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Panel on Health Services

Report of the Subcommittee on Issues Relating to the Support for Cancer Patients

Purpose

This paper reports on the deliberations of the Subcommittee on Issues Relating to the Support for Cancer Patients ("the Subcommittee") formed under the Panel on Health Services ("the Panel").

Background

2. Cancer is the top killer in Hong Kong. It claimed 14 594 lives in 2018, accounting for about one third of the total deaths in the local population. Among all, lung cancer, colorectal cancer and liver cancer topped the list and made up more than 52% of all cancer deaths. With a growing and an ageing population[1], the number of new cancer cases and related healthcare burden is set to rise. The latest statistics of the Hong Kong Cancer Registry ("the Cancer Registry")[2] shows that a total of 33 075 new cancer cases were diagnosed in Hong Kong in 2017, hitting a record high with 1 607 more cases or a rise of 5.1% compared with 2016. It is projected that with the prevailing trends in incidence and population structure in Hong Kong, the annual number of new cancer cases would increase by around 30% to more than 42 000 by 2030 from current level. At the same time, with the ageing population and treatment advancement, the survival rates of most cancers have improved over the years with more patients living with and beyond cancer.

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[1] According to the Administration, cancer is primarily a disease of older people. The median age at diagnosis of cancer in 2016 was 67 years for male and 61 years for female. The median age at death due to cancer was 72 years for both male and female in 2018.

[2] Due to the time required for cancer data collection, compilation, analysis and quality control, there is a time gap of 22 months in the presentation of data (which is a common phenomenon recognized in other countries).

3. The Administration has established the Cancer Coordinating Committee since 2001 to formulate strategies on cancer prevention and control and steers the direction of work covering prevention and screening, surveillance, research and treatment. Separately, the latest statistics of the Hospital Authority ("HA") shows that around 90% of the new cancer patients are ever diagnosed or treated in HA within the first six months of cancer diagnosis, making HA being the major provider of cancer services in Hong Kong.[3] In 2019-2020, the total number of cancer patient episodes that received treatment at standard fees and charges in HA was 144 000.[4]

The Subcommittee

4. At the Panel meeting on 21 May 2018, members agreed to appoint a Subcommittee under the Panel to study and review the Government's policies on promoting the short, medium and long-term development and support for prevention and treatment of cancer as well as relevant issues, and make timely recommendations. The Subcommittee commenced its work in March 2019 upon the availability of a vacant slot for subcommittees on policy issues. Dr Hon CHIANG Lai-wan and Hon Elizabeth QUAT were elected as Chairman and Deputy Chairman of the Subcommittee respectively. The Subcommittee's terms of reference and membership list are in **Appendices I and II** respectively.

5. The Subcommittee held a total of seven meetings with the Administration, and received oral representations from 26 deputations on the overall strategy for the prevention and treatment of cancer, prevention and screening of cancer, and support for cancer drug treatment at three of these meetings. A list of organizations and individuals which/who have given oral representation to the Subcommittee is in **Appendix III**.

Deliberations of the Subcommittee

Cancer surveillance system

6. The availability of comprehensive cancer data of a population is crucial to the planning of cancer services and to assess the impact of the cancer control programmes in place. Locally, the Cancer Registry is the Government-recognized agency tasked to compile cancer surveillance data in Hong Kong. It collects from both private and public hospitals the basic

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[3] Cancer services in HA are mainly operated through the six cluster-based oncology centres located in Pamela Youde Nethersole Eastern Hospital, Prince of Wales Hospital, Princess Margaret Hospital, Queen Elizabeth Hospital, Queen Mary Hospital and Tuen Mun Hospital, each of which is networked with other hospitals and clinics within the cluster.

[4] Projection as of 31 December 2019.

demographic data, information on the topography and histology of all cancers diagnosed in Hong Kong within a calendar year to provide local surveillance data on incidence, mortality, trends and projections of different cancers. Apart from the above, the Cancer Registry has started collecting information on staging, initial treatment and survival data in recent years, and has developed colorectal and breast cancer-specific registries to collect and compile comprehensive clinical and outcome data on these two cancers.

