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Legislative Council

LC Paper No. CB(2)1369/14-15
(These minutes have been seen by the Administration)

Ref : CB2/PL/HS

Panel on Health Services

Minutes of meeting
held on Monday, 15 December 2014, at 4:30 pm
in Conference Room 3 of the Legislative Council Complex

Members present	:	Prof Hon Joseph LEE Kok-long, SBS, JP, PhD, RN (Chairman) Dr Hon LEUNG Ka-lau (Deputy Chairman) Hon Albert HO Chun-yan Hon WONG Ting-kwong, SBS, JP Hon CHAN Kin-por, BBS, JP Hon Albert CHAN Wai-yip Hon YIU Si-wing Hon Charles Peter MOK, JP Hon CHAN Han-pan, JP Hon Alice MAK Mei-kuen, JP Dr Hon KWOK Ka-ki Dr Hon Fernando CHEUNG Chiu-hung Dr Hon Helena WONG Pik-wan Dr Hon Elizabeth QUAT, JP Hon POON Siu-ping, BBS, MH
Member attending	:	Hon CHAN Chi-chuen
Members absent	:	Hon Vincent FANG Kang, SBS, JP Hon CHEUNG Kwok-che Hon Christopher CHUNG Shu-kun, BBS, MH, JP

Public Officers attending : Item III

Dr KO Wing-man, BBS, JP
Secretary for Food and Health

Mr Richard YUEN Ming-fai, JP
Permanent Secretary for Food and Health (Health)

Professor Sophia CHAN Siu-chee, JP
Under Secretary for Food and Health

Dr Constance CHAN Hon-yee, JP
Director of Health

Item IV

Mr Richard YUEN Ming-fai, JP
Permanent Secretary for Food and Health (Health)

Mr Sidney CHAN, JP
Head (eHealth Record)
eHealth Record Office
Food and Health Bureau

Ms Ida LEE
Deputy Head (eHealth Record)
eHealth Record Office
Food and Health Bureau

Item V

Professor Sophia CHAN Siu-chee, JP
Under Secretary for Food and Health

Mr Davey CHUNG Pui-hong
Deputy Secretary for Food and Health (Health) 2

Dr Sarah CHOI Mei-yee, JP
Assistant Director of Health (Special Health Services)
Department of Health

Dr Kellie SO Pui-sheung
Principal Medical and Health Officer (3)
Department of Health

Item VI

Professor Sophia CHAN Siu-chee, JP
Under Secretary for Food and Health

Miss Fiona CHAU
Principal Assistant Secretary for Food and Health (Health) 1

Dr LEUNG Ting-hung, JP
Controller, Centre for Health Protection
Department of Health

Dr Regina CHING, JP
Consultant Community Medicine (Non-Communicable Disease)
Department of Health

Dr Alexander CHIU
Chief Manager (Integrated Care Programs)
Hospital Authority

Clerk in attendance : Ms Maisie LAM
Chief Council Secretary (2) 5

Staff in attendance : Ms Janet SHUM
Senior Council Secretary (2) 5

Ms Priscilla LAU
Council Secretary (2) 5

Ms Michelle LEE
Legislative Assistant (2) 5

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I. Confirmation of minutes
[LC Paper No. CB(2)437/14-15]

The minutes of the meeting held on 20 October 2014 were confirmed.

II. Information paper(s) issued since the last meeting
[LC Paper No. CB(2)401/14-15(01)]

2. Members noted that a joint letter dated 1 December 2014 from Miss CHAN Yuen-han and Miss Alice MAK suggesting the Panel to discuss the provision of healthcare and support services for patients with chronic

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diseases had been issued since the last meeting. Members agreed to include the subject in the list of outstanding items for discussion.

