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香港中華醫學會有限公司

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HKCMA Membership Application



For Doctor



For Associate Member

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President's Message 會長的話



Dr. Jane CK Chan
President
HKCMA

Dear colleagues and friends,

It is with great excitement that I am introducing this second issue of the HKCMA newsletter, named as the HKCMA Bulletin, to you and the broad medical community. For those of us having worked on the articles in this issue, there were many hours lost in sleep, work, and play in order to fulfill our mission of giving an in-depth presentation of the views of HKCMA on the Government's initiatives in transforming our healthcare services in Hong Kong. The product you are now holding in your hands or reading online is hence the hard work and dedication of the HKCMA council; the energy shining through this issue of our Bulletin certainly shows how much we love Hong Kong and how much we would like to see Hong Kong's healthcare services heading in a healthy direction. A big round of applause to all our council members who have authored and advised!

The current issue of the Bulletin reflects the core values of being a medical doctor in Hong Kong, which are firstly that we think in the interests of Hong Kong people and our patients, current and future generations; secondly our great team work in this project; and thirdly fraternity among medics, feeling the pulse of different sectors and resonating where appropriate.

The HKCMA holds dearly the positive attitude to embrace the transformative changes required of a dynamic socio-economic-political ecosystem. Nonetheless, the HKCMA has looked beyond the Government's crystal ball and highlighted considerations that may shed light on how the Government and the medical profession can join hands in walking steadfastly into the sustainable future of healthcare services.

Happy Reading!

Editor's Words 主編的話



Dr. Kacey KC Hau
Editor
HKCMA Bulletin

侯鈞翔醫生
香港中華醫學會會訊主編

為香港醫療把脈

我們站在歷史的高點。面對大國崛起，政治勢力此消彼長地調整，同時大流行帶來對醫療的各種反思——在香港擁有眾多光環的醫療產業、背負前輩們開拓的重要基石，究竟醫療專業、市民診治疾病的服務保障、維持及提升整個社會的健康，何去何從？

因此，特首今年度的施政報告，成為未來發展的重要藍圖，指標位置非常重要。

香港與祖國血脈相連，兩地消費頻繁，醫療事業的關係日益密切；大灣區一步之遙，彼此配合發展的契機明顯。

怎樣才是最佳的融合模式？香港擁有兩間世界及亞洲區排名榜頭的醫學院，其中有領先全球如港大微生物學系，中大內分泌及糖尿、及肝臟科等等，作為特別行政區的城市規模，擁有眾多一流高端醫療人才，同一城市有兩間頂級學者密度最高而指點天下的醫學院，相信是區內罕有。

還有其他方面如中醫、器械發展等，在會長陳真光領導下，香港中華醫學會內閣因應特首的醫療政策分成九個專業小組，多月來馬不停蹄，經過反覆推敲討論，把這九個專案輯集成今次會訊專題。

我們一眾編委認為這是非常重要的討論文件，因此希望所有同仁能細閱，以此拋磚引玉，一石激起千層浪。

各位，這是一個重要的時刻。希望這個歷史性的契機，能帶領香港醫療事業邁向另一篇章。將來的醫療服務，也關乎你我他，我想大家能利用這個平台，多交流，多分享，齊齊為香港醫療把脈。

（本期刊封面文字來自行政長官李家超第三份《施政報告》主題。）



The HKCMA Response to the Policy Initiatives of the Health Bureau Presented at the Legislative Council Panel on Health Services 2024 Policy Address dated 18 October 2024

The Policy - Section 1. Advance Primary Health Care Development in Hong Kong

The Policy Address Says

The Government will redefine the roles of the various health care departments, including the Primary Healthcare Commission (PHCC), while empowering the PHCC to regulate and monitor primary healthcare providers and set service standards. Key initiatives include expanding District Health Centres (DHCs), introducing a community drug formulary for affordable medications, and improving outpatient services for the underprivileged. To tackle chronic diseases and cancer, the Government will launch enhanced screening programmes, public health efforts will focus on health promotion, revamped family planning and parenting services, tobacco control, and school-based health programs. Oral health will be supported with new dental schemes for adolescents, the underprivileged, and preschool children. End-of-life care will also be improved through legislation and enhanced services for terminally ill patients and their families.



