中華人民共和國香港特別行政區政府總部食物及衞生局
Food and Health Bureau, Government Secretariat
The Government of the Hong Kong Special Administrative Region
The People's Republic of China

本函檔號 Our ref.: FHB/H/1/19
來函檔號 Your ref.: CB2/PS/l/l 7

電話號碼 Tel. No.: 3509 8959
傳真號碼 Fax No.: 2102 2471

17 May 2019

Ms Maisie Lam
Clerk to Subcommittee
Subcommittee on Issues Relating to the Support for Cancer Patients
Panel on Health Services
Legislative Council Complex
1 Legislative Council Road
Central

Dear Ms Lam,

Panel on Health Services
Subcommittee on Issues Relating to the Support for Cancer Patients
Follow-up to the meeting on 26 April 2019

Thank you for your letter dated 30 April 2019 regarding the follow-up actions arising from the discussion at the meeting of the Subcommittee on Issues Relating to the Support for Cancer Patients on 26 April 2019. Having consulted the Department of Health ("DH") and the Hospital Authority ("HA"), the requested supplementary information is provided in the ensuing paragraphs.

(a)(i-iii)

2. The Government attaches great importance to cancer prevention and control. As early as 2001, the Government established the Cancer Coordinating Committee ("CCC"). Chaired by the Secretary for Food and Health and comprising members who are cancer experts, academics, doctors in public and private sectors, as well as public health professionals, the CCC formulates strategies on cancer prevention and control and steers the direction of work covering prevention and screening, surveillance, research and

treatment.

3. The Cancer Expert Working Group on Cancer Prevention and Screening ("CEWG") set up under the CCC regularly reviews international and local evidence and makes recommendations on cancer prevention and screening applicable to the local situations. The CEWG members consist of representatives from relevant Colleges of Hong Kong Academy of Medicine, local universities, non-governmental organisations, the Hospital Authority, as well as the Government. Membership and the terms of reference of the CEWG are detailed at **Annex A**[1].

4. Since its establishment in 2002, 28 CEWG meetings have been held to discuss issues on prevention and screening of common cancers in Hong Kong. At present, the CEWG has made recommendations on prevention and screening for nine selected cancers, namely cervical, colorectal, breast, prostate, lung, liver, nasopharyngeal, thyroid and ovarian cancers (**Annex B**)[2]. Meanwhile, a full set of recommendations specific for health professionals, as well as concise materials tailored for members of the public, are also available on the website of the CHP.

5. The CEWG adopted the list of criteria below promulgated by the WHO for instituting a screening programme as guiding principles in considering population-based screening –

(a) the condition sought should be an important health problem;

(b) there should be an accepted treatment for patients with recognized disease;

(c) facilities for diagnosis and treatment should be available;

(d) there should be a recognizable latent or early symptomatic stage;

(e) there should be a suitable test or examination;

(f) the test should be acceptable to the population;

---

[1] The relevant information has also been uploaded onto the website of the Centre for Health Protection ("CHP") at https://www.chp.gov.hk/en/static/100854.html.

[2] These recommendations are uploaded on the website of the CHP at http://www.chp.gov.hk/en/content/9/25/31932.html.

(g) the natural history of the condition, including development from latent to declared disease, should be adequately understood;

(h) there should be an agreed policy on whom to treat as patients;

(i) the cost of case-finding (including diagnosis and treatment of patients diagnosed) should be economically balanced in relation to possible expenditure on medical care as a whole; and

(j) case-finding should be a continuing process and not a "once and for all" project.

6. Based on the above considerations, not all screening methods justify with evidence a population-based screening programme. Furthermore, all screening tests have their limitations as they are not 100% accurate. From the public health perspective, the Government must carefully assess a number of factors when considering whether to introduce a population-based screening programme for a specific cancer, such as local prevalence of the cancer, accuracy and safety of the screening tests, effectiveness in reducing incidence and mortality rates, feasibility of implementation of a screening programme, the capacity of the healthcare system with respect to resources, manpower and infrastructure, and public acceptance. The overriding principle is whether screening does more good than harm to the society.