III. Items for discussion at the next meeting

[LC Paper Nos. CB(2)429/14-15(01) and (02) and CB(2)481/14-15(01)]

Consultation documents on "Voluntary Health Insurance Scheme" and "Regulation of Private Healthcare Facilities"

3. The Chairman said that the Government had published the Consultation Document on Voluntary Health Insurance Scheme and the Consultation Document on Regulation of Private Healthcare Facilities on the day of the meeting to consult the public on the proposals to implement the Voluntary Health Insurance Scheme ("VHIS") and revamp the existing regulatory regime for private healthcare facilities respectively. He had invited the Secretary for Food and Health ("SFH") to give a short introduction of the two Consultation Documents to members at the meeting. A special meeting would be arranged to enable members to discuss the proposals in detail.

4. At the invitation of the Chairman, SFH briefed members on the two Consultation Documents, details of which were set out in his speaking note (LC Paper No. CB(2)481/14-15(01)) tabled at the meeting.

5. Dr KWOK Ka-ki expressed strong dissatisfaction that SFH only gave a short introduction but did not plan to discuss with members on the proposals put forth in the two Consultation Documents which were of significant importance to the development of the healthcare system in Hong Kong. In his view, the Administration should take the very first opportunity to answer questions from members of the relevant committees of the Legislative Council ("LegCo") on the two Consultation Documents. SFH responded that the Administration had briefed and discussed with members the proposals to implement VHIS and revamp the existing regulatory regime for private healthcare facilities before their finalization at a number of meetings of the Subcommittee on Health Protection Scheme set up under the Panel, and the meeting of the Panel on 21 July 2014 respectively.

6. Noting that around 88% of inpatient services (in terms of number of bed days) were currently provided by public hospitals, Dr Helena WONG asked how far the implementation of VHIS could improve the imbalance between the public and private sectors in hospital services. SFH advised that according to the consultant commissioned by the Administration to conduct a study on HPS, it was expected that VHIS would recalibrate the public-

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private balance to a healthier and more sustainable level. In terms of inpatient (overnight and day cases) discharge, the public to private ratio in 2040 was projected to be 81:19 under VHIS.

7. Given the complexity of the issues involved in the two Consultation Documents, Dr KWOK Ka-ki asked why the public consultation period for the Consultation Documents was set for three months but not longer. SFH advised that a three-month public consultation period was a normal practice of the Administration. That said, the Administration would extend the duration of the consultation period of the Consultation Documents if such a need arose during the consultation period.

8. The Chairman advised that a special meeting for members to discuss the two Consultation Documents with the Administration would be scheduled, and members would be informed of the meeting date in due course.

(*Post-meeting note:* The special meeting has been scheduled for 13 January 2015 at 4:30 pm.)

Items for discussion at the next regular meeting

9. Members agreed to receive a policy briefing by SFH on the Chief Executive's 2015 Policy Address in respect of the portfolio of health services at the next regular meeting scheduled for 19 January 2015 at 4:30 pm. Members also agreed to discuss the item "Expansion of United Christian Hospital" at the next regular meeting.

10. The Chairman suggested that the next regular meeting be extended by 30 minutes to end at 7:00 pm in order to allow sufficient time for discussion of the agenda items. Members agreed.

IV. Retention of the two supernumerary directorate posts of the Electronic Health Record Office for three years

[LC Paper Nos. CB(2)429/14-15(03) and (04)]

11. The Chairman reminded members that in accordance with Rule 83A of the Rules of Procedures, they should disclose the nature of any direct or indirect pecuniary interests relating to this funding proposal before they spoke on the subject.

12. Permanent Secretary for Food and Health (Health) ("PSFH(H)") briefed members on the proposal to retain two supernumerary directorate posts of the Electronic Health Record Office ("eHRO") in the Health Branch of the Food and Health Bureau ("FHB"), which were respectively designated

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as Head (eHealth Record) ("H(eHR)") and Deputy Head (eHealth Record) ("DH(eHR)") in eHRO, for another three years, details of which were set out in the Administration's paper (LC Paper No. CB(2)429/14-15(03)).

13. Members noted the background brief entitled "Electronic Health Record Office" (LC Paper No. CB(2)429/14-15(04)) prepared by the LegCo Secretariat.