7. Since cancer survival was a key element for evaluation of the overall effectiveness of cancer control and care management, members welcomed the Administration's plan to expand the role of the Cancer Registry with a view to developing a local cancer surveillance system to report stage-specific cancer survival rates for the most prevalent cancers on a regular basis. They were also pleased to note that the Cancer Registry had endeavoured to shorten the time lag in the reporting of annual cancer statistics which currently stood at about 22 months. While the completeness of registration by the Cancer Registry was reckoned to be 97% or higher, which was at a high level according to the International Agency for Research on Cancer of the World Health Organization ("WHO"), some members were concerned that reporting of cancer cases by medical practitioners was not mandatory. The Administration advised that the Cancer Registry had built partnership with 11 private hospitals, except Matilda International Hospital which did not have a pathology laboratory, to sustain a complete and high coverage of cancer data in Hong Kong. Since the pathology services of Matilda International Hospital was supported by another private hospital, relevant data had been contributed to the Cancer Registry.

8. Members made various suggestions to improve the comprehensiveness of cancer surveillance data. These included expanding the scope of the Cancer Registry's cancer information to cover also the risk factor(s) leading to higher incidence rate of a particular gender for certain types of cancers, such as lung and liver cancers which recorded higher male to female ratios; making statistics relating to the treatment underwent by the cancer patients and their survival data available in the Cancer Registry's website to serve as a reference for patients and their carers on treatment options for different types of cancer; and refining the website of the Cancer Registry to provide greater and more interactive access to the database for local cancer surveillance.

Cancer screening and vaccination

9. Detecting cancer early is a critical step in reducing mortality as a result of cancer. Screening as a tool for secondary prevention aims to detect early cancers or to identify precancerous disease in asymptomatic individuals, so that treatment can be carried out early and more effectively. According to WHO, when planned effectively, screening can reduce deaths from cancer and the risk of developing cancer in some cancer types. At present, the Cancer

Expert Working Group on Cancer Prevention and Screening ("the Expert Working Group") set up under the Cancer Coordinating Committee regularly reviews international and local evidence and makes recommendations on cancer prevention and screening applicable to the local setting. The Expert Working Group adopts a list of criteria promulgated by WHO in its deliberations for population-based screening which covers (a) the condition sought should be an important health problem; there should be an accepted treatment for patients with recognized diseases; (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; (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 "one and for all" project.

10. Members noted that since its establishment in 2002, the Expert Working Group had so far made recommendations on prevention and screening for nine selected cancers, namely cervical, colorectal, breast, prostate, lung, liver, nasopharyngeal, thyroid and ovarian cancers. On the basis of the recommendations and the overriding principle as to whether screening would do more good than harm to the society, the Administration had launched territory-wide screening programmes for cervical cancer [5] and colorectal cancer[6] respectively. Referring to the observation of the Cancer Registry that it was worthy to note that the number of newly diagnosed invasive and in-situ breast cancer had recorded a historic high of over 5 000 cases during 2017 and the findings of a study which revealed that biennial mammography screening had reduced stage II or above breast cancer cases by 30% and breast cancer mortality by 41% in Taiwan during the period from 1999 to 2009, many members including Dr CHIANG Lai-wan, Ms Elizabeth QUAT, Mr CHAN Han-pan, Dr KWOK Ka-ki, Dr Fernando CHEUNG, Dr Helena WONG, Mr

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[5] The territory-wide Cervical Screening Programme, which was launched in 2004, 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 sterilization 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.

[6] The Colorectal Cancer Screening Programme was originally launched on a pilot basis in 2016 to provide subsidized screening service to asymptomatic Hong Kong residents aged between 61 and 70. The Programme was regularized in August 2018 and is being implemented in three phases to subsidize asymptomatic Hong Kong residents aged between 50 and 75 to undergo screening for early detection of colorectal cancer.