7. Based on the above principles, the Government has launched territory-wide screening programmes for cervical cancer and colorectal cancer and details are described below. Information about screening programmes of cervical cancer and colorectal cancer implemented in certain overseas countries/region is at **Annex C**.

Cervical Screening Programme

8. The territory-wide Cervical Screening Programme ("CSP") was launched by the Government in March 2004, in collaboration with healthcare professionals in the public and private sectors and NGOs, to facilitate and encourage women to receive regular cervical cancer screening. The CSP has established a computerised central registry called Cervical Screening Information System for storing the screening records of registrants for issue of reminders and facilitating continuity of follow-up services.

9. The CSP encourages women aged between 25 and 64 who ever had sex to receive regular screening by cytology every three years after two consecutive

normal annual smears. Women aged 65 or above who ever had sex and have not received routine screening over the past 10 years, even after menopause, no sex for years or with sterilisation done, should be screened. Women aged between 21 and 24 who ever had sex and have risk factors (such as multiple sex partners, smoking and weakened immunity) should consult their doctors about the need for cervical cancer screening.

10. The major service providers under the CSP include the MCHCs and Woman Health Centres of the DH, NGOs and private healthcare service providers. The MCHCs of DH provide subsidised cervical cancer screening to the public[3]. There are about 100 000 attendances for cervical screening service per year in the MCHCs. In December 2017, the DH launched a Community Care Fund Pilot Scheme on Subsidised Cervical Cancer Screening and Preventive Education for Eligible Low-income Women.

Colorectal Cancer Screening Pilot Programme

11. In September 2016, the Government launched a three-year Colorectal Cancer Screening Pilot Programme ("Pilot Programme") to provide subsidised screening service to asymptomatic Hong Kong residents aged between 61 and 70 for prevention of colorectal cancer. The screening workflow comprises two stages. Participants will first undergo the subsidised Faecal Immunochemical Test ("FIT") provided by enrolled primary care doctors. If the FIT result is positive, the participant will receive subsidised colonoscopy service provided by enrolled colonoscopy specialist to find out the cause of occult bleeding in stool. The Pilot Programme was then regularised in August 2018 and is being implemented in three phases to subsidise asymptomatic Hong Kong residents aged between 50 and 75 to undergo screening for early detection of colorectal cancer.

(b)(i)

12. **Annex D** sets out the lower quartile (25th percentile), median (50th percentile), upper quartile (75th percentile) and longest (90th percentile) waiting time of cases triaged as Priority 1, Priority 2 and Routine cases for computed tomography ("CT"), magnetic resonance imaging ("MRI"), ultrasonography and mammogram of HA in 2018-19. HA does not maintain statistics on waiting time for diagnostic radiological imaging investigations by

---

[3] Fees are waived for women who are 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, or Level 0 voucher holders of the Pilot Scheme on Residential Care Service Voucher for the Elderly.

cancer type.

13. HA hospitals arrange diagnostic radiological imaging investigations for patients according to the medical assessment by doctors of patients' conditions. Patients who are confirmed or suspected of having cancer will be accorded priority for arrangement according to urgency of their clinical conditions.

(b)(ii)

14. HA places high importance to the provision of appropriate care for cancer patients and reviews on a regular basis the waiting time for patients with colorectal cancer, breast cancer and nasopharyngeal cancer to receive their first treatment after diagnosis. During the period between July 2017 and June 2018, the waiting time at the 90th percentile[4] for patients with colorectal cancer, breast cancer and nasopharyngeal cancer[5] to receive their first treatment after diagnosis were 74 days, 65 days and 56 days respectively. HA does not have relevant statistics on the waiting time for other types of cancer.

(c)

15. HA procures from time to time a wide variety of new and replacement medical equipment items to meet operational requirements. HA deliberates and formulates annual medical equipment requirement plan in respective committees, based on factors such as risk (e.g. obsolescence risk, equipment age, and patient / staff safety), impact to patient care, operational needs and requirement of additional equipment items essential for provision of new or improved services to dovetail with HA's strategic directions. Moreover, HA will take into account advice from healthcare professionals and overseas practices to facilitate planning for medical equipment, and consider the availability of expertise, manpower and facilities.