Retention of supernumerary directorate posts

14. Dr KWOK Ka-ki expressed grave concern about the trend of the Administration to retain the supernumerary directorate posts, and in some cases for more than one time, in recent years. This showed that the Administration was often unable to accurately estimate the required duration of the supernumerary directorate posts when they were created. Holding the view that the retention of the supernumerary directorate posts was indicative of an expansion of the management structure, Mr Albert CHAN raised a similar concern and sought information about the changes in the number of supernumerary directorate posts and non-directorate posts in the Health Branch of FHB in the past few years. He said that he would object to the proposal unless the Administration could provide further justifications for it.

15. PSFH(H) advised that there were eight permanent directorate posts, and four supernumerary directorate posts designated as H(eHR), DH(eHR), Head (Healthcare Planning and Development Office) and Deputy Head (Healthcare Planning and Development Office) in the Health Branch of FHB. After recapitulating the portfolio and workload of the existing two permanent directorate officers at D3 and D4 levels as set out in Annex E to the Administration's paper, PSFH(H) explained that the four supernumerary directorate officers were responsible for providing steer and leadership over the tasks entrusted to eHRO and the Healthcare Planning and Development Office respectively on a time-limited basis. The Administration had carefully assessed whether there was any scope for internal redeployment of the existing permanent directorate officers to undertake the tasks of these four supernumerary directorate officers and considered this not operationally feasible as all existing permanent directorate officers were fully engaged in their respective duties. Mr Albert CHAN remained unconvinced of the need to retain the two posts of H(eHR) and DH(eHR), adding that it was not uncommon for existing permanent directorate officers of other Bureaux to discharge project based tasks and duties involving policy reviews through internal redeployment.

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Proposed period of retention

16. Dr KWOK Ka-ki asked whether the two supernumerary posts would be retained after, subject to the passage of the Electronic Health Record Sharing System Bill ("the Bill") which was being scrutinized by a Bills Committee, the establishment of office of the Commissioner for the Electronic Health Record ("eHRC"). Noting that the full development of the Electronic Health Record Sharing System ("eHRSS") was a 10-year, two-stage programme which straddled from 2009-2010 to 2018-2019, Mr CHAN Han-pan asked why the Administration's proposal was to extend the two posts for three years up to March 2018 but not four years until March 2019.

17. PSFH(H) advised that with the funding approval of the Finance Committee ("FC"), the two supernumerary directorate posts were created in 2009 for four years to provide directorate support in the planning, development and implementation of Stage One eHRSS. FC subsequently approved in 2013 the retention of these two posts up to March 2015. It was proposed under the eHRSS Bill that the SFH might appoint a public officer to be eHRC. Subject to the passage of the Bill, the eHRSS developed in Stage One would commence operation and a new office of eHRC would be set up. H(eHR) would assume the role of eHRC, with directorate support from DH(eHR). Hence, there was a need to retain the two supernumerary posts for another three years up to March 2018 so that the post holders could oversee the completion of the legislative process and the operation of eHRSS in the initial years, as well as to pursue the development of Stage Two eHRSS. The Administration would review the continued need for the two posts by early 2018 having regard to the operational experience of Stage One eHRSS and the development progress of Stage Two eHRSS.

Progress and work target of the eHRSS programme

18. Mr YIU Si-wing expressed support for the implementation of eHRSS to foster public-private collaboration in healthcare delivery. He asked how far H(eHR) and DH(eHR) had achieved the work targets set for the past six years. Dr KWOK Ka-ki enquired about the work plans of the holders of the two posts in the coming three years.

19. PSFH(H) advised that the main targets of the Stage One Electronic Health Record ("eHR") Programme included setting up the eHR sharing platform, developing modules and applications to facilitate private healthcare providers to connect to the eHR sharing platform, and devising the legal framework necessary for operating eHRSS. The core technical work for the commissioning of the Stage One eHRSS had been completed in April 2014. The Bill, which was introduced into LegCo on 30 April 2014,

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was currently under scrutiny of the relevant Bills Committee. Subject to the passage of the Bill in early 2015, the Administration targeted to commission Stage One eHRSS in the latter half of 2015. As mentioned earlier at the meeting, the two post holders had to oversee the completion of the legislative process in the coming months and the operation of eHRSS in the initial years, as well as to pursue the development of Stage Two eHRSS in the coming three years. The tentative project scope of Stage Two eHRSS would cover, among others, expanding the scope of sharable data to cover radiological image sharing and facilitating Chinese medicine practitioners to take part in the sharing process.

