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Panel on Health Services

Subcommittee on Issues Relating to the Support for Cancer Patients

**Information note prepared by the Legislative Council Secretariat
for the meeting on 17 March 2020**

**Support for cancer patients and their carers and
the role of non-governmental organizations**

Background

The provision of cancer care services in the Hospital Authority ("HA") currently adopts a holistic patient-centred approach with multi-disciplinary teams to address patients' social and psychological needs throughout the cancer journey, as well as the needs of their carers. The teams comprise doctors, nurses, medical social workers, clinical psychologists, radiation therapists, medical physicists, physiotherapists, occupational therapists, dietitians, other allied health professionals, spiritual workers and volunteers who work as a team to provide holistic care. Separately, HA launched the Cancer Case Manager programme in 2010-2011. Under the Programme, the cancer case manager acts as the single contact point between patients and the multi-disciplinary service team in HA to streamline patients' care pathway and improve the coordination of care. The Programme currently covers patients with complex breast or colorectal cancer.

2. At present, Patient Resources Centres are established in 36 public hospitals or institutions to support patients of HA and their families or carers, and facilitate the connection and mutual support between patient and patient groups. As of December 2018, there were more than 220 patient groups under HA's liaison network at the corporate or cluster/hospital levels, including more than 40 cancer-related patient groups. HA leverages on the patient groups, which organize ward or home visits to patients, in promoting self-care and sharing of experience among patients. Patient Resources Centres also engage

patient groups as volunteers to participate in various projects in hospitals, such as the setting up of Patient Support Stations and Information Kiosks, to strengthen the psycho-social support to patients.

3. Separately, Cancer Patient Resource Centres are established by HA in collaboration with the Hong Kong Cancer Fund in United Christian Hospital and the six Clinical Oncology Centres in Pamela Youde Nethersole Eastern Hospital, Prince of Wales Hospital, Princess Margaret Hospital, Queen Elizabeth Hospital, Queen Mary Hospital and Tuen Mun Hospital. They offer free resources and services for cancer patients, including a cancer information library, professional counselling services, rehabilitation workshops, peer support activities, information and assistance to newly-diagnosed patients, as well as rehabilitation or palliative support.

4. As regards online resources, HA maintained a Smart Patient Website to provide a one-stop electronic platform with information on disease management and community resources to help patients, including cancer patients, self-manage their cancer pathways. According to HA, all patient groups listed on the Website are invited to its regular sharing sessions, where patient-related topics, imminent issues and the latest information on healthcare services are discussed. Representatives of the patient groups may also provide feedback on service enhancement based on patients' needs.

5. Two written questions concerning the service and support for patients and their carers were raised at the Council meetings of 12 April and 8 November 2017 respectively. The questions and the Administration's replies are in **Appendices I and II**.

Latest developments

6. The Administration launched the Hong Kong Cancer Strategy¹ in July 2019 to offer a holistic plan for cancer prevention and control for Hong Kong. The objectives in relation to support for cancer patients and their carers include adopting a holistic approach for the care of cancer patients and capitalizing on partnership and resources in the community to support service delivery. Through the Cancer Strategy, the Administration seeks to reduce the agony and anxieties among those who are affected by cancer through people-oriented measures, allocation of resources and collaboration with community partners. It has set its goals by 2025 to develop and launch additional Cancer Case

¹ The Strategy can be accessed at the website of the Food and Health Bureau at https://www.fhb.gov.hk/download/press_and_publications/otherinfo/190700_hkcs/e_hkcs_fully.pdf.

Programmes; establish a dedicated online resources hub to enhance health communications and to serve as a centralized directory to inform the public of cancer-related resources, and set up a platform involving the civil society, named Cancer Network of Partners, to enhance the role of community groups in delivering cancer services.

7. The Administration will brief the Subcommittee on 17 March 2020 on the support offered for cancer patients and their carers and the direction of enhancing cancer services in collaboration with non-governmental organizations.

