(Translation)

Elderly Commission
Minutes of the 121st Meeting

Date : 18 December 2025 (Thursday)
Time : 3:00 p.m.
Venue : Conference Room 3, G/F, Central Government Offices, 2 Tim Mei Avenue, Tamar, Hong Kong

Present

Chairman
Dr LI Kwok-tung, Donald, GBS, JP

Members
Prof BAI Xue
Dr CHAN Chi-kau, Johnnie Casire, SBS, JP
Ms CHAN Man-yee, Grace
Ms IP Shun-hing, SBS, MH, JP
Prof LAI Wing-leung, Daniel
Prof LAM Chiu-wa, Linda
Mr LAU Tat-chuen
Mr LIT Hoo-yin, Horace
Dr LUK Ka-hay, James
Ms MAN Wei-yin, Queenie
Mr NGAI Shi-shing, Godfrey
Mr SIU King-wai, Kyrus
Mr SU Yau-on, Albert, MH, JP
Ms WONG Chor-kei, Macy, MH

Prof LO Chung-mau, BBS, JP	Secretary for Health
Ms LAU Yim, Alice, JP	Permanent Secretary for Labour and Welfare
Mr TO Wing-hang, Edward, JP	Director of Social Welfare
Dr YAU Shui-wah, Carol	Principal Medical and Health Officer (Primary Care), Department of Health
Mr CHOY Kwan-wing	Chief Manager/Management (Support Services Section 2), Housing Department
Dr LEUNG Lok-hang, Will	Chief Manager (Primary and Community Services), Hospital Authority

In attendance

Mr CHONG Wing-wun, JP	Deputy Secretary for Labour and Welfare (Welfare) 2
Mr LEE Lik-kong, Eddie, JP	Deputy Secretary for Health 2
Ms LEUNG Susanna	Principal Assistant Secretary for Labour and Welfare (Welfare) 3
Ms YAN Lai-ming, Jenny	Assistant Director of Social Welfare (Elderly)
Dr CHEUNG Wai-lun, JP	Director of Strategic Purchasing Office, Health Bureau
Ms LEE See-wing, Anna	Subject Matter Expert (Pharmacy) (Strategic Purchasing), Health Bureau
Dr HO Nga-sze, Caci	Chief Manager (Service Model Development), Primary Healthcare Commission, Health Bureau
Ms HO Koon-ling, Rosanna	Chief Executive Officer (Welfare) 4, Labour and Welfare Bureau
Mr LAM Chi-kwong, Ares	Executive Officer (Welfare) 4, Labour and Welfare Bureau

Absent with apologies

Mr LEE Sing-kan, MH
Dr LEE Shun-wah, Jenny
Mr MA Heng, Theodore

Secretary

Ms CHAN Ah-wing, Ivy	Principal Assistant Secretary for Labour and Welfare (Welfare) 4

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Dr LI Kwok-tung, Donald, the Chairman, welcomed all Members to the meeting, in particular Prof LO Chung-mau, Secretary for Health, and Dr YAU Shui-wah, Carol, Principal Medical and Health Officer (Primary Care), Department of Health, who were attending for the first time.

2. The Chairman reminded Members that they must declare potential conflicts, if any, between their interests and matters under discussion.

Agenda item 1: Confirmation of the Minutes of the 120th Meeting

3. Members did not propose any amendments to the Chinese and English versions of the draft minutes issued by the Secretariat on 28 November 2025. The minutes were confirmed.

Agenda item 2: Matters arising

4. There were no matters arising from the 120th meeting.

Agenda item 3: Development of Community Drug Formulary and Community Pharmacy Programme

5. With the aid of presentation slides, Ms LEE See-wing, Anna, Subject Matter Expert (Pharmacy) (Strategic Purchasing) of the Health Bureau (HHB), briefed Members on the development of Community Drug Formulary (CDF) and Community Pharmacy Programme (CPP).