20. Referring to a case whereby a chronic disease patient of HA was required to undergo the medical assessments again when visiting another public hospital, Mr YIU Si-wing sought clarification as to whether sharing of patients' electronic medical records had been implemented across all public hospitals. Replying in the affirmative, PSFH(H) advised that patients' records were internally sharable among HA hospitals. He suspected that the case mentioned might be related to assessments conducted or data kept by the clinics of the Department of Health ("DH"). The sharing of the DH's records with HA and other healthcare providers registered under eHRSS could be achieved in the future through the Clinical Information Management System being developed in DH. He undertook to follow up the case referred to by Mr YIU Si-wing if more information could be provided after the meeting.

Conclusion

21. In closing, the Chairman concluded that a majority of the members present at the meeting supported the submission of the staffing proposal to the Establishment Subcommittee for consideration.

V. Legislative proposal to prohibit sex selection using reproductive technology

[LC Paper No. CB(2)429/14-15(05)]

22. Under Secretary for Food and Health ("USFH") briefed members on the Administration's proposal to amend the Human Reproductive Technology Ordinance (Cap. 561) ("HRTO") to prohibit advertisements on the provision of sex selection services through human reproductive technology ("RT") procedures, details of which were set out in the Administration's paper (LC Paper No. CB(2)429/14-15(05)).

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Sex selection using RT procedures

23. Mr CHAN Chi-chuen considered that prohibition under HRTO should be lifted so that RT would be made available for all persons in need, in order to tie in with the population policy to encourage birth. While taking no particular position on sex selection through RT procedures, he disagreed with the Administration's view that allowing sex selection would attribute to perpetuating sex discrimination, encouraging eugenics and upsetting sex ratio in the population, which apparently was based on an assumption of the community's preference for having male children. Mr WONG Ting-kwong held the view that sex selection through RT procedures on non-medical grounds went against the rules of nature. He did not foresee that there would be much controversy in the community over the legislative proposal. Mr POON Siu-ping enquired whether the Council on Human Reproductive Technology ("CHRT") had received any complaints relating to local advertising activities on sex selection services through RT procedures since the enactment of HRTO in 2000. Mr Charles MOK asked how prevalent the problem of promoting the use of RT procedures to achieve the purpose of sex selection that warranted legislation to outlaw such activities.

24. Assistant Director of Health (Special Health Services), DH ("ADH(SHS), DH") advised that during the period of January 2010 to November 2014, there was a total of 12 cases known to be related to promoting on local media the sex selection services using RT procedures available in other countries. These included two press reports, eight advertisements and two leaflets. The medical profession and other relevant stakeholders had expressed concern on the increasingly aggressive promotional activities in this regard. Against this background, the Administration considered it necessary to amend HRTO to prohibit such activities. In response to Mr Charles MOK's enquiry about whether similar ban was imposed in other jurisdictions, ADH(SHS), DH advised that advertisement on sex selection services through RT procedures was prohibited in Canada and the Mainland.

25. Dr Helena WONG expressed support for the legislative proposal. Noting that HRTO currently prohibited the use of RT procedures to select the sex of babies except for avoiding the birth of a child suffering from any of the sex-linked genetic diseases specified in Schedule 2 to HRTO, she asked whether there were any non-compliance cases in the past. USFH advised that according to the Code of Practice on Reproductive Technology and Embryo Research promulgated by CHRT, RT treatment centres licensed by CHRT under HRTO had to report to CHRT on cases of sex selection achieved through RT within three months after the procedure had taken place. The licensed centres should only conduct sex selection using RT

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procedures for the purpose of avoidance of the birth of a child with a sex-linked genetic disease.