16. HA will make use of the additional funding support from the Government to further modernise and upgrade its medical equipment to provide quality services to patients. For example, modernisation and addition

---

[4] The 90th percentile waiting time refers to the number of days between the date when a case is diagnosed with cancer after pathological examination and the date when the patient receives the first treatment. The waiting time of 90 per cent of such cases is shorter than the value indicated.

[5] The calculation of the 90th percentile waiting time for patients with nasopharyngeal cancer is based on the data of the period from January 2018 to December 2018.

of linear accelerators, computed tomography scanners and magnetic resonance imaging scanners with more advanced functionalities can improve the diagnosis and treatment of cancer patients. Besides, HA will plan the diffusion of advanced technology such as additional robotic surgery system to augment minimal invasive surgical services, and Next Generation Sequencing technology to help treat patients, including cancer patients.

Yours sincerely,

(Jonathan CHIU)
for Secretary for Food and Health

c.c. Chief Executive, Hospital Authority (Attn.: Ms Dorothy Lam)
Department of Health (Attn.: Dr Rita Ho)

Annex A

Cancer Expert Working Group on Cancer Prevention and Screening

Terms of Reference

1. To review the scientific evidence on effectiveness and efficacy of primary prevention and screening intervention on cancers.
2. To assess primary prevention and screening interventions on cancers currently practised in Hong Kong as related to the scientific evidence.
3. To formulate guidelines for cancer primary prevention and screening in both clinical and community settings.
4. To recommend strategies for implementation of the guideline and monitoring/ evaluation of mechanism(s) for performance.

Membership

Chairman :	Dr Thomas TSANG Ho-fai
Co-chairman :	Dr WONG Ka-hing
Members :	Dr Kate ALLEN
	Dr Karen CHAN Kar-loen
	Dr Miranda CHAN Chi-mui
	Dr David CHAO VK
	Prof Annie CHEUNG Nga-yin
	Dr Cecilia FAN Yuen-man
	Dr Edwin HUI Pun
	Dr Dennis IP Kai-ming
	Dr LAM Ka-on
	Dr LAW Chun-key
	Prof LAW Wai-lun
	Dr Herbert LOONG Ho-fung
	Dr WONG Kam-hung
	Prof Martin WONG Chi-sang
	Dr Rebecca YEUNG Mei-wan
	Dr Anthony YING Chi-ho
Secretary :	Dr Rita HO Ka-wai

Annex B

Latest Recommendations on Screening for Nine Selected Cancers Made by Cancer Expert Working Group on Cancer Prevention and Screening ("CEWG")

Cancer	For asymptomatic population at average risk	For persons at increased risk
A. Cervical cancer	1. Women aged 25 to 64 who ever had sexual experience are recommended to have cervical cancer screening by cytology every three years after two consecutive normal annual smears. 2. Screening may be discontinued in women aged 65 or above if three previous consecutive smears within 10 years are normal. 3. Women at or above 65 years of age who have never had a cervical smear should have the test.	4. Women aged 21 to 24 years who ever had sexual experience and with risk factors for HPV acquisition / persistence or cervical cancer (e.g. early fist sexual intercourse, multiple sexual partners, tobacco use etc.) considered at increased risk. They may be screened by cytology every three years after two consecutive normal annual smears, depending on doctor's assessment. 5. Other women at high risk of developing cervical cancer may require more frequent screens based on doctor's assessment.

Cancer	For asymptomatic population at average risk	For persons at increased risk
B. Colorectal cancer	1. Individuals aged 50 to 75 years should consider screening by one of the screening methods including : (a) annual or biennial faecal occult blood test ("FOBT"); or (b) sigmoidoscopy every five years; or (c) colonoscopy every 10 years.	2. For carriers of mutated gene of Lynch Syndrome, the CEWG recommends screening for colorectal cancer ("CRC") by colonoscopy every one to two years from age 25 onwards. 3. For carriers of mutated gene of familial adenomatous polyposis ("FAP"), the CEWG recommends screening by sigmoidoscopy every two years from age 12. 4. For individuals with one first degree relative diagnosed with CRC at or below 60 years of age, or more than one first degree relatives with CRC irrespective of age at diagnosis, colonoscopy should be performed every five years beginning at the age of 40 or 10 years prior to the age at diagnosis of the youngest affected relative, but not earlier than 12 years of age. * Recommendation on genetic testing for CRC : For CRC patients with identifiable genetic mutations, two-tier screening by genetic testing followed by endoscopic examination can be offered to their family members to reduce the number of unnecessary investigations, as well as to reduce the risk of potential complications.