Dr. Henry CF Yeung

HKCMA response to Section 1

Dr. Henry CF Yeung, HKCMA Vice President with advice from Dr. Daniel WS Chu, HKCMA Vice President, and from HKCMA council members Dr. Albert YF Kong, Dr. Mike YW Kwan, and Dr. James YM Wong

Hong Kong's primary healthcare system consistently ranks among the top globally and plays a pivotal role in providing world-class health care to her residents. With the Government's solid foundation for primary health care, we propose to build upon these successes.

A. Strengths of the Primary Healthcare System

A1. Accessibility

The Government's unwavering commitment to a comprehensive public health network enables residents to access competitive and affordable

primary care services. With public and private clinics strategically located across the territory, residents benefit from a myriad of convenient options in selecting healthcare services.

A2. Comprehensive services

The health care system in Hong Kong is universally praised for its wide-ranging services, spanning across preventive care, chronic disease management, maternal and child health, and mental health support. This holistic approach effectively addresses the varying health needs of the broad range of age groups and demographics.

A3. Integration with secondary and tertiary care

Hong Kong's health care system excels in integrating primary, secondary, and tertiary services. This seamless coordination ensures that patients receive continuous and coordinated care, with smooth referrals to specialists when needed.

A4. Public health initiatives

Successful vaccination programmes and health screening programmes with effective public engagement shows the proactive measures Hong Kong has taken to safeguard the health of residents.

B. Further recommendations

B1. Reducing waiting time

To address the challenge during peak hours in public clinics, the Government can employ innovative solutions to reduce waiting time.

B2. Augmenting resource allocation

The government can consider reallocating funding to provide more primary health care services and ensuring service quality in delivering exemplary care. This would also reduce economic burden from complicated, untreated and/or defaulted cases. Emphasis on primary care equates to accessibility to healthcare services.

B3. Enhancing service navigation

Efforts to simplify service navigation for patients can be considered so as to deliver smoother access to follow-up care, including patients who have defaulted follow-up for personal reasons. In this way, overall patient experience is enhanced.

B4. Addressing health inequities

The Government remains committed to bridging health disparities among socio-economic groups. Ongoing initiatives aimed at supporting vulnerable populations can ensure equitable access to quality care for all residents.

C. General Recommendations

C1. Increase funding and resources

To address overcrowding and improve service quality, the Government may consider increasing funding for primary health care. Most concretely, funding needs to be stepped up to support hiring locum and part-time healthcare providers to accommodate patient needs at times of temporary manpower shortage. Full time healthcare providers may be recruited in the longer term to minimise waiting time.

C2. Expand telehealth services

Telehealth services will alleviate the workload of public clinics. Via virtual consultations, patients will be able to access healthcare readily, which adds an extra dimension of convenience and comfort to our residents. Introduction of such services should be done in a stepwise and monitored fashion to ensure that telehealth is provided safely and effectively,

C3. Strengthen community health programmes

We recognise that the Hong Kong Government has established a solid foundation for community health. Building on this, we would like to propose target initiatives that focus on vulnerable, low-income and underprivileged populations.

C4. Improve health literacy

Improving health literacy within the community is crucial for navigating the healthcare system effectively. Educational campaigns can empower individuals to take charge of their own health, to understand available services, and to seek care when needed. We can leverage our existing resources, such as District Health Centres (DHCs), and social media platforms to disseminate health information and educate our residents.

C5. Foster collaboration among providers

Ongoing collaboration among primary care providers, specialists, and community organizations is encouraged to improve care coordination. Utilisation of shared electronic health records will facilitate communication and ensure that patients receive comprehensive holistic care.

D. Specific Key Recommendations to Strengthen Primary Health Care in Hong Kong

The primary healthcare system in Hong Kong faces various challenges and harbours opportunities for improvement. These challenges can be dealt with by the correct use of targeted strategies. In turn, stakeholders can improve service delivery, accessibility, and overall health outcomes. Below are our key recommendations to strengthen the primary health care system.

D1. Partnership with general practitioners

D1.1. Assembling general practitioners

Engaging private general practitioners (GPs) in the decision-making process is crucial for designing effective primary healthcare programs. GPs can contribute by offering their insights into how to meet community and patient needs. Establishing monthly consultations with GPs can enable constructive feedback, foster interdisciplinary collaboration and aid health policy development.

D1.2. Recruiting community doctors to join District Health Centres



Encouraging greater involvement of community GPs in DHCs will be effective in delivering quality health services. The integration of community GPs into these centers will enable the patients to receive more comprehensive care, including preventive services and chronic disease management, thus improving health outcomes in local populations.