Scope of the prohibition

26. Dr Helena WONG sought clarification as to whether the prohibition would cover all advertising activities purporting to promote sex selection services through human RT procedures, whether or not the services were provided in Hong Kong. Mr CHAN Chi-chuen asked whether introducing the availability of overseas sex selection services through RT procedures to interested couples during individual face-to-face discussions in a seminar or briefing on RT would become prohibited activities. Mr WONG Ting-kwong enquired whether information soft-selling these services on the Internet would be regarded as advertisements. While expressing support for the legislative proposal, Dr KWOK Ka-ki and Mr YIU Si-wing expressed a similar concern. In particular, it might be arguable whether merely providing an email address or a hyperlink in a message posted on an online discussion forum but did not by itself communicate information suggesting that sex selection services were available would constitute an advertising activity. The circumstances would be more complicated where the email address was in an overseas domain or the hyperlink was connected to an overseas website.

27. USFH responded that the Administration proposed to amend HRTO to prohibit any advertisements on sex selection services through RT posted on the media (including the Internet), irrespective of whether the services were provided within or outside Hong Kong. ADH(SHS), DH supplemented that "advertisement" as defined under section 2 of HRTO included any form of advertising whether to the public generally, to any section of the public or individually to selected persons. Whether the particular scenarios cited by members would amount to an advertisement purporting to promote sex selection services would depend on the evidence available and the circumstances of each case.

Enforcement of the proposed ban

28. Mr WONG Ting-kwong expressed grave concern as to how the Administration could catch those sex selection service providers who published an advertisement targeting at local couples on a webpage under the management of overseas website hosts or operators. In his view, the Administration should critically examine whether it would be able to enforce the legislation effectively in considering the amendments to be proposed to an ordinance. Mr POON Siu-ping raised a similar concern. Dr KWOK Ka-ki asked whether overseas sex selection services providers which promoted its services in local media, and the local media agencies or

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companies providing the platform for these advertising activities, such as publisher of newspapers and magazines and webpage host or operator, would be held liable for such acts.

29. USFH advised that subject to availability of evidence, local media agencies or companies which knowingly posted advertisements purporting to promote sex selection services on a newspaper, magazine or webpage under their management would be held liable. ADH(SHS), DH supplemented that the initiation of enforcement actions also hinged on the question of jurisdiction. The primary basis of criminal jurisdiction in Hong Kong was territorial. So long as the act of publishing or distributing the advertisement was committed in Hong Kong, it would fall within the jurisdiction of Hong Kong courts. Subject to the passage of the bill to amend HRTO, the Administration would step up publicity targeting the local media agencies and companies on the new offence. Mr YIU Si-wing opined that when internet advertising was involved, the concept of "territorial" would become complicated. He suggested that reference could be made to the enforcement of other legislation involving advertisements on the Internet. Mr Charles MOK remarked that while it might be difficult to combat all such activities, the introduction of the proposed ban could create a deterrent effect to discourage the relevant parties from continual advertising on sex selection services on local media.

30. Expressing support for the legislative proposal, Miss Alice MAK asked whether there was a need to increase the manpower to cope with the likely increased workload required for monitoring all local media, in particular the Internet, on advertising in breach of the proposed ban on sex selection services using RT procedures. ADH(SHS), DH advised that at present, advertisements relating to commercial dealings of gametes or embryos and surrogacy arrangements were prohibited under HRTO. The manpower for monitoring of advertising activities on using RT procedures to achieve sex selection would be absorbed within existing resources.

Conclusion

31. In closing, the Chairman concluded that members were supportive of the Administration's proposal to amend HRTO to prohibit advertisements on the provision of sex selection services through RT procedures.

VI. Colorectal Cancer Screening Pilot Programme

[LC Paper Nos. CB(2)429/14-15(06) and (07)]

32. USFH briefed members on the background and progress of the development of the Colorectal Cancer Screening Pilot Programme ("the Pilot

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Programme"), details of which were set out in the Administration's paper (LC Paper No. CB(2)429/14-15(06)).

33. Members noted the information note entitled "Colorectal Cancer Screening Pilot Programme" (LC Paper No. CB(2)429/14-15(07)) prepared by the LegCo Secretariat.