6. After the briefing, the Chairman and Members expressed views and raised questions as follows:

(a) the implementation of the CPP was welcomed. In addition to facilitating drug refill for eligible patients in the community and residential care homes (RCHs), the CPP could enhance the safety of drug handling procedures and accuracy of drug dispensing. It could also streamline daily drug packaging process, achieving greater economic efficiency;

(b) it was enquired whether the HHB would provide incentives to encourage RCHs to join the CPP, such as subsidies or technical support for participating RCHs to assist in their establishment of related computerised systems or staff training;

(c) enquiries were made regarding the drug dispensing service under the CPP, and how the HHB would monitor the standard of community pharmacies;

(d) it was suggested that fee concessions should be offered to RCHs during

the initial stage of the CPP (RCH) to encourage more RCHs to try out the services;

(e) given the difference in drug price across places, there were concerns over the possibility of non-Hong Kong residents taking advantage of the CPP (Community) to purchase large quantity of drugs. Enquiries were made on the eligibility criteria for the CPP;

(f) it was enquired whether pharmacies participating in the CPP (Community) would assist the Government in promoting vaccination and other health-related information to the public;

(g) it was suggested that the HHB should broaden the categories of drugs included in the CDF to benefit more patients. In addition, enquiries were made on the variety of drugs available at community pharmacies, and whether the drug packaging service would cover medications in liquid formulation;

(h) it was enquired whether patients participating in the CPP (Community) could change their choice of pharmacies and authorise family members to collect the drugs on their behalf, and how the identification of pharmacies could be improved; and

(i) it was suggested that the HHB should give priority to operators of District Health Centres (DHCs) when selecting pharmacies for the CPP (Community), with a view to strengthening the collaboration between primary healthcare and district services.

7. In response to Members' views and questions, Prof LO Chung-mau, Dr CHEUNG Wai-lun and Ms Anna LEE gave consolidated replies as follows:

(a) Many RCHs were receiving a large volume of drugs dispensed by the Hospital Authority (HA) to their residents and faced heavy workload arising from drug repackaging, storage and daily management. Without the support of computerised systems for dispensing medication, they were unable to effectively and systematically control drugs and manage associated risks. Under the CPP (RCH), participating pharmacies would regularly dispense HA-prescribed drugs for HA patients residing RCHs and package the daily required medications for

individual patients, while pharmacists would assist RCHs in adopting information technology for drug management to ensure the safety and accuracy of drug dispensing in RCHs. This service model would effectively improve the quality of drug handling and risk management in RCHs, as it was akin to making available hospital pharmacy services in RCHs. It was expected that RCHs, especially those that had already procured medication packaging services, would find the CPP (RCH) attractive. Pharmacies participating in the CPP (RCH) could expand their scope of service targets and acquire drugs listed in the CDF through HA drug suppliers, thereby enhancing the efficiency of drug dispensing for patients. The CPP would also help alleviate the burden on the public healthcare system and reduce drug wastage while supporting the sustainable development of the primary healthcare system. The HHB would roll out the CPP in a progressive manner with a view to engaging more pharmacies and RCHs;

(b) there were two service models under the CPP for the community and RCHs respectively. The CPP (Community) would provide drug dispensing and other relevant professional value-added pharmacy services to HA patients in the community and participants of specified Government primary healthcare programmes, while the CPP (RCH) would provide services such as drug dispensing, medication reconciliation, packaging and management, as well as medication administration systems and other relevant professional value-added services to patients residing in RCHs. Medications would be delivered to RCHs at least once a month;

(c) all participating pharmacies were licensed and regulated by the DH. Furthermore, the Guidelines of Practice for Community Pharmacy, published in October 2025, systemically outlined the operation model and practical guidance for service provision of a community pharmacy under the established service framework. The Guidelines covered the operation and staff standards, premise requirements, daily operation procedures and scope of services of community pharmacies. As for pharmacists providing the services, they were subject to the regulation of the Pharmacy and Poisons Board of Hong Kong. On-site inspections would be conducted by the HHB to ensure that the operation of pharmacies was in compliance with the relevant requirements. A complaint mechanism would also be established under the CPP.