D2. Drug issues

D2.1. Joint purchasing of drugs

Implementing a joint purchasing system for pharmaceuticals between public and private sectors can help secure fair pricing for patients. By collaborating with community pharmacies, the Government can negotiate better rates, ultimately reducing costs for both patients and public funding sources. This approach can enhance the sustainability of our healthcare system while ensuring access to essential medications.

D2.2. Extending community pharmacy services

Expanding community pharmacy services to include nearby doctors can facilitate easier access to medications for patients. This integration allows for better coordination of care, ensuring that patients can obtain prescriptions and medications conveniently, thereby improving adherence to treatment plans.

D3. Health Screening Programmes

D3.1. Developing protocol-based health screening programmes

Establishing internationally recognised, protocol-based screening programmes for breast cancer, lung cancer, and hepatitis B can standardise care and improve early detection rates. By implementing evidence-based guidelines, Hong Kong can enhance her preventive health strategies and reduce the burden of these diseases.

D3.2. Inclusion of prostate cancer screening

Adding prostate cancer screening to existing programmes is essential for comprehensive cancer prevention. By addressing this significant health issue, the healthcare system can promote early detection and treatment, improving survival rates in men.

D4. eHealth issues

D4.1. Increasing Government subsidy on

electronic healthcare voucher scheme

Increasing the Government subsidy for the Electronic Healthcare Voucher Scheme to HK\$2,500/\$3,000 per person per year, with HK\$500/\$1,000 allocated specifically for preventive medicine, can facilitate access to services. This increase will encourage individuals to seek preventive care, ultimately reducing the burden on the healthcare system.

D4.2. Strengthening eHealth initiatives

By promoting digital health solutions, such as telemedicine and electronic health records, the Government can improve the efficiency and accessibility of the healthcare system, as well as enabling better patient engagement.

D5. Streamlining health services

D5.1. Enhancing GOPC services

General Outpatient Clinics (GOPCs) should be enhanced to provide services for all residents. Establishing public-private partnerships can broaden the reach and capacity of primary healthcare services, ensuring that all demographic populations will benefit from quality care. This collaborative approach can alleviate pressure on public facilities while enhancing service availability.

D5.2. Ensuring quality dental services

The Government may invest in dental health initiatives, including preventive care and education, to improve oral health outcomes across the population.

D6. Local plan to reduce alcohol-related harm

A plan should be in place for public education, support services, and treatment options to mitigate the negative health impacts associated with excessive alcohol consumption. Collaborative efforts with community organizations can enhance outreach and effectiveness.

E. Conclusion

By implementing these recommendations, Hong Kong can build on her strong foundation and further strengthen her primary healthcare system. Engaging stakeholders, enhancing services, and promoting preventive care will ensure evidence-based, bespoke health services to our citizens.



The Policy - Section 2. Enhance Public and Private Healthcare Services

The Policy Address Says

The policy address outlines a comprehensive strategy to strengthen Hong Kong's healthcare system through structural reforms and targeted improvements. Key strategies include revising the fee structure for public healthcare, enhancing centralized procurement of drugs and medical devices, and advancing treatments for rare diseases through precision medicine and research. Plans also focus on expanding regional healthcare access with new hospital developments, reducing wait times for critical services like cataract surgeries, and integrating outpatient care to improve efficiency. Additionally, the government seeks to establish evidence-based standards for healthcare quality, enhance transparency in private healthcare pricing, and mandate the use of electronic health records to build a more equitable and efficient system.



Dr. Norman TY Chan

HKCMA response to Section 2

Dr. Norman TY Chan, HKCMA council member with advice from HKCMA Hon. Secretary Dr. Loletta KY So, and HKCMA council members Dr. Charas YT Ong, and Dr. James YM Wong

A. In Support of the Government's Initiatives to Strengthen Hospital Authority Services

It has been stated that since its establishment, the Hospital Authority (HA) has been committed to providing comprehensive, high-quality and people-oriented services to the people of Hong Kong. The HKCMA is supportive of all further measures the Government will take to strengthen the publicly funded healthcare services provided by the HA, including:

A1. Deepening the reform of the overall systematic and structural issues in the public hospital management system, with a view to enhance the overall quality and safety of the publicly funded healthcare system and maintaining public trust in HA services.