POON Siu-ping and Ms CHAN Hoi-yan strongly urged the Administration to introduce population-based, or at the very least, risk-based free or subsidized mammography screening in Hong Kong, and make use of mobile mammography screening vehicles to facilitate the public's access to the services. Separately, there were suggestions that the Administration should introduce alpha-fetoprotein blood test and ultrasonography for patients with chronic hepatitis B virus infection (which was a major cause of liver cancer in Hong Kong) or hepatitis C virus infection, as well as population-based prostate-specific antigen blood test for early detection of liver cancer and prostate cancer.

11. Dr Pierre CHAN drew members' attention that population-based screening might not be suitable for all types of cancer. In addition, all screening tests had their limitations. False-positive result in cancer screenings would lead to additional investigations which turned out to be unnecessary as well as anxiety and stress of the person who underwent the tests. He called on the Administration to enhance public education in this regard.

12. The Administration explained that it was necessary to gather more research findings and data to explore whether it was appropriate to implement population-based mammography screening for asymptomatic women at average risk. To bridge the knowledge gap for risk prediction of breast cancer in the local female population, it had commissioned The University of Hong Kong in October 2015 to conduct a study on risk factors associated with breast cancer for local women ("the Study"). The aim of the Study was to formulate a risk prediction model for breast cancer in Hong Kong using a case-control study approach under which a comparison was made between women with and without breast cancer. It also aimed to find out the relations between breast cancer development and its risk factors (including demographic characteristics, body mass index ratio, physical activity level, known breast cancer risk factors such as age at menarche, age at first live birth or nulliparous, family history of breast cancer and prior benign breast disease diagnosis). The Administration would consider what type of screening was to be adopted for women of different risk profiles having regard to the scientific evidence, the findings of the Study and the latest recommendations of the Expert Working Group on breast cancer screening.

13. Members noted at the meeting on 17 March 2020 that the Study had been completed in December 2019 and the Expert Working Group had reviewed its recommendations in relation to breast cancer screening for reporting to, and endorsement by, the Cancer Coordinating Committee sometime around May 2020.[7] Since it had to complete its work by 21 March 2020 in accordance with

[7] According to the Administration, the timing for the Cancer Coordinating Committee to meet for the purpose had been affected by the local outbreak of coronavirus disease 2019.

House Rule 26(c), the Subcommittee requested the Administration to report to the Panel on the proposed way forward for breast cancer screening within the current legislative session.[8] Members further urged the Administration to make public the full report, or at the very least the major observations and the conclusion, of the Study.

14. Members had followed up with the Administration on the effectiveness of the Colorectal Cancer Screening Programme after its first three years of implementation since September 2016. Members were advised that more than 154 000 participants had submitted Faecal Immunochemical Test ("FIT") specimen with analyzable results. About 12.6% of the participants had positive FIT results in the first round of screening. Among those FIT-positive participants who underwent colonoscopy examination services, about 11 900 persons (66.7%) had colorectal adenomas and around 1 170 persons (6.6 %) had colorectal cancer. Among the latter, the preliminary analysis of 755 cases revealed that about 60% of these cases belonged to earlier stages. Members considered that the above results reinforced the importance of undergoing timely screening tests to identify people at increased risk of disease for early treatment, as the removal of colorectal adenoma in the course of colonoscopy would prevent lesions from turning into cancer. It was also worthy to note that the percentages of colorectal cancer cases belonged to earlier stages (and hence, having more favorable prognoses) among patients who were diagnosed under the Programme vis-a-vis those who did not join the Programme were 60% and 44% respectively.