Council Business Division 2
Legislative Council Secretariat
16 March 2020

Appendix I

Press Releases

LCQ5: Prevention of cancers and cancer treatment

Following is a question by the Hon Kwong Chun-yu and a written reply by the Secretary for Food and Health, Dr Ko Wing-man, in the Legislative Council today (April 12):

Question:

The Government launched the Colorectal Cancer Screening Pilot Programme (the Pilot Programme) in September last year to subsidise people of specific age groups for receiving colorectal cancer screening. In addition, the Hong Kong Cancer Fund has collaborated with the Hospital Authority (HA) in setting up Cancer Patient Resource Centres in some public hospitals to offer resources and assistance to cancer patients. HA has also launched the cancer case manager programme, under which experienced nurses are assigned as case managers specifically tasked with the responsibility of following up confirmed cancer patients. Regarding the prevention of cancers and provision of treatment and support for cancer patients, will the Government inform this Council:

(1) of the number of participants in the Pilot Programme since its launch; among such participants, the numbers and percentages of those diagnosed with colorectal cancer, broken down by age group (i.e. 45 to 50, 51 to 55 and 56 to 60); the number of primary care doctors currently engaged in the Pilot Programme, and the average number of persons provided with examination services by each of those doctors in a month;

(2) whether it knows the current waiting time for patients with the cancers listed in the table below to receive their first treatment in public hospitals (set out in the table below); whether HA has plans to shorten such waiting time and draw up relevant performance pledges; if HA does, of the details; if not, the reasons for that;

Type of cancer	Waiting time					
	30-59 days	60-89 days	90-119 days	120-149 days	150-179 days	180 days or above
Colorectal cancer						
Lung cancer						
Breast cancer						
Liver cancer						
Prostate cancer						
Corpus uteri cancer						
Nasopharyngeal cancer						
Thyroid cancer						
Stomach cancer						
Non-Hodgkin lymphoma cancer						

(3) whether it knows the number of patients who received services in various Cancer Patient Resource Centres, and the percentage of that number in the total number of cancer patients in public hospitals in the relevant year, in each of the past three years; whether such centres only serve patients of specific types of cancer; if so, of the details;

(4) whether it knows if HA has reviewed the efficacy of the cancer case manager programme; if HA has, of the outcome (including the relevant data); of the number of patients serviced by the programme, and the percentage of that number in the total number of cancer patients in public hospitals in the relevant year, in each of the past two years; the number of cases that each case manager needs to handle concurrently at present;

(5) whether it has plans to provide the public with more information about caring for cancer patients; if so, of the details; if not, the reasons for that; and

(6) whether it knows the number of cancer patients who received palliative care services in public hospitals in each of the past five years (broken down by type of service); whether HA has partnered with any private healthcare institution at present to provide such services for patients so as to reduce the pressure on public hospitals; if HA has, of the details; if not, the reasons for that?

Reply:

President,

(1) The Government launched the three-year Colorectal Cancer Screening Pilot Programme (Pilot Programme) on September 28, 2016 to subsidise in phases asymptomatic Hong Kong residents born from 1946 to 1955 to undergo colorectal cancer screening tests. The aim of the Pilot Programme is to help identify those people who are more likely to develop colorectal cancer or who already have the disease, so that treatment can start earlier to improve the chances of a cure. According to the screening procedures of the Pilot Programme, a participant will first undergo the government-subsidised Faecal Immunochemical Test (FIT) by an enrolled primary care doctor (PCD). If the FIT result is positive, the PCD will, according to the participant's choice, refer him/her to undergo a government-subsidised colonoscopy examination by an enrolled colonoscopy specialist (CS) to find out the cause of occult blood in their stool.

The Pilot Programme is conducted in three phases. The first phase was launched on September 28, 2016 with target participants born from 1946 to 1948. The second phase was launched on February 27, 2017 with its coverage extended to those born from 1946 to 1951. As at March 31, 2017, 600 PCDs had joined and provided government-subsidised FIT service for about 24 800 participants under the Pilot Programme. On average, each enrolled PCD had provided FIT service for about 40 participants. In addition, 136 CSs had joined the Pilot Programme to provide government-subsidised colonoscopy examination service for participants with a positive FIT result. As at March 31, 2017, about 3 200 participants were found to have a positive FIT result. Excluding those who selected to undergo colonoscopy examination service at public hospitals or other private healthcare institutions, each enrolled CS provided colonoscopy examination service for about 20 FIT positive participants.