[At this juncture, the Chairman informed members of his decision to extend the meeting for 15 minutes beyond its appointed time to allow more time for discussion of this item.]

Target population

34. Mr POON Siu-ping said that he saw no reason for not supporting the Pilot Programme. He, however, considered that the age threshold for the Pilot Programme, which was set at the age of 61 years at the time of programme launch, should be lowered. Pointing out that more people in the younger age groups were prone to the risk of colorectal cancer due to unhealthy lifestyles, Mr Albert HO was of a similar view. He went further to suggest that, instead of subsidizing asymptomatic population of specific age groups to undergo screening, consideration should be given to subsidizing patients having a positive faecal immunochemical test ("FIT") result and were on the waiting list of the Hospital Authority ("HA") for colonoscopy to undergo the examination in the private sector if they met a means test, so that early treatment could be offered where necessary to improve disease prognosis. To his understanding, the waiting time for undergoing colonoscopy at HA could be six months or longer. In addition, the high cost for undergoing colonoscopy in the private sector, which would at least cost about $4,000 or $7,000 if involved anaesthesia, had rendered the assessment unaffordable to many patients with limited economic means.

35. USFH explained that in medical terms, screening meant examining asymptomatic individuals with the aim to detect disease or find people at increased risk of disease. It was often the first step that led to making a definitive diagnosis. To address the rapidly increasing burden of colorectal cancer in Hong Kong, the Pilot Programme aimed to assess the performance and implications of population-based screening on the healthcare system. It would form the basis for further deliberation of whether and how best colorectal cancer screening service might be provided to the wider population. Taking into account that the target population had to be sufficiently representative but would not end up overwhelming current service capability, it was considered appropriate to invite asymptomatic people aged 61 to 70 years to undergo screening. USFH added that screening was a tool for secondary prevention against colorectal cancer. The

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Administration would also enhance public education on colorectal cancer prevention.

36. Miss Alice MAK urged the Administration to ensure fairness and transparency in working out the specific age groups eligible for participating in the Pilot Programme and the later population-based colorectal cancer screening programme. The timetable of the latter should be made public as early as practicable.

37. USFH advised that the Cancer Expert Working Group on Cancer Prevention and Screening set up under the Cancer Coordinating Committee would regularly review and discuss latest scientific evidence, local and worldwide, with a view to providing recommendations on suitable cancer prevention and screening measures for the local population. The implementation of population-based colorectal cancer screening programme as a strategy in cancer prevention required careful consideration of factors such as service capacity and programme logistics. To first pilot on specific age groups could gather local experience to shed light on whether, and if so, how best colorectal cancer screening should be extended to cover the wider population. Controller, Centre for Health Protection ("Controller, CHP") supplemented that DH, with the support from HA, had set up a multi-disciplinary taskforce ("the taskforce") to plan for the implementation of the Pilot Programme having taken into account of factors such as disease prevalence, screening protocol, public acceptability, cost-effectiveness and colonoscopy capacity. After due consideration and on the basis of the outcome of a commissioned study conducted by the School of Public Health of The University of Hong Kong, it was decided that the Pilot Programme would target at persons aged 61 to 70 years at the time of programme launch.

Screening protocol

38. Dr LEUNG Ka-lau declared that he was a privately practised specialist in colorectal surgery. Pointing out that overseas experience recommended that FIT screening should be performed annually or biennially, he sought elaboration about the number of FIT screening required of each participant during the three-year pilot period.

39. Consultant Community Medicine (Non-Communicable Disease), DH ("CCM(NCD), DH) advised that taking into account the capacity of the healthcare system in coping with screening and management of positive screening test results, the taskforce proposed to invite eligible individuals by phases over a period of three years. Persons aged 68 to 70 years, 65 to 67 years and 61 to 64 years at the time of programme launch would be invited to participate in the Pilot Programme and undergo FIT screening in the first, second and third year respectively. Participants who underwent screening in

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the first year during the three-year pilot period would be invited to undergo rescreening in the third year. Controller, CHP advised that participants would be required to provide two stool samples for each screening.