15. The current-term Government has pledged to set up District Health Centres ("DHC") in 18 districts progressively to enhance primary healthcare through district-based services, public-private partnership and medical-social collaboration. It is expected that DHCs will be set up in seven districts within the term of the current Government and interim DHC Express will be established in the remaining 11 districts where full-fledged DHCs would yet to be set up within the term of the current Government. The Subcommittee passed a motion urging the Government to, among others, incorporate cancer-related items, such as public education and simple medical check-up services, in the service scope of DHC and DHC Express with a view to enable members of the public to have an early detection of the disease.

16. Separately, human papillomavirus ("HPV") vaccination which has been shown to provide protection against HPV infections is an effective strategy

[8] The Administration has briefed the Panel on the key findings of the Study and the revised recommendations on breast cancer screening made by the Expert Working Group on 10 July 2020. According to the Administration, it will adopt a risk-based approach, instead of an aged-based or population-based approach, in determining the next step for breast cancer screening in Hong Kong. It has undertaken to announce further details of the way forward of breast cancer screening within 2020.

for reducing the incidence of cervical cancer. While pleased to note that the Hong Kong Childhood Immunization Programme had been expanded such that starting from the 2019-2020 school year, eligible female primary school students of suitable ages[9] would be provided with HPV vaccination to prevent cervical cancer, Ms Elizabeth QUAT called on the Administration to launch a one-off catch-up programme to enable all secondary and tertiary female students to receive the vaccination.

Cancer diagnostic services of HA

17. Early diagnosis is critical for cancer cases in improving the clinical outcomes and addressing patients' concerns. At present, most cancer patients are referred to the Specialist Outpatient Clinics ("SOPC") of HA via referral letter for further investigation of suspected cancers, after consultation with private or primary healthcare doctors. HA adopts a triage mechanism for new SOPC referrals, whereby patients are classified as urgent (Priority 1), semi-urgent (Priority 2) or stable (Routine) cases, to ensure that patients with urgent conditions will be accorded priority for diagnostic investigations.[10] Common diagnostic investigations for cancer diagnosis include imaging (such as Computed Tomography ("CT") Scans, Magnetic Resonance Imaging ("MRI"), X-rays and ultrasound), endoscopy procedures, biopsy and laboratory tests.

18. Noting that HA's 90th percentile waiting time for routine cases for mammogram, CT scan and MRI stood at 162, 115 and 116 weeks respectively in 2018-2019, members were concerned about whether the diagnostic service capacity of HA could meet with the escalating service demand arising from the increase in cancer cases. To ensure that patients would receive investigations in a timely manner and confirm the diagnosis at an earlier stage, members urged HA to install additional advanced imaging machines (such as 3D mammography machines) and explore collaboration with the private sector to enhance service capacity in diagnosis. HA advised that it had done so and had provided extended-hour service to improve its diagnostic service capacity. The numbers of CT and MRI machines in use in HA had reached 33 and 23 in 2019-2020 respectively. HA had also implemented the Project on Enhancing Radiological Investigation Services through Collaboration with the Private Sector since May 2012 to provide selected cancer patients fulfilling pre-defined clinical criteria with an option to receive CT and MRI examinations in the private sector. The

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[9] The first dose of HPV vaccine would be given via outreach by the School Immunisation Teams of the Department of Health to Primary Five female students at their schools, and a second dose would be given to the girls when they reach Primary Six in the following school year.

[10] The target waiting time for specialist assessment is two weeks and eight weeks respectively for Priority 1 and Priority 2 cases.

Project currently covered 11 cancer groups.[11] As at end December 2019, over 104 000 examinations had been completed under the Project. Results of investigations would generally be available within one week.