(d) With respect to the service fees payable by participating RCHs, the tender requirements of the CPP stipulated that a registered pharmacy bidding for the provision of services for the CPP (RCH) must have partnered with a certain number of RCHs. Successful bidders would operate on a market-driven basis and determine service charges directly with their partner RCHs;

(e) an eligible individual of the CPP (Community) must be a Hong Kong Identity Card holder, and a patient of the HA's Family Medicine Out-patient services or a patient under the Government's designated primary healthcare programmes;

(f) apart from basic drug dispensing service, pharmacies participating in the CPP (Community) would also provide professional value-added pharmacy services (e.g. medication management service), and assist the Government in promoting health information (e.g. encouraging vaccination). To press ahead with the overall development of the pharmacy sector, the Primary Healthcare Commission would promote further advancement of community pharmacy service in accordance with the Primary Healthcare Blueprint, with a view to providing the public with enhanced professional pharmaceutical and drug dispensing services;

(g) community pharmacies would cover drugs commonly used in primary healthcare, including preventative drugs, drugs for managing chronic diseases and drugs for treating episodic illnesses. Given the current technical challenges in adopting single-dose packaging for liquid medicine, the packaging service at community pharmacies would only cover solid medicine at the present stage. The Government would review the relevant arrangement in a timely manner. To ensure accuracy in medication administration, barcodes would be printed on the outer packaging of all types of medicines (including liquid medicine) dispensed by community pharmacies, providing easy access to medication details (e.g. drug name, administration, dosage, etc.) and supporting verification against patients' prescribed regimens;

(h) patients participating in the CPP (Community) could pair with their preferred community pharmacies for drug refill. To ensure service

continuity, patients were advised not to switch pharmacies frequently. If a change was required (for example, due to home relocation), the patient concerned must go through relevant procedures to ensure that the newly-paired pharmacy was able to receive his/her particulars and prescriptions. Patients could make appointments with the paired pharmacies for drug refill. Those unable to collect the drugs themselves might authorise their family members to collect on their behalf. The arrangement was consistent with that prevailing at HA pharmacies which allowed patients to authorise others to collect drugs . As patients had already paired with designated community pharmacies, those pharmacies would not be mistaken as non-programme pharmacies; and

(i) the tender procedures for community pharmacies must adhere to the principles of openness, impartiality and fairness. The Government would assess all registered pharmacies meeting the tender requirements according to the established mechanism. In addition, DHCs, which acted as case managers under Government primary healthcare programmes, would collaborate with community pharmacies to enhance drug dispensing and pharmaceutical consultation services in the community, thereby strengthening the role of DHCs as resource hubs in primary healthcare service.

Agenda item 4: End-of-life Care: Implementation Arrangements for the Advance Decision on Life-sustaining Treatment Ordinance

8. Professor LO Chung-mau briefed Members on the legislative background of the Advance Decision on Life-Sustaining Treatment Ordinance (Ordinance). With the aid of presentation slides, Mr LEE Lik-kong, Eddie, Deputy Secretary for Health 2, then briefed Members on the main content of the Ordinance and the implementation arrangements.

9. After the briefing, the Chairman and Members expressed views and raised questions as follows:

(a) advance medical directives (AMDs) allowed adult patients who were mentally capable of deciding on life-sustaining treatments (LSTs) to indicate in advance their wish to refuse LSTs in the event that they

became mentally incapable and the preconditions specified in the AMDs were met. A Member relayed that some patients had expressed concerns regarding the possibility that their wish might be overridden by the objections of others when they became mentally incapable, despite having made legally binding AMDs in accordance with the Ordinance;

(b) it was enquired whether AMDs made by end-stage dementia patients before the advanced stage of their illness would remain valid in the event of subsequent compulsory hospitalisation;

(c) enquiries were made regarding the legal protection provided to healthcare professionals and ambulance services personnel (e.g. Auxiliary Medical Services and St. John Ambulance Brigade) under the Ordinance for complying with AMDs and do-not-attempt cardiopulmonary resuscitation (DNACPR) orders;

(d) it was noted that consequential amendments would be made to the relevant provisions of the Fire Services Ordinance (Cap. 95) and the Mental Health Ordinance (Cap. 136) to stipulate the applicable conditions and scope for the operation of AMDs and DNACPR orders under the aforementioned provisions. In view of the requirement of having a first-aider on duty at RCHs as well as the upcoming implementation of the "one nurse per RCH" arrangement, personnel concerned would administer first aid when needed. Enquiries were made regarding the relevant requirements for RCH healthcare personnel when executing DNACPR orders pursuant to the Ordinance, and whether an electronic version of a DNACPR order could be accepted as a validating copy of the order by virtue of the Ordinance;