As the Pilot Programme has been implemented for just half a year and covering only those born from 1946 to 1951, the Department of Health cannot provide the figures and percentage of diagnosed cases by age groups for the time being. The Government will decide on future service arrangements after reviewing the effectiveness of the Pilot Programme.

(2) As the diagnosis and treatment process of individual cancer patients vary depending on the types of cancer and their clinical symptoms, the Hospital Authority (HA) does not have a standardised approach to assess the waiting time for different cancer diseases.

The HA reviews regularly the waiting times for patients with colorectal cancer, breast cancer and nasopharyngeal cancer respectively to receive their first treatment after diagnosis. Between July 2015 and June 2016, the waiting times at the 90th percentile (note) for patients with colorectal cancer, breast cancer and nasopharyngeal cancer respectively to receive their first treatment after diagnosis were 69 days, 64 days and 53 days respectively.

The HA has planned to enhance its cancer services in 2017-18 through, for example, increasing the service capacity of chemotherapy and radiotherapy.

(3) The HA has partnered with the Hong Kong Cancer Fund to establish Cancer Patient Resource Centres (CPRCs) in Queen Mary Hospital, Tuen Mun Hospital, Pamela Youde Nethersole Eastern Hospital, Prince of Wales Hospital, Princess Margaret Hospital, Queen Elizabeth Hospital and United Christian Hospital. The CPRCs provide free resources and services for cancer patients, including a cancer information library, professional counselling services, rehabilitation workshops, peer support activities, services which seek to provide information and assistance to newly-diagnosed patients, as well as rehabilitation or palliative support for those who are going through other stages of the cancer journey. Some activities organised by the CPRCs are funded by the Hong Kong Cancer Fund. The HA does not maintain statistics on the usage of the CPRCs.

(4) The HA has implemented the cancer case manager programme in phases since 2010-11 for patients with complex breast cancer or colorectal cancer. Under the programme, the cancer case managers act as the single contact persons between these patients and the doctors. The programme was extended to all the clusters in 2014-15. There are currently 21 cancer case managers serving those cancer patients participating in the programme. The number of cancer patients benefitting from the programme in the past two years are as follows:

Year*	Number of cancer patients benefitting from the cancer case manager programme
2014-15	4 558
2015-16	5 837

* Figures for 2016-17 are not available.

In 2016, the HA conducted a patient satisfaction survey on the cancer manager programme, the results of which showed that patients were satisfied with the programme. Another survey on

the quality of life conducted at the same time also showed that patients covered by the programme were satisfied with their quality of life.

(5) The HA provides comprehensive disease information for patients suffering from chronic diseases (including cancer patients) and their families through the "Smart Patient Website", a one-stop information hub that helps strengthen their ability in disease management. The "Cancer in Focus" section of the website offers cancer patients disease information and self-care tips.

(6) The HA provides appropriate palliative care services for terminally-ill patients (including cancer patients and patients with organ failure) and their families according to the principle of "providing holistic care for patients". Such services are delivered in an integrated mode through multi-disciplinary palliative care teams comprising doctors, nurses, medical social workers, clinical psychologists, physiotherapists and occupational therapists.

At present, palliative care services, including in-patient service, out-patient service, day care service, home care service, bereavement counselling, are provided in all seven clusters of the HA. The statistics on the utilisation of each type of palliative care services from 2012-13 to 2016-17 (as at December 31, 2016) are set out at Annex.

The HA will continue to review the demands for various medical services and plan its services, including various types of palliative care services, according to factors such as population growth and changes, advancement of medical technology and healthcare manpower. Improvements will be made while ensuring efficient use of resources with a view to meeting the overall public demand.

Currently, the HA does not have any plans for public-private partnership in the provision of palliative care services for cancer patients.

Note: 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 first treatment. The waiting time of 90 per cent of such cases is shorter than the value indicated.