A2. Strengthening the financial sustainability of targeted subsidy of public healthcare services, to ensure resources are allocated to the appropriate group(s) of patients. We further emphasise that

public healthcare service should provide a safety net but not a premier service, such as a tiered charging system so that the well-off can pay more while those on CSSA receive free-of-charge services. The HA must continue to provide acute and emergency healthcare services as well as providing treatments for severe diseases and those requiring complex procedures and/or scientific research.

A3. Strengthening the centralized procurement of drugs and medical devices in various clusters of the public healthcare system, so as to enhance the bargaining power of purchasing drugs and medical devices. The Government also needs to realise the collective bargaining power of the Greater Bay area as well. The Government's plan to reduce by about half the lead time for introducing to the Drug Formulary new drugs with proven efficacy and cost-effectiveness is highly desirable.

A4. Formulating a registry for inherited and rare diseases using the genomic data collected by the Hong Kong Genome Institute, thereby facilitating early diagnosis and treatment by clinical teams. Relevant research and clinical trials to promote precision medicine must be encouraged but patients with abnormal genetic make-up and inherited disease should not be penalized.

A5. Fully integrating paediatric services of various clusters and developing more advanced healthcare services to enable the Hong Kong Children's Hospital to better fulfil its function as the Centre of Excellence in Paediatrics, thereby enhancing the quality of paediatric care in



Hong Kong and providing a platform conducive to research development and professional training. However, regional services should not be disrupted or downgraded; Hong Kong Children's Hospital should collaborate with other hospitals for research of rare diseases and earn its reputation as a tertiary centre.

A6. Setting up, in accordance with the national accreditation standards, the First Stroke Centre, at a public hospital with a view to enhancing quality of acute stroke services is a piece of belated good news.

A7. Preparing for the setting up of a second Chest Pain Centre at Prince of Wales Hospital within 2025 based on the experience of Hong Kong's first Chest Pain Centre at Queen Mary Hospital is most welcome. However, the service should not disrupt the day-to-day routine cardiology services.

A8. Enhancing the triage system and referral arrangements of specialist out-patient services (SOPD), including inter-specialty, integrated, outpatient clinics to avoid the need for multiple referrals so that (1) patients with acute needs could receive appropriate specialist services in a timely manner, (2) patients with mild and stable conditions may receive integrated care, and (3) patients do not have overlapping appointment for the same illness. They can have the necessary service under one roof. The SOPD should have guidelines/criteria to discharge patients.

A9. Increasing the service capacity for cataract surgery by at least 20% to shorten patients' waiting time is also good news to the elderly cataract patient who is waiting for the surgery.

B. In Disagreement with the Government's Initiatives

We hold reservations about finalizing the projects and timetable of the Second Hospital as the need for a public hospital in a high-tech business centre is minimum and the Government had better leave such decision to the private market, especially when the Government will run into insufficient funds in the near future. Furthermore, the incorporation of artificial intelligence such as in low-altitude transport in the to-be-built infrastructure may render a new hospital totally unnecessary. Despite our reservation, we fully

support the development plan to dovetail with the development of the Northern Metropolis and addressing local healthcare needs of various districts while increasing service capacity, enhancing service quality and upgrading hospital facilities in a timely manner.

C. In Support of the Government's Initiatives to Enhance the Quality and Efficiency of Healthcare Services, including:

C1. Establishing a professional platform for developing evidence-based clinical protocols and exploring the feasibility of devising service quality and efficiency standards for public and private healthcare sectors. We advise to enhance the current function of existing platform e.g. GOPC PPP instead of developing a new platform as most of the providers are familiar with the current platform. The platform must be equipped with user-friendly interface.

C2. We suggest establishing a clear definition of essential health data in personal eHealth accounts before compulsory input is in force. Moreover, many of the private practitioners are not fully digitalized. It may be difficult for all the healthcare providers to be connected to the system.

D. Not In Support

The pricing and charges within the private healthcare sector has become more and more transparent. It has been improving over the time. There is no urgent need for such legislation in the current state of affairs.

E. Conclusion

There appears to be a significant opportunity to improve collaboration between the private and public sectors. We propose exploring methods to streamline patient referrals and data sharing. The money should follow the patients. Additionally, we should consider incentivizing private providers to participate in public health initiatives. This could involve financial support or streamlined administrative processes. By fostering a more integrated healthcare system, we can improve access to care and optimize resource allocation.