Follow-up of FIT positive cases

40. Dr Helena WONG sought clarification as to whether colonoscopy was covered under the Pilot Programme. USFH advised that a two-tier screening protocol and a public-private partnership model would be adopted for the Pilot Programme. Participants with a positive FIT result would be referred by the private primary care doctors to undergo colonoscopy for assessment by a privately practised colonoscopist. They would be provided with a subsidy from the government and, as the case might be, a co-payment by the participant for the services. Participants with limited economic means might also choose to undergo colonoscopy in public hospitals. CCM(NCD), DH supplemented that it was expected that the assessment result could be made available within two to three months' time if the colonoscopy was performed in the private sector. In response to Mr Albert HO's enquiry about the present waiting time for patients with symptoms to undergo colonoscopies in public hospitals, Chief Manager (Integrated Care Programs), HA ("CM(ICP), HA") advised that the waiting time depended on the urgency of individual cases. A triage system was in place to ensure that patients in need for urgent endoscopy services would be treated with priority. There might be cases that patients would have to wait for six to nine months for undergoing colonoscopy, albeit that the number of colonoscopy provided by HA had amounted to about 40 000 cases each year.

41. Dr KWOK Ka-ki was of the view that the Pilot Programme would widen the gap between those FIT-positive participants who were able to afford the co-payment for undergoing colonoscopy in the private sector and those less privileged participants who could only resort to the public sector with a long queuing time. While agreeing that the Pilot Programme would benefit the target population through enabling prevention and detection of colorectal cancer at an early stage, Dr Fernando CHEUNG expressed a similar concern. He said that nearly 30% of the respondents of a survey indicated that they would not participate in the Pilot Programme, as they could not afford the co-payment for private endoscopy services if being tested FIT-positive and expenses for the self-financed drugs in the HA Drug Formulary if being diagnosed as a confirmed case.

42. Mr Albert HO considered the arrangement not fair to patients who lacked the means to undergo colonoscopy in the private sector. Noting that it was estimated that 2 712, 1 636 and 292 new cases of adenoma, advanced neoplasm and colorectal cancer would respectively be detected among the some 10 000 FIT-positive cases, he suggested that a full subsidy subject to a

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means test should be provided to the less privileged FIT-positive participants to help them to undergo colonoscopy earlier for diagnosis and follow up treatment. While considering that there was no reason to not support the Pilot Programme, Miss Alice MAK was concerned that the long waiting time for the less privileged FIT positive cases to undergo colonoscopies in public hospitals would induce anxiety to the participants concerned during the waiting period and lead to delay in treatment for the confirmed cases.

43. USFH took note of members' concern, adding that operational details of the Pilot Programme would be hammered out in due course. When determining the amount of subsidy, due consideration would be given to the market practice and experience of existing subsidy schemes, as well as issues related to affordability, accessibility and equity of screening activities. These included, among others, the affordability of individuals with limited economic means, such as those on Comprehensive Social Security Assistance. Controller, CHP supplemented that colorectal cancer arose predominantly from adenomatous polyps. Given that the development of a polyp into a cancer could take around 10 years, participation in the Pilot Programme could enable those participants with a positive FIT result, who were originally asymptomatic, to undergo colonoscopy at an earlier time for an identification and, where necessary, removal of polyps to reduce the chance of developing into cancer.

44. Mr POON Siu-ping sought information from HA on the measures, in particular manpower resources, to be put in place to meet the expected increase in demand for colonoscopy upon the implementation of the Pilot Programme. CM(ICP), HA said that it was expected that there would be an increase in demand for colonoscopy in public hospitals from participants of the Pilot Programme, as well as individuals from other age groups who decided to undergo FIT screening as a result of enhanced awareness of colorectal cancer prevention after the launch of the Pilot Programme. To cope with the anticipated escalating demand for colonoscopy, efforts had been made by HA to open additional endoscopy units and operation theatres in recent years. Additional colonoscopy sessions had been provided by doctors of the medicine and surgery specialties with a view to clearing the backlog of cases on the waiting list. Looking forward, the increase in the number of local medical graduates completing their internship from 2015-2016 would help ease the medical manpower shortage, and hence the waiting time for various services in HA.