Cancer treatment services of HA

First treatment after diagnosis

19. HA currently provides a comprehensive range of cancer treatments including chemotherapy, radiotherapy, surgery, targeted therapy, hormonal therapy and immunotherapy, etc. to cancer patients in different settings (inpatient, outpatient and ambulatory care, and outreach home care). The Administration advised the Subcommittee that to meet the escalating service demand, HA had progressively increased operating theatre sessions and chemotherapy clinic, extended service hours for radiotherapy in various clusters and installed more advanced Linear Accelerator facilities to enhance its radiotherapy service capacity in recent years. Members expressed concern that despite the above efforts, statistics of HA revealed that during the period between July 2017 and June 2018, the waiting time at the 90th percentile[12] for patients with colorectal cancer, breast cancer and nasopharyngeal cancer[13] to receive their first treatment after diagnosis still stood long at 74 days, 65 days and 56 days respectively.[14] In addition, the first cancer treatment waiting times varied across and within clusters. They called on HA to address these problems squarely.

Drug treatment

20. On drug treatment, cancer drugs provided by HA are categorized into General Drugs, Special Drugs and self-financed drugs with or without safety net coverage by the Samaritan Fund or the Community Care Fund Medical Assistance Programme (First Phase Programme)[15] ("the two safety nets") under

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[11] The 11 cancer groups included breast cancer, cervix cancer, colorectal cancer, corpus uteri cancer, germ cell tumor, head and neck cancer, lymphoma, nasopharyngeal cancer, prostate cancer, sarcoma and stomach cancer.

[12] 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.

[13] 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.

[14] According to HA, it does not have relevant statistics on the waiting time for other types of cancer.

[15] The Community Care Fund Medical Assistance Programme (First Phase Programme) was launched in August 2011 to offer patients financial assistance to purchase specified self-financed cancer drugs which have not yet been brought into the Samaritan Fund safety net but have been rapidly accumulating medical scientific evidence and have relatively higher efficacy.

the Hospital Authority Drug Formulary ("the Drug Formulary"). As of February 2019, there were 109 drugs available in the Drug Formulary for treatment of various types of cancer. Under HA's established mechanism, experts of the Drug Advisory Committee would meet every three months to evaluate new applications for inclusion into the Drug Formulary under an evidence-based approach following the principles of safety, efficacy and cost-effectiveness of drugs. To provide more timely support to needy patients, HA has increased the frequency of the prioritization exercise for including self-financed drugs in the safety net from once to twice a year since 2018 so as to shorten the lead time for introducing suitable new drugs to the safety net. In addition, as endorsed by the Commission on Poverty in October 2019, the approval process for introducing new drugs and medical devices to the Community Care Fund Medical Assistance Programmes has been streamlined starting from 2020-2021.

21. With more and more new cancer drugs come on stream, members considered that HA should streamline the procedures for introducing new drugs into the Drug Formulary, set up a fast-track mechanism for evaluating new cancer drugs for inclusion into the Drug Formulary, increase the transparency of the drug inclusion mechanism, and further increase the frequency of reviewing drug proposals for inclusion into the safety net, say, from twice to four times a year. Separately, the Administration should provide financial support to cancer patients in purchasing medical consumables. Concern was also raised as to the reason for the unreasonably high cancer drug price in Hong Kong when compared with that in other places such as Taiwan. There was a suggestion that the Administration and HA should consider setting up a mechanism to join hands with the Guangdong-Hong Kong-Macao Greater Bay Area ("the Greater Bay Area") or the whole Mainland in procurement of cancer drugs with a view to lowering Hong Kong's cancer drug cost through bulk purchase and making the drugs more affordable to patients.

22. The Administration explained that when comparing the drug prices in different countries or regions for assessing the provision of sustainable and affordable treatment to patients, there was a need to take into account a number of factors, such as the local healthcare policy and drug subsidy mechanism, various treatment options, etc. HA would continue to collaborate with drug companies to formulate patient access programmes in providing affordable, sustainable and appropriate support for patients.[16] On the suggestion to collaborate with the Mainland in the procurement of drugs, it should be noted that the legal systems and healthcare policies as well as the import and export

[16] Under the patient access programmes, HA and different parties would contribute to the drug costs in specific proportions within a defined period, or the drug treatment costs to be borne would be capped, with a view to facilitating patients' early access to specific drug treatments.

mechanisms of medicines of Hong Kong and the Mainland were different. HA would stand ready to maintain communications with various stakeholders and learn from their experience, and carefully consider different factors when exploring the suggestion.