(e) the core principle in making an AMD was to respect a patient's autonomy, yet family members of the patient might hold different views on the AMD. An enquiry was made regarding the measures to facilitate adequate communication between patients and their family members in the course of making an AMD;

(f) after making an AMD, a patient might change his/her wish due to shifts in personal circumstances or environment. Enquiries were made regarding the mechanism available to assist patients in timely reviewing, updating or revoking the AMDs they had previously made; and

(g) enquiries were made on the applicable circumstances of advance decision instruments (ADIs, i.e. AMDs and DNACPR orders), and whether an AMD made in accordance with the Ordinance by an elderly person who subsequently relocated to the Mainland would still be applicable in the Mainland.

10. In response to Members' views and questions, Prof LO Chung-mau and Mr LEE Lik-kong, Eddie gave consolidated replies as follows:

(a) prior to the implementation of the Ordinance, Hong Kong had no statute law that provided for the legal status of ADIs. As such, both individuals making ADIs and healthcare professionals encountered practical difficulties in adhering to the wishes expressed in these instruments, such as withholding or withdrawing LSTs. To further safeguard the autonomy of terminally-ill patients regarding their treatment and care arrangements, the Government enacted the Ordinance, which established a corresponding legal framework for ADIs and provided legal protection to patients, healthcare professionals and rescuers when complying with ADIs. ADIs made by patients in accordance with the Ordinance must be respected and complied with by all parties. The Ordinance was scheduled to take effect around mid-2026;

(b) an AMD of a dementia patient would remain valid provided that it was made at a time when the patient was mentally capable of deciding on LSTs and that it fulfilled all other statutory requirements set out in the Ordinance (including that all instructions in the AMD were presented in a clear way; the maker of the AMD signed the directive in the presence of not less than two witnesses; both witnesses, to the best of their knowledge, were not interested persons of the maker; one of the witnesses was a registered medical practitioner (RMP); the other witness was an adult, etc.);

(c) the provisions on the protection of treatment providers were thoroughly elucidated in the Ordinance. According to the Ordinance, when specified conditions were met, healthcare professionals, ambulance personnel and rescuers (professionally trained or otherwise) would not incur legal liability for subjecting or not subjecting a patient to LSTs. Specifically, if healthcare professionals or rescuers administered

specified treatments stipulated in the AMD or cardiopulmonary resuscitation (CPR) to a patient who had made an AMD or a DNACPR order, but were unaware of the existence of such directive or order; or if they honestly and reasonably believed that the instruction therein was not valid or applicable, they would not incur civil or criminal liability solely for subjecting the patient to LSTs or CPR. Similarly, healthcare professionals or rescuers would not incur legal liability for not subjecting a patient to specified LSTs or CPR, if they honestly and reasonably believed that the instruction specified in an AMD or a DNACPR order was valid and applicable. The Ordinance had provided sufficient explanation as to what constituted a valid and applicable AMD or DNACPR order;

(d) the Ordinance covered two types of ADIs, namely AMDs and DNACPR orders. To facilitate adherence to instructions in an AMD by ambulance personnel or rescuers in situations demanding immediate decisions without the presence of healthcare professionals (e.g. outside the hospital setting), the Ordinance stipulated that RMPs might make DNACPR orders for adults who had specified in their AMDs the refusal of CPR or who were mentally incapable of deciding on LSTs, and minors, so as to instruct CPR not to be performed on them under applicable circumstances. If healthcare professionals or rescuers noticed a valid DNACPR order, they would comply with it and would not perform CPR on the patient. On the contrary, if healthcare professionals or rescuers had any reasonable grounds for suspecting the validity or applicability of a DNACPR order, under the principle of "if in doubt, save life first", they must continue to administer LSTs;

