. Based on the doctor's assessment of the health and medical history of their children, parents can make informed decision as to whether their children should receive such vaccines for personal protection.

The DH will continue to work with the SCVPD to continually monitor the situation of vaccine preventable diseases and the scientific development of new vaccines, and will seek expert advice as necessary to appropriately review and update the HKCIP.

- End -