Ends/Wednesday, April 12, 2017
Issued at HKT 17:40

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LCQ5

Statistics on the utilisation of each type of palliative care services

Palliative Care Service	Number of Attendances				
	2012-13	2013-14	2014-15	2015-16	2016-17 (as at December 31, 2016) [Provisional figures]
Palliative care in-patient service ¹ (Number of in-patient/day in-patient discharges and deaths)	8 005	8 240	8 254	7 970	6 006
Palliative care specialist out-patient service ¹	9 342	9 260	9 449	9 058	7 130
Palliative home visit ²	32 280	33 386	33 199	34 311	30 273
Palliative day care service	11 544	12 321	12 275	12 231	9 560
Bereavement service	3 610	3 930	3 034	3 436	2 942

Notes:

1. The above statistics include the throughput of the hospice specialty only.
2. The definition of the statistics was revised in April 2016. As a result, no comparison can be made between the figures before and after April 2016.

Appendix II

Press Releases

LCQ10: Treatment for uncommon disorders and cancers

Following is a question by the Dr Hon Elizabeth Quat and a written reply by the Secretary for Food and Health, Professor Sophia Chan, in the Legislative Council today (November 8):

Question:

It is learnt that there are more than 7 000 known rare diseases worldwide, and most of them are hereditary diseases, autoimmune diseases and cancers. While the European Union, the United States, Australia, Japan, South Korea and Taiwan have drawn up their official definitions for rare diseases and the relevant medical care policies, Hong Kong has not followed suit. Some concern groups have pointed out that the existing support measures of the Government for patients of rare diseases and cancers also lag behind those of other advanced countries or regions. In this connection, will the Government inform this Council:

(1) whether the authorities will expeditiously draw up an official definition for "rare diseases" and the relevant policies on supporting the patients; if so, of the details; if not, the reasons for that;

(2) given that the Policy Address just delivered has put forward the provision of more assistance for patients with uncommon diseases, whether the "uncommon diseases" mentioned include: (i) non-infectious non-anterior uveitis, (ii) acute lymphoblastic leukemia, (iii) familial amyloid polyneuropathy, (iv) cortical-basal ganglionic degeneration, (v) hereditary thrombocytopenia and (vi) fabry disease; if so, of the details; if not, the reasons for that;

(3) whether the authorities will establish a database on rare diseases for reference by the relevant personnel when making policy decisions on medical care, making clinical decisions and conducting medical researches; if so, of the details; if not, the reasons for that;

(4) whether the authorities will set up an one-stop centre for rare diseases at the Hong Kong Children's Hospital to be commissioned shortly, so that tasks such as screening, diagnosis, treatment, rehabilitation, research and training relating to rare diseases can be centrally handled there; if so, of the details and the timetable; if not, the reasons for that;

(5) as most rare diseases are hereditary diseases, whether the authorities will make improvements to the existing public prenatal check-up services, including extending the scope of such services to cover more non-invasive genetic tests relating to hereditary diseases, and include genetic tests relating to common hereditary diseases in public premarital or prenatal check-up services, with a view to reducing the incidence of newborn babies suffering from rare diseases; if so, of the details; if not, the reasons for that;

(6) of the top 10 deadliest cancers in Hong Kong at present and, in respect of each of them, (i) the number of new confirmed cases

and (ii) the number and age distribution of deaths in each of the past 10 years (set out in a table);

(7) of the average length of time taken from a public hospital patient being suspected by a doctor of having cancer to that patient receiving first treatment, and the respective numbers of people queuing to receive the relevant treatments (with a tabulated breakdown by type of cancer);

(8) of the drugs newly developed for treating rare diseases and cancers which were registered in Hong Kong in the past 10 years, and the average time taken by the authorities to vet and approve the applications for registration of these drugs; whether the authorities will put in place a mechanism for the speedy registration of drugs for treating such diseases; if so, of the details; if not, the reasons for that;

(9) whether the authorities will make references to overseas practices and introduce a risk-sharing scheme on drug expenses for the treatment of rare diseases and cancers, under which the Hospital Authority (HA) is to enter into agreements with pharmaceutical companies on payments for drugs based on the efficacy of drug treatment achieving the target specified, or based on the duration of treatment specified in the agreement concerned, with a view to capping the drug expenses for HA and the patients concerned; if so, of the details; if not, the reasons for that; and

(10) whether it knows the existing number of patient groups which provide support services for patients with rare diseases or cancers and their carers; whether the authorities will enhance the cooperation with such patient groups so as to support these patients and their carers more effectively; if so, of the details; if not, the reasons for that?