45. In response to Mr POON Siu-ping's enquiry about the timetable for hammering out the operational details of the Pilot Programme, USFH advised that the taskforce would engage the relevant stakeholders in early 2015 to finalize the details of the Pilot Programme. It was expected that the Pilot Programme would be launched by end 2015 the earliest.

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Participation of eligible individuals and healthcare professionals

46. Noting that some 60% of the eligible population would participate in the national colorectal cancer screening programme in some overseas countries, Dr LEUNG Ka-lau sought explanation about the reason why it was assumed that only 30% of the target population would be willing to join the Pilot Programme. Controller, CHP responded that reference had been made to overseas experience in estimating the uptake rate of the Pilot Programme. It was noted that the participation rate for national colorectal cancer screening programme of places in the Asia pacific region was not high, viz. 38% in Australia and 11% in Taiwan.

47. Dr LEUNG Ka-lau surmised that if this was the case, most of the participants of the Pilot Programme would be those individuals who were more health conscious and would undergo colorectal cancer screening regardless of whether it was subsidized by the Government or not. He asked how the Administration could encourage participation among those less health conscious eligible persons. CCM(NCD), DH advised that there would be territory-wide publicity activities through multiple channels to raise public awareness on colorectal cancer prevention and screening, and the launch of the Pilot Programme. This apart, promotion and recruitment activities would be organized for primary care doctors and colonoscopists in the private sector, who could promote to their eligible patients the Pilot Programme. The social service providers for the target population, such as the Social Welfare Department and non-governmental organizations, would also be enlisted to support and promote the Pilot Programme. Dr LEUNG Ka-lau asked whether reference would be made to the practice of some overseas countries to issue invitation direct to the target population. CCM(NCD), DH replied in the negative, as no such data was readily available.

48. Referring to the media reports that not all primary care doctors and colonoscopists could take part in the Pilot Programme and that some private hospitals had recently increased the charges for colorectal cancer screening, Dr KWOK Ka-ki expressed concern about whether the Pilot Programme would become a form of "transfer of benefit" to the private sector. USFH reiterated that details of the Pilot Programme were yet to be hammered out by the taskforce. The Administration would strive to engage the healthcare professionals to take part in the Pilot Programme.

Treatment of confirmed cases

49. While expressing support for the Pilot Programme, Dr Helena WONG was concerned about the follow up treatment to be provided to new cases of colorectal cancer detected under the Pilot Programme. She asked whether HA would consider adding more target therapy drugs for colorectal cancer,

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in particular for metastatic colorectal cancer, in the HA Drug Formulary in tandem with the launch of the Pilot Programme. Dr Fernando CHEUNG pointed out that patients having colorectal cancer did not always have symptoms and around 25% of patients had metastasis at the time of the initial diagnosis. He held the view that target therapy drugs for metastatic colorectal cancer should be classified as first line treatment in the HA Drug Formulary in tandem with the launch of the Pilot Programme to benefit the some 292 new cases of colorectal cancer to be detected during the three-year pilot period according to the projection.

50. CM(ICP), HA explained that the purpose of colorectal cancer screening was to identify and provide early treatment for persons with no symptoms, but had lesions with the potential of developing into colorectal cancer. For established diseases, surgical removal of tumor was the mainstay treatment for colorectal cancer. Chemotherapy and/or radiotherapy might be considered as adjuvant therapy or for cases with metastasis involving other organs. Target therapy drugs could also be used in conjunction or after all these treatments had been tried.

Conclusion

51. In closing, the Chairman said that more information should be provided by the Administration to enable members to have an in-depth discussion on the merits of the Pilot Programme. In the light of this, the Administration should revert to the Panel on further details of the Pilot Programme prior to its commencement. USFH agreed.

52. There being no other business, the meeting ended at 6:48 pm.

Council Business Division 2
Legislative Council Secretariat
30 April 2015