Cancer	For asymptomatic population at average risk	For persons at increased risk
C. Breast cancer	1. There is insufficient evidence to recommend for or against population-based mammography screening for asymptomatic women at average risk in Hong Kong. 2. There is insufficient evidence to recommend regular breast self-examination as a screening tool. Women are advised to be breast aware (be familiar with the normal look and feel of their breasts) and visit doctors promptly if suspicious symptoms appear. 3. There is insufficient evidence to recommend clinical breast examination. 4. Individuals considering breast cancer screening should be adequately informed by doctors about the benefits and harms.	5. Women at **moderate risk** (i.e. family history of only one first-degree female relative with breast cancer diagnosed at ≤50 years of age, or two first-degree female relatives diagnosed with breast cancer after the age of 50 years) should discuss with their doctors the pros and cons of breast cancer screening before deciding whether to start screening by mammography every two to three years. 6. Women at **high risk** (e.g. confirmed carriers of *BRCA1/2* deleterious mutations, family of breast / ovarian cancer) should seek advice from doctors; and (a) have mammography screening every year; (b) begin screening at age 35 or 10 years prior to the age at diagnosis of the youngest affected relative (for those with family history), whichever is earlier, but not earlier than age 30; and (c) for confirmed carriers of *BRCA1/2* deleterious mutations or women who had radiation therapy to chest for treatment between age 10 and 30 years, consider additional annual screening by MRI.

Cancer	For asymptomatic population at average risk	For persons at increased risk
D. Prostate cancer	1. There is insufficient scientific evidence to recommend for or against population-based prostate cancer screening in asymptomatic men by Prostate Specific Antigen ("PSA") and/or Digital Rectal Examination ("DRE"). 2. For asymptomatic men considering prostate cancer screening, CEWG encourages them to discuss with their doctor about individual circumstances and make informed decision on whether or not to go for prostate cancer screening.	3. Men at increased risk, namely African American men or those with one or more first-degree relatives diagnosed with prostate cancer before age 65, should consider seeking advice from doctors regarding the need for and approach of screening. While the screening blood test to be considered is PSA, the DRE may also be done as part of screening. The PSA screening should start at an age not earlier than 45 until age 70, and the interval should not be more frequent than once every two years.
E. Lung cancer	For general or high risk populations : 1. Routine screening for lung cancer with chest X-ray or sputum cytology is not recommended. 2. There is insufficient evidence to recommend for or against lung cancer screening by low dose computed tomography ("LDCT") in asymptomatic persons or for mass screening.	

Cancer	For asymptomatic population at average risk	For persons at increased risk
F. Liver cancer	1. Routine screening with alpha-fetoprotein ("AFP") or ultrasonography ("USG") for asymptomatic persons at average risk is not recommended.	2. People with chronic hepatitis B virus ("HBV") or hepatitis C virus ("HCV") infection, or cirrhosis regardless of cause are at increased risk of hepatocellular carcinoma ("HCC"). Depending on certain criteria such as age, family history, presence of cirrhosis and other clinical parameters, some subgroups are at higher risk and should consider receiving periodic surveillance (e.g. every 6-12 months) with AFP and USG. People with chronic HBV or HCV infection, or liver cirrhosis should thus seek advice from doctors to determine their need for and approach of cancer surveillance.
G. Naso-pharyngeal cancer	1. There is insufficient evidence to recommend a population-based nasopharyngeal cancer ("NPC") screening programme for asymptomatic people using IgA against specific Epstein-Barr virus ("EBV") viral antigens and EBV DNA test.	2. Family members of NPC patients may consider seeking advice from doctors with relevant expertise before making an informed decision about screening.