Reply:

President,

My reply to the question raised by the Dr Hon Elizabeth Quat relating to uncommon disorders and cancers is as follows:

(1) to (3) Currently, there is no internationally agreed definition of uncommon disorders. The definition varies among countries/regions depending on their own healthcare system and situation. The Government's policy is to strive to ensure appropriate treatment for all patients, including those with uncommon disorders.

With the advancement of technology, new treatment options, including drugs, surgery and invasive treatment, are being developed. In assessing the treatment options for various disorders, including uncommon disorders, the Hospital Authority (HA) would take into consideration the following factors:

i. Newly developed treatment options, having only preliminary medical evidence in safety and efficacy, may vary significantly in terms of treatment responses in different patients.

ii. Due to the small number of cases or patient groups for conducting scientific research at the initial stage, and the brief duration of research conducted, it is not easy to ensure the completeness of the clinical data.

iii. The ultra-high cost of such options in the market is unaffordable for average patients.

Under the current healthcare policy, we strive to ensure that all patients, whether they are patients with uncommon disorders or those suffering from other general illnesses, will not be denied appropriate treatment due to lack of means. The healthcare support provided by the HA covers patients with uncommon disorders and those suffering from other diseases, and the mechanism in place also addresses the needs of all patients, including those with uncommon disorders. The HA will continue to review and enhance its existing mechanisms and supporting arrangements to strengthen its services and support. The HA maintains data on different types of disorders, which can facilitate research and policy formulation.

(4) The Hong Kong Children's Hospital (HKCH) is expected to commence operation by phases in late 2018. HKCH will serve as a territory-wide tertiary referral centre for serious, complex and uncommon paediatric cases requiring multidisciplinary management. While providing diagnosis, treatment and rehabilitation of higher quality to sick children from birth to 18 years of age who require such services, HKCH will also pool relevant expertise which will strengthen research and training regarding paediatric and genetic diseases.

Meanwhile, the paediatric departments in the regional hospitals will mainly provide secondary, emergency and community paediatric care. Under this hub-and-spoke model, HKCH and the regional hospitals will form a coordinated and coherent paediatric service network, enhancing the overall healthcare quality of the public paediatric service.

(5) In examining whether to introduce expanded carrier screening, the HA needs to carefully consider various factors, such as the types of genetic or hereditary diseases with testing available in Hong Kong, interfacing between genetic testing services and genetic counselling, as well as the accuracy and safety of the screening tests. The HA has discussed the development and effectiveness of safeT21(T21) tests at the relevant Coordinating Committee. The HA is now exploring the facilities required for the introduction of T21 testing in HKCH as a second tier screening test for Down's syndrome and preparing for manpower training in this respect.

(6) In 2015, the top 10 causes of cancer deaths were cancers of the lung, colorectum, liver, pancreas, stomach, breast, prostate, non-Hodgkin lymphoma, leukaemia and nasopharynx. Of these cancers, the number of new cases and registered deaths with a breakdown by age group from 2006 to 2015 recorded by the Hong Kong Cancer Registry of the HA are set out at Annex.

(7) As the diagnosis and treatment process of individual cancer patients vary depending on the types of cancer and their clinical symptoms, the HA does not have a standardised approach to assess the waiting time for different types of cancer.

The HA 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. In the period between January and December 2016, the waiting time at the 90th percentile (note) for patients with colorectal cancer, breast cancer and nasopharyngeal cancer to receive their first treatment after diagnosis were 76 days, 64 days and 54 days

respectively.

(8) According to the Pharmacy and Poisons Ordinance and its subsidiary legislation, "pharmaceutical products" must satisfy the criteria of safety, efficacy and quality, and must be registered with the Pharmacy and Poisons Board (the Board) before they can be sold in Hong Kong.