23. Members were concerned that cancer patients who were lack of means were unable to access expensive cancer drugs. While welcoming the introduction of enhancement measures for the means test mechanism of the two safety nets in early 2019 which had resulted in an increase in the number of approved applications and the amount of subsidy granted,[17] members were of the view that the mechanism should be further relaxed to alleviate the financial burden of patients (including cancer patients) and their families arising from drug expenditure. They also shared some deputations' view that tax deduction should be provided for cancer drug expenses. In response, the Administration advised that it had undertaken to revert to the Panel on the implementation of the enhancement measures for the means test mechanism of the two safety nets one year after implementation. As regards the tax deduction suggestion, it had to carefully consider the suggestion having regard to factors including fairness in allocation of resources, the read-across implication, etc.

Integrated Chinese-Western medicine services

24. Members noted that cancer palliative care was one of the four selective disease areas under the Integrated Chinese-Western Medicine Pilot Programme implemented by HA, which provided inpatient service and Chinese medicine outpatient follow-up service for participating patients. The cancer palliative care service had been tested out in Tuen Mun Hospital and Princess Margaret Hospital since September 2014 and December 2015 respectively. Up to 31 December 2019, the number of inpatient bed-days incurred under cancer palliative care was 6 229. According to the Administration, it was planned that cancer rehabilitation or palliative service would be one of the special disease programmes to be provided at the future Chinese Medicine Hospital. Some members considered that the Administration and HA should further strengthen the role of Chinese medicine as an aid to the western medicine treatment of cancer patients.

Manpower and medical equipment for cancer services

25. Having an adequate healthcare manpower supply is essential to ensure the quality and sustainability of the cancer services provided by HA. While

[17] The enhancement measures included modifying the calculation of annual disposable financial resources for drug subsidy application by counting only 50% of the patients' household net assets; and refining the definition of "household" adopted in financial assessment.

noting that HA adopted a multi-disciplinary team approach in the provision of cancer treatment and care services, members were particularly concerned about the manpower shortage of clinical oncologists in public hospitals. They noted that the attrition rate of full-time clinical oncologists in HA was 9.3% in 2018-2019 and the manpower strength of the clinical oncology specialty was 153 as at 31 March 2019, which included some 100 oncologists and 50 trainee doctors.

26. HA advised that it had implemented a series of recruitment strategies to strengthen its workforce and introduced different schemes, such as the enhanced Special Honorarium Scheme and re-employment of suitable retired or retiring staff upon their retirement or completion of contract at or beyond their normal retirement age, to further alleviate manpower issues. Given the medical manpower constraint of HA, Ms CHAN Hoi-yan was of the view that the Administration should set up an internet-based directory containing practice information of oncologists in the community to facilitate members of the public to choose oncologists of their choice. Ms Elizabeth QUAT suggested that HA should consider establishing partnership with hospitals of Tier 3 Class A in the Greater Bay Area to allow its cancer patients, if they so wished, to receive treatment in these hospitals.

27. Members noted that $5 billion had been earmarked in the 2019-2020 Budget for expediting the upgrading and acquisition of medical equipment of HA, including the introduction of advanced medical equipment and technology for cancer treatment. According to HA, it planned to further improve its service capacity in cancer diagnosis by installing additional imaging machines, introducing more advanced modalities or functionalities based on clinical needs, introducing Next Generation Sequencing to enhance diagnostic efficiency, and exploring the introduction of Smart Treatment Planning System to reduce the time for producing cancer treatment plans. Some members including Dr CHIANG Lai-wan suggested that apart from providing funding to HA to modernize its medical equipment, the Administration should consider subsidizing patients in need to receive Hong Kong's first proton therapy to be launched by a private hospital in due course.