政策 (3) — 匯聚醫療專業人才

政策摘要

本地公營醫療體系面對醫護人手長期不足，單憑現時本地不同院校的訓練容量實難滿足日益增加的醫療服務需求。有見及此，政府會推廣早前通過的新法律框架，積極引入非本地醫生、護士和牙醫來港執業以增加人手。同時，政府會在 2025 年年初提交修訂《輔助醫療業條例》的草案，引入合資格非本地培訓的輔助醫療專業人員，並完善規管措施以提升專業發展及維持高水平的醫療服務。



梁漢邦醫生

香港中華醫學會對政策 (3) 的回應

梁漢邦醫生

香港中華醫學 會榮譽司庫

A. 背景

醫護人手短缺推算



圖一．未來廿年香港醫護人手推算

根據 2023 年醫衛局報告指出，香港醫生短缺情況遠遠比其他先進經濟體嚴峻。每 1000 名人口 2.16 名醫生，遠低於星加坡及日本 2.5。如果根據西方發展經濟體美國 3.0 和澳洲 3.8 名對千人口，推算香港缺乏 12000 名醫生。

醫管局 2024 年新一份「醫療人手推算」，其中醫生會在 2030 年擴至 1,570 個空缺，之後逐年回落，但到 2045 年仍缺 940 人（圖一）。

牙醫短中期雖分別有 180 個短缺，但至 2040 年起人力差距逆轉，至 2045 年擴至溢出 180 人（圖一）。但牙齒衛生員人手會短中長則仍有 470 人短缺。

報告揭示護士短缺問題至 2045 年都得不到解決，報告預料其人力差距會進一步擴闊，2025 年空缺達 9,500 人，至 2045 年仍推算有 4,200 個空缺（圖一）。

B. 醫管局的醫生人手的未來估計

政府早於十年前已經開始人手規劃，並以假設相關人手培訓、服務需求不變及缺乏人口流動的人口結構改變，作為前設來估算未來 20 年人力資源情況。

如果以現在醫院管理局醫生人手短缺作基準，即 1440 醫生人手短缺數，此數目將於 2030 達到巔峰，達 1570 人，比現時人手短缺 130 名。隨後醫生人手將持續改善，並於 2045 年比現在人手編制多 500 位醫生。護士人手缺乏情況，更是每年會持續改善。

維持甚至提升現時香港公眾醫療水平，誠然是醫衛局以至整個醫療行業同仁的初心及奮戰目標。

以現行方案，引入海外醫生到香港，看似能夠即時應對中短期醫生短缺問題，但亦可能有以

下兩個隱患：

- 長期醫療融資負擔
- 未能針對性持續解決公營醫療體系醫生人手問題

C. 事實回顧

討論這個政策(3)前，需要先擷取一個更宏觀的鳥瞰角度。以下為不爭事實：

- 香港人均壽命全球最長。
- 香港醫生一半人手在公營體系服務，處理全港 90% 醫療工作。
- 香港市民從來未有因經濟原因而未能接受緊急以及非緊急的適切醫療服務。
- 香港政府用於醫療上的經費為 10% GDP，在發展中國家中算是最低。
- 過去及未來數年，本港人口有巨大流動。大量中年市民移居外地，同時有相近數目的青年移居香港。
- 現時推基層醫療、中西協作、慢病共治及預早篩查，能夠及早發現同時積極控制病情，一定會成功減少醫療工作壓力及負擔。
- 照現時醫管局編制，每聘請 1 名醫生，需要額外聘請 4.3 名護士，1.30 名專職醫療人員，以及 6 名支援員工。每聘請一名醫生，每年需要多 1178 萬。
- 香港兩間醫學院每年有 650 名畢業生，並於 5 年後加至 800 人，而外地來港醫生，包括經免試註冊、特別註冊及經過執業資格試完成註冊的醫生，每年 250 人，五年後每年會達 500 人。

D. 再增加人手的隱藏弊端

可以理解，香港公營醫療系統，是全球最高經濟效益，同時更是全球最頂尖水平。實際上，香港醫療系統應是全球政府爭相仿效的目標。妄自菲薄，盲目追求醫生對市民比例，實際上是一

個誤點。不單模糊發展目標，更會拖垮整個醫療系統。

古巴每 1000 人有 8.4 個醫生，瑞典有 7.0 個醫生、比利時有 6.3 個、英國是 3.2、美國是 3.6、日本有 2.4，中國有 1.9。可見醫生數量跟醫療水平並沒有直接關係。