(e) regarding the specific applicable circumstances of ADIs, the Hong Kong Academy of Medicine had released the Best Practice Guidelines on Advance Medical Directives, offering practical advice on clinical decision-making, doctor-patient communication and ethical considerations for healthcare professionals' reference. Besides, the HA had formulated guidelines and prepared a set of concise FAQs on AMDs and DNACPR orders for reference by the public and healthcare professionals. RCHs might refer to the related guidelines and formulate relevant service and operational guidelines in alignment with their specific operational needs;

(f) to facilitate the presentation of a DNACPR order by a maker or his/her family members to emergency rescue personnel and/or ambulance personnel, the Ordinance stipulated that in addition to the original copy of a DNACPR order, its certified true copies would be accepted as validating copies. Given that DNACPR orders would mainly be executed under emergency situations outside hospital setting, for easy identification and verification by emergency rescue personnel, there would be no electronic version of DNACPR orders. DNACPR orders must be made in writing using a prescribed form as required by the Ordinance or else would be considered invalid;

(g) AMDs and DNACPR orders under the Ordinance formed part of the advance care planning (ACP). The primary purpose of ACP was to allow patients with advanced and progressive diseases to express their preferences for medical and personal care comprehensively and in advance, so that decisions could be made on their future and end-of-life (EoL) care. Through discussion, healthcare professionals could help patients and their family members understand the medical conditions of the patients and available treatment options, thereby enabling the patients to make informed decisions regarding their own treatment and care arrangements, and express preferences for future medical or personal care. In the course of discussion, mentally capable adult patients could consider signing an AMD. Mentally incapable adult and minor patients were also covered under the ACP. Healthcare professionals and family members could establish a consensus on future medical or personal care plans based on the patients' best interests (including taking into account any previously expressed wishes and weighing the benefits and burdens of treatments);

(h) by formulating ACP, patients and their family members could be better prepared psychologically for the deterioration of the patients' condition. The Government encouraged healthcare professionals to assist patients and their families in formulating ACP during their discussion on EoL care, before proceeding with the making of AMDs to refuse LSTs based on the patients' wishes. The HA would continue to promote ACP with a view to incorporating it progressively into EoL care services for more patients with severe illnesses through training and various educational initiatives;

(i) regarding revocation of an AMD, the Ordinance adopted the principle of "cautious making, easy revoking". As long as a maker was mentally capable of deciding on LSTs, he/she might revoke the AMD at any time verbally, in writing, or by destroying the AMD. If a maker changed his/her mind on the instructions in the existing AMD, he/she should take the initiative to review the AMD with an RMP, and update the AMD or make a new one as needed; and

(j) an AMD made under the Ordinance was only applicable within Hong Kong's jurisdiction, it would have no legal effect in the Mainland. Elderly persons relocating to the Mainland should establish legal documents related to their AMDs in accordance with the prevailing laws of the Mainland.

Agenda item 5: Progress Report by the Committee on Elder Academy Development Foundation

11. Ms CHAN Ah-wing, Ivy, Secretary to the Commission, reported that the second round of funding applications to the Elder Academy Development Foundation (EADF) in 2025-26 was closed on 31 October 2025, with a total of about 30 applications received. The Committee on EADF would assess the funding applications in due course.

Agenda item 6: Any Other Business

12. The Chairman informed Members that the Commission had tentatively scheduled a visit to the studio of The Project Futurus, a social enterprise in Tsuen Wan, on 20 January 2026 (Tuesday) with a view to understanding swallowing difficulties encountered by the elderly, and the development and production of softmeal. The organisation was founded by Member Ms MAN Wei-yin, Queenie in 2018, with the aim of enhancing the quality of life for the elderly and patients suffering from swallowing difficulties. The Commission thanked Ms Man for arranging the subject visit. The Secretariat would extend a formal invitation to Members in due course and hoped that they could join the visit amid their busy schedules.

【Post-meeting note: The Secretariat invited the Chairman and Members to join the above visit by email on 18 December 2025.】

Time of Adjournment

13. The meeting was adjourned at 4:30 pm.

Date of Next Meeting

14. The next meeting was tentatively scheduled for 6 March 2026 (Friday). The Secretariat would advise Members of the meeting details in due course.

February 2026