In order to facilitate timely registration of new pharmaceutical products for the treatment of patients in Hong Kong, the above legislation was amended in February 2015 to enable legislative amendments relating to new pharmaceutical products could be made via negative vetting procedures to expedite registration in Hong Kong.

In the past 10 years (i.e. between 2007 and October 31, 2017), the Product Registration Committee established under the Board has considered and approved the registration of 171 new pharmaceutical products containing 100 new pharmaceutical substances for the treatment of cancer, or for the treatment of uncommon disorders as defined by the United State or European Union drug regulatory authorities. These 171 new products included 99 new pharmaceutical products (containing 63 new pharmaceutical substances) were approved for registration between 2007 and 2014 before the above legislative amendments, with the average processing time of 5.4 months per application (i.e. between the date upon submission of complete registration documents by the applicant and the date when the Department of Health (DH) issued the letter to inform the applicant that the Board has approved its application); and 72 new pharmaceutical products (containing 37 new pharmaceutical substances) were approved for registration between 2015 and October 31, 2017 after the above legislative amendments, with the average processing time of 2.7 months per application.

The DH conducts regular monthly seminars to explain the registration requirements of pharmaceutical products. If necessary, applicants can contact the DH via hotline, and the DH will provide assistance to the applicants as appropriate.

(9) The HA holds discussions with pharmaceutical companies from time to time on setting up risk sharing or capping programmes for individual expensive drug treatments where both HA and pharmaceutical companies would contribute to the drug costs in specific proportions in a defined period or cap the drug treatment costs to be borne by patients, so as to provide the concerned patients with sustainable, affordable and optimal drug treatments in the long term. Moreover, the HA would liaise with pharmaceutical companies on providing special or compassionate drug programmes, having regard to the exceptional circumstances of specific individual patients, so as to facilitate early access to drug treatments.

(10) Promoting partnership with patients is one of the key strategic directions of the HA in delivering patient-centred care. The HA regularly organises sharing sessions with patient groups. All patient groups listed on the Smart Patient Website (SPW) are invited. During these sharing sessions, the HA discusses patient-related topics and imminent issues with patient representatives, and updates them on the latest information on healthcare services, such as HA Drug Formulary, waiting time for new specialist out-patient cases, and Patient Experience and Satisfaction Surveys, etc. Representatives of patient groups may also provide feedback on service enhancement based on patients'

needs. As at July 2017, more than 200 patient groups were listed on the HA's SPW, including the Hong Kong Alliance for Rare Diseases and relevant organisations, as well as cancer-related patient groups.

In parallel, the HA has set up Patient Resource Centres (PRCs) in cluster hospitals to provide support for patients and their families/carers, including facilitating the connection with patients groups and self-help groups for mutual support. In particular, the HA leverages on the patient groups in promoting self-care and sharing of experience among patients. At present, ward or home visits are conducted by many patient groups to show care and concern for patients. Community networks are also established to support patients for early reintegration into community. PRCs will also engage patient groups as volunteers to participate in various projects in hospitals, such as setting up of Patient Support Stations and Information Kiosks, as well as Scheme on Collaborative Projects of Patient Groups and PRCs, etc, to strengthen the psycho-social support to patients. Such partnership can also enhance the mutual trust between patient groups and healthcare staff.

Note: 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.

Ends/Wednesday, November 8, 2017
Issued at HKT 20:05

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**Table 1: Number of new cases in the past decade of the 10 major causes of cancer deaths
in 2015**

Site	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Lung	4 233	4 261	4 236	4 365	4 480	4 401	4 610	4 631	4 674	4 748
Colorectum	3 918	4 084	4 031	4 335	4 370	4 450	4 563	4 769	4 979	5 036
Liver	1 745	1 690	1 745	1 832	1 863	1 858	1 790	1 852	1 847	1 791
Pancreas	432	479	448	500	513	548	574	608	655	766
Stomach	1 018	1 007	1 058	1 078	1 107	1 101	1 113	1 100	1 146	1 167
Breast	2 595	2 723	2 633	2 962	3 025	3 440	3 522	3 544	3 883	3 920
Prostate	1 068	1 205	1 369	1 484	1 492	1 644	1 631	1 655	1 709	1 831
Non-Hodgkin lymphoma	677	663	672	730	779	765	804	877	918	976
Leukaemia	431	421	421	467	488	487	489	547	540	560
Nasopharynx	959	925	926	914	858	862	819	841	834	876