純計本地兩間醫學院畢業生每年 650 人，增長為每 1000 人 0.085。七年後，就算第三間醫學院還未有畢業生，香港醫生對人口比率已經超越英國，大幅拋離美國。計及海外醫生，香港醫生達每千人 3.26 醫生。屆時醫療支出未計通脹會達 2600 億，比現時多 55%。到時候政府要思考恆常多出的 6% GDP 要由那個社會服務資源抽走。

簡單來說，如果只是增加公營醫生數目，但政府未能承諾相關龐大資源可以永久性撥予醫療項目，2002 年醫管局肥雞餐將會歷史重演。

E. 再增加人手的方案

說回頭，整個醫療人手改革的目的是維持甚至改善醫療水平，那麼，未來 20 年，在最差的時間，只是比現在少 130 位醫生。

E1. 要增加 130 位醫生的供應，可以考慮以下政策

E1.1. 加強退休後重聘機制

E1.2. 推動在私人市場工作的醫生以兼職形式提供公營服務

E1.3. 積極吸納於核准的外地醫學院港人畢業生回流

E1.4. 利用一人一病歷系統及社區藥房，把部份重複及低風險醫療服務下載到社區的私營醫生

E1.5. 強化大灣區醫療協作

E2. 對應方案包括

E2.1. 醫管局每年有 480 位醫生退休或離職，醫管局應該增加工作彈性安排，鼓勵離職及退休員

工重聘。

E2.2. 跟專科學院協商，私營市場醫生若回公立醫院工作，可獲持續進修時數，甚至是續牌要求。

E2.3. 選擇港人海外醫科畢業生的原因是他們能操流利本地語言，亦熟悉本地文化。可考慮如果在政府醫院工作超過十年可以享受部分學費回撥資助，相比以公帑培訓一名醫生，可能使用更少的資源。

E2.4. 提供經濟或行政誘因，鼓勵市民到大灣區接受醫療服務，例如白內障、人工關節、中風復康等等。

E2.5. 提供七年期免試執業有限度註冊，同時提供宿舍等優惠，以短期四年加三年合約招聘國內及海外醫療專才到港以緩解中短期人手不足的狀

況。期間六年給予國內十倍薪酬吸引到港。七年期內照顧他們生活需要，並鼓勵他們積極準備執業資格試。如在合約期內完成執業試，可以常規聘請。七年時間應該足夠他們瞭解是否適合在香港發展及準備執業試。如果屆時經濟不許可，又或者本地培訓醫生已經足夠，他們可以回原居地發展。

F. 結語

政府撰寫施政報告時，還建議引入境外牙醫。但是，現在牙醫診所門堪羅雀。政府必須借鑒牙科人手因應近年市民消費模式改變而瞬間大幅逆轉的情況。制定人手政策時，必需切實平衡人手過剩伴隨泥足深陷的恆常經濟負擔風險。





The Policy - Section 4. Support Establishment of a New Medical School

The Policy Address Says

The government plans to establish a third medical school alongside increasing training places in existing schools. A task group of local and international experts will guide the process, inviting university proposals by early 2025 and recommending a suitable institution by the end of the year. The new school will require substantial public funding, teaching resources, and facilities, including a teaching hospital, and its curriculum must meet the Medical Council's accreditation standards. To provide long-term support, land in the Northern Metropolis will be allocated for the school's campus as well as an integrated medical teaching and research hospital.



Dr. Jane CK Chan

HKCMA response to Section 4

Dr. Jane CK Chan

HKCMA President

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This paper explores relevant issues which will be pivotal in realising the two stated goals of a third medical school, firstly "to increase the number of doctors" and secondly "to support the development of HK into an international health and medical innovation hub". As well put in the policy paper, "the establishment of a third medical school involves substantial public funding and other medical teaching resources." Funding is a key limiting factor. This paper will only dwell upon the non-financial aspects of this proposal.

A. New Teaching and Research Hospital

The Government has an admirable plan of building a new integrated medical teaching and research hospital alongside a third medical school. Historically in Hong Kong (HK), the teaching hospital of a medical school is a general public hospital under the administrative and financial jurisdiction of the Hospital Authority (HA) staffed by both university and HA doctors. Clinical work remains top priority in a HA hospital, where teaching and research take second or third fiddle. The Government's commitment to

building a teaching and research hospital is firstly avantgarde and secondly overdue in HK, and such a hospital should preferably be under the administrative governance of the university, not the HA, so that teaching and research will take priority over clinical work.