<u>Support to cancer patients and cancer survivors</u>

28. HA has implemented the Cancer Case Manager programme for patients with breast or colorectal cancer since 2010-2011. Under the programme, cancer case managers and patients will first meet on the day that the doctor informs the patient about the diagnosis. The cancer case managers will act as the contact persons between patients and doctors as well as the care coordinators who navigate the patients along the patient journey and facilitate the coordination of the diagnostic process and treatment. As of December

2019, a total of around 20 300 breast cancer new cases and 23 900 colorectal cancer new cases benefited from the programme. Holding the view that the programme could improve care coordination for cancer patients throughout their cancer journey and help alleviate the pressure and anxiety of patients and their carers due to the complex treatment process, members welcomed HA's plan to explore extending the service to cover patients with gynaecological and haematological cancers. They urged HA to increase the manpower support for the programme to alleviate the heavy workload of the existing 21 cancer case managers and further extend the services to cover more cancer types.

29. With more and more patients living beyond cancer, members considered it necessary for the Administration and HA to enhance the support to cancer survivors to facilitate their adaption to the new life in the community. Members noted that HA would set up nursing coordinators to facilitate survivorship care, which included providing support to multi-disciplinary teams and Family Medicine Team, facilitating referrals, providing guidance, psychosocial support and education to patients, and reinforcing collaboration with non-governmental organizations and patient support groups. Members considered that HA could leverage the existing community resources and strengthen collaboration with primary care providers as well as cancer support or patient groups in this regard. The Subcommittee passed a motion urging the Government to, among others, integrate the primary healthcare services with a view to providing support for, and monitoring and following up with the conditions of, cancer survivors under a medical-social collaboration model.

Recommendations

30. The Subcommittee recommends that the Administration and/or HA should:

(a) improve the comprehensiveness of cancer surveillance data by, say, expanding the scope of the Cancer Registry's cancer information to cover also the risk factor(s) leading to higher incidence rate of a particular gender for certain types of cancers; and refine the website of the Cancer Registry to provide greater and more interactive access to the database;

(b) introduce (i) population-based, or at the very least, risk-based free or subsidized mammography screening (with the use of mobile mammography screening vehicles to facilitate the public's access to the services) for early detection of breast cancer; (ii) alpha-fetoprotein blood test and ultrasonography for patients with chronic hepatitis B virus infection or hepatitis C

virus infection; and (iii) population-based prostate-specific antigen blood test for early detection of breast, liver and prostate cancers, and enhance public education on limitations of screening tests;

(c) incorporate cancer-related items, such as public education and simple medical check-up services, in the service scope of DHC and DHC Express with a view to enable members of the public to have an early detection of the disease;

(d) launch a one-off catch-up programme to enable all secondary and tertiary female students to receive HPV vaccination;

(e) install additional advanced imaging machines (such as 3D mammography machines) and explore collaboration with the private sector to enhance HA's service capacity in diagnosis;

(f) address the problems of long waiting time for first treatment after cancer diagnosis and variations of the first treatment waiting time across and within clusters;

(g) streamline the procedures for introducing new drugs into the Drug Formulary; set up a fast-track mechanism for evaluating new cancer drugs for inclusion into the Drug Formulary; increase the transparency of the drug inclusion mechanism; further increase the frequency of reviewing drug proposals for inclusion into the safety net; and provide financial support to cancer patients in purchasing medical consumables;

(h) consider setting up a mechanism to join hands with the Greater Bay Area or the whole Mainland in procurement of cancer drugs with a view to lowering Hong Kong's cancer drug cost through bulk purchase;

(i) further relax the threshold for the means test mechanism of the two safety nets and consider providing tax deduction for cancer drug expenses;

(j) further strengthen the role of Chinese medicine as an aid to the western medicine treatment of cancer patients;

(k) in view of the medical manpower constraint of HA, set up an internet-based directory containing practice information of oncologists in the community to facilitate members of the public to choose oncologists of their choice and establish partnership with hospitals of Tier 3 Class A in the Greater Bay

Area to allow cancer patients under the care of HA to receive treatment in these hospitals if they so wished;

(l) consider subsidizing patients in need to receive proton therapy to be introduced in the private sector;

(m) recruit more cancer case managers and further extend the services to cover more cancer types under the Cancer Case Manager programme; and

(n) strengthen the collaboration with primary care providers as well as cancer support or patient groups to enhance support for cancer patients and cancer survivors under a medical-social collaboration model.