Cancer	For asymptomatic population at average risk	For persons at increased risk
H. Thyroid cancer	1. Screening for thyroid cancer is not recommended in asymptomatic persons at average risk.	2. Persons at increased risk, including those with a history of head or neck irradiation in infancy or childhood, familial thyroid cancer or family history of multiple endocrine neoplasia type 2 (MEN2), should consider seeking advice from doctors regarding the need for and approach of screening.
I. Ovarian cancer	1. Screening for ovarian cancer is not recommended in asymptomatic women at average risk.	2. Women at increased risk, such as with strong family history of ovarian / breast cancer or inherited deleterious gene mutations (e.g. BRCA1/2, Lynch Syndrome), should consider seeking advice from doctors for assessment of their ovarian cancer risk and the need for and approach of screening.

Annex C

Information about Screening Programmes of Cervical Cancer and Colorectal Cancer in Certain Overseas Countries/Region

Table A - Cervical Cancer Screening Programme

Country/ Region	Recommended Screening Tool	Recommended Screening Interval	Recommended Target Population	Government Subsidy
Hong Kong	Cytology	Every three years after consecutive normal annual smear	Aged 25-64	Government subsidy at 31 Maternal and Child Health Centres and three Women Health Centres
United Kingdom	Cytology	Every three years for women aged 25-49; Every five years for women aged 50-64	Aged 25-64	Government subsidy under NHS Cervical Screening Programme[1]
United States	Cytology	Every three years	Aged 21-64	Subsidised programme for low-income group under National Breast and Cervical Cancer Early Detection Program[2]
Australia	Primary HPV DNA testing (since Dec 2017)	Every five years	Aged 25-74	Government subsidy under National Cervical Screening Programme[3]
Singapore	Cytology	Every three years	Aged 25 or above	Government subsidy at designated clinics under Screen for Life[4]

[1] https://www.gov.uk/topic/population-screening-programmes/cervical
[2] https://www.cdc.gov/cancer/nbccedp/about.htm
[3] http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/cervical-screening-1
[4] https://www.healthhub.sg/programmes/61/Screen_for_Life

Table B – Colorectal Cancer Screening Programme

Country/ Region	Recommended Screening Tool	Recommended Screening Interval	Recommended Target Population	Government Subsidy
Hong Kong	Faecal Occult Blood Test ("FOBT")	Biennial	Aged 50-75	Government subsidy under the Colorectal Cancer Screening Programme[5]
United Kingdom	FOBT	Biennial	Aged 60-74[6]	Government subsidy under the Bowel Cancer Screening Programme[7]
United States	Different states in US have variations but FOBT is commonly adopted	Annual for FOBT	Aged 50-64	Subsidised programme for low-income group under the Colorectal Cancer Control Programme[8]
Australia	FOBT	Biennial	Aged 50-74	Government subsidy under the National Bowel Cancer Screening Programme[9]
Singapore	FOBT	Annual	Aged 50 or above	Subsidised under the Singapore Cancer Society supported by Health Promotion Board[10]

5 https://www.colonscreen.gov.hk/en/public/index.html

6 In August 2018, the UK ministers agreed that in the future bowel cancer screening in England will start at the age of 50. (https://www.gov.uk/guidance/bowel-cancer-screening-programme-overview#target-population)

7 https://www.gov.uk/guidance/bowel-cancer-screening-programme-overview#target-population

8 https://www.cdc.gov/cancer/crccp/pdf/CRCCP_FactSheet.pdf

9 http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/the-screening-process

10 https://www.singaporecancersociety.org.sg/get-screened/fit-50.html

Annex D

Waiting time for investigations at the Hospital Authority

Modality	Priority 1				Priority 2				Routine			
	Waiting Time (week)				Waiting Time (week)				Waiting Time (week)			
	25th	50th	75th	90th	25th	50th	75th	90th	25th	50th	75th	90th
	percentile				percentile				percentile			
Computed tomography	1	6	17	33	13	24	41	65	32	53	86	115
Magnetic resonance imaging	1	6	21	37	16	27	44	60	34	54	82	116
Ultrasonography	<1	3	10	22	16	27	55	81	30	62	99	132
Mammogram	<1	1	4	35	12	27	51	78	50	89	133	162