B. Funding is not the only limiting factor for building a medical school.

B1. Where Can the New Medical Faculty be Sourced?

Even if funding is amply provided for a new medical school, manpower resources remain a very sensitive and difficult issue. One will need to take reference from the Chinese University of HK, whose very first batch of clinical teachers in the newly erected medical school was entirely built from overseas recruitment. Overseas recruitment offers the advantage of averting the need to "steal" faculty members from existing medical schools, thus averting possibly de-stabilising the existing medical school faculty mix. Overseas recruitment necessitates a highly competitive salary package and guaranteed research laboratory facilities, which may create logistical uncertainty.

An alternative source of recruitment from outside Hong Kong is to recruit from the Mainland. Although the overall command of medical English in the Mainland has improved steadily over the past decade, recruitment of Mainland medical academicians may still suffer from cross-cultural gaps which may compromise Hong Kong as an international city.

B2. Where Can Honorary Clinical Teachers be Sourced?

One must be cognizant of the fact that bedside teaching in existing medical schools heavily rely on a massive group of honorary clinical teachers, usually former senior clinical staff now in private practice. Their contribution to clinical teaching should be clearly calculated by the two medical schools so that one can appreciate how a new medical school can fully meet its clinical teaching load when honorary clinical teachers are hardly there given the young age of the school, unless the new medical school "steals" from the existing pool of honorary clinical teachers or identification of more honorary teachers, the latter potentially diluting the quality of bedside teaching.

C. Facts About Supply and Demand of Medical Doctors in Hong Kong

C1. On the supply side, the often quoted doctor number per capita of 2.16 per 1,000 persons for HK is lower than those of Australia (4, 2021 data), Singapore (2.6, 2021 data), the U.K. (3.2, 2022 data) and the U.S. (3.6, 2022 data). (<https://data.who.int/indicators/i/CCCEBB2>)

This per capita figure will predictably improve over the next decade as the Government has set in motion an increase in the supply of locally trained medical graduates and of nonlocally trained doctors. The manpower gap will narrow from 1570 (in year 2030), to 1400 (in year 2035), and to 1200 (in year 2040) (Leg Co. report in July 2023). The measures have included stepping up total number of medical student intake from 530 to 590 per cohort in the 2022/23 to 2024/25 triennia, and further to 650 in the near future. The recently created pathway of special registration has paved the way for non-locally trained doctors to join the HK workforce with lesser barrier.

C2. On the demand side, "manpower shortage of doctors persists in the short to long term owing to general demographic factors such as population growth and population ageing, coupled with growing medical burden associated with chronic diseases," as stated in a 2023 policy address at the LegCo.

C3. Alternative medical manpower not appearing in any formal supply-demand equation of medical doctors are the 10,000 Chinese medicine practitioners who have been serving the community often as the first point of care for the patients, which implies that we are more endowed than what appears on paper.

C4. Underutilised medical manpower in the private sector has been phrased as public-private imbalance. Currently, over 5000 private doctors are serving 15% of hospitalized patients while the 5000 public doctors are serving 85% of hospitalized patients in HK. Public doctors complain of overworking while private doctors are faced with lesser demand for private services since the COVID pandemic.

D. How to Transform HK into an International Health & Medical Innovation Hub?

To be an international hub, HK will need to be a leader in clinical research. The Government is tasking the new medical school with the mission to produce first-rate clinician scientists with academic excellence commanding international respect.

D1. Current HK medical school enrollment choices

HK has historically followed the "Commonwealth" model and enrolls secondary school graduates directly into a 5-6 year medical school, as compared to the North American model of 4 years of non-medical undergraduate study followed by 4 years of medical school. Despite this difference on paper, post-first degree enrollees, over the past 15 years, have made up about 10% or more of each entering medical class in HK. While the intake of post-first degree enrollees means the intake of more mature students who may be better trained in the sciences, there is no guarantee that such post-first degree medical enrollees would one day become fine researchers.

D2. The North America (NA) pathway to the making of a clinician scientist

The NA medical education model is to enroll MD students into a 4-year medical school after a first degree. As the medical degree (MD) is largely a professional degree, about 5% of each entering MD class would be selected into a government-funded MD/PhD training programme, which requires the student to undergo structured scientific research training. Candidates applying for the MD/PhD pathway are expected to demonstrate significant research experience in their undergraduate years as reflected