Advice sought

31. Members are invited to note the deliberations and recommendations of the Subcommittee.

Council Business Division 2
Legislative Council Secretariat
17 July 2020

Appendix I

Panel on Health Services

Subcommittee on Issues Relating to the Support for Cancer Patients

Terms of reference

To study and review the Government's policies on promoting the short, medium and long-term development and support for prevention and treatment of cancer as well as relevant issues, and make timely recommendations.

Appendix II

Panel on Health Services

Subcommittee on Issues Relating to the Support for Cancer Patients

Membership list*

Chairman	Dr Hon CHIANG Lai-wan, SBS, JP
Deputy Chairman	Hon Elizabeth QUAT, BBS, JP
Members	Hon Tommy CHEUNG Yu-yan, GBS, JP Prof Hon Joseph LEE Kok-long, SBS, JP Hon CHAN Han-pan, BBS, JP Dr Hon KWOK Ka-ki Dr Hon Fernando CHEUNG Chiu-hung Dr Hon Helena WONG Pik-wan Hon POON Siu-ping, BBS, MH Dr Hon Pierre CHAN Hon KWONG Chun-yu Hon CHAN Hoi-yan
	(Total : 12 members)
Clerk	Ms Maisie LAM
Legal Adviser	Ms Wendy KAN

* Changes in membership are shown in Annex.

Annex to Appendix II

Panel on Health Services

Subcommittee on Issues Relating to the Support for Cancer Patients

Changes in membership

Member	**Relevant date**
Hon WONG Ting-kwong, GBS, JP	Up to 19 November 2019
Hon CHAN Kin-por, GBS, JP	Up to 13 November 2019
Hon YIU Si-wing, BBS	Up to 13 November 2019
Hon Charles Peter MOK, JP	Up to 13 November 2019
Hon SHIU Ka-chun	Up to 5 June 2019

Appendix III

Panel on Health Services

Subcommittee on Issues Relating to the Support for Cancer Patients

A. Organizations and individuals which/who have made oral representation to the Subcommittee

1. Alliance for Patient's Right
2. Cancer Patient Alliance
3. Cancer Strategy Concern Group
4. Central and Western Concern Group
5. Happy-Retired Company Limited
6. Health In Action
7. Hong Kong Academy of Pharmacy
8. Hong Kong Ample Love Society
9. Hong Kong Breast Cancer Foundation
10. Hong Kong Take the Lead Institute
11. Karen Leung Foundation
12. Labour Party
13. Liberal Party
14. Life-Med Foundation Group Ltd
15. The Hong Kong Anti-Cancer Society
16. The Hong Kong Pharmaceutical Care Foundation Limited
17. Tseung Kwan O Neighbouring Social Welfare Association
18. WeCareBill Foundation
19. Mr Leslie CHAN Ka-long
20. Mr CHAN Yiu-fai
21. Mr CHEUNG Mei-hung
22. Mr Stanley HO Wai-hong
23. Ms LAM Sin-man
24. Miss Doris LEUNG
25. Dr LI Lai-fung
26. Ms TOU Lai-lin

B. Organizations and individual which/who have provided written submissions to the Subcommittee only

1. Blue Skies China
2. Cancerinformation.com.hk Charity Foundation
3. Civic Party
4. The Hong Kong Association of The Pharmaceutical Industry
5. 癌症資訊網慈善基金肺癌關顧組
6. Mr CHAN Weng-cheong