Table 2: Number of deaths by age group in the past decade of the 10 major causes of cancer deaths in 2015

Site	Age group (years old)	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Lung	0-19	0	0	1	0	0	0	0	1	0	0
	20-44	94	75	79	86	59	70	72	64	61	77
	45-64	852	872	866	890	967	1 022	1 048	1 001	1 031	1 037
	65 and above	2 585	2 701	2 551	2 716	2 670	2 697	2 773	2 800	2 774	2 917
	Total*	3 531	3 648	3 497	3 692	3 696	3 789	3 893	3 867	3 866	4 031
Colorectum	0-19	0	1	0	0	0	0	0	0	0	1
	20-44	39	51	46	40	41	39	48	47	39	50
	45-64	386	361	398	415	425	481	433	482	507	488
	65 and above	1 203	1 277	1 242	1 297	1 398	1 384	1 422	1 452	1 488	1 534
	Total	1 628	1 690	1 686	1 752	1 864	1 904	1 903	1 981	2 034	2 073
Liver	0-19	2	3	1	2	0	2	1	4	2	2
	20-44	61	64	85	53	50	60	60	51	59	43
	45-64	484	532	562	537	563	534	526	519	540	503
	65 and above	915	850	851	896	917	940	918	950	983	1 023
	Total*	1 462	1 449	1 499	1 488	1 530	1 536	1 505	1 524	1 585	1 571
Pancreas	0-19	0	0	0	0	0	0	0	0	0	0
	20-44	18	6	6	7	13	7	16	8	10	13
	45-64	107	121	130	130	137	148	183	166	181	220
	65 and above	272	307	290	312	323	353	339	410	385	458
	Total	397	434	426	449	473	508	538	584	576	691
Stomach	0-19	0	0	0	0	0	0	0	0	0	0
	20-44	38	28	26	31	32	28	25	19	25	27
	45-64	145	165	156	173	190	177	165	166	155	179
	65 and above	452	447	443	451	464	482	467	440	477	463
	Total*	635	640	625	656	686	687	657	625	657	669

Breast	0-19	0	0	0	0	0	0	0	0	0	0
	20-44	67	62	62	62	57	39	60	69	41	53
	45-64	221	270	255	283	289	306	315	303	323	362
	65 and above	177	197	198	210	220	209	229	228	246	222
	Total	465	529	515	555	566	554	604	600	610	637
Prostate	0-19	0	0	0	0	0	0	0	0	0	0
	20-44	0	0	0	1	1	0	0	1	1	0
	45-64	22	17	21	21	20	22	23	24	32	20
	65 and above	263	279	261	284	298	277	339	347	365	384
	Total	285	296	282	306	319	299	362	372	398	404
Non-Hodgkin lymphoma	0-19	1	3	2	2	1	4	4	2	0	3
	20-44	20	21	20	30	20	14	19	14	18	16
	45-64	79	78	67	82	88	87	76	99	83	97
	65 and above	219	216	207	214	253	204	252	237	251	242
	Total	319	318	296	328	362	309	351	352	352	358
Leukaemia	0-19	10	17	6	8	14	16	7	11	11	7
	20-44	33	30	31	38	34	40	23	25	29	38
	45-64	72	62	76	72	66	108	78	80	88	77
	65 and above	139	172	176	152	174	165	168	186	188	219
	Total	254	281	289	270	288	329	276	302	316	341
Nasopharynx	0-19	0	1	0	1	0	0	0	0	1	0
	20-44	58	39	38	35	28	36	37	43	24	37
	45-64	190	186	212	215	201	197	188	161	165	182
	65 and above	110	111	108	108	91	119	104	108	118	108
	Total	358	337	358	359	320	352	329	312	308	327

*Includes cases with age unknown.

(Remark): New cases and deaths regarding various cancer types in a year might not be contributed by the same pool of patients. Rankings for 10 major causes of cancer deaths were not the same as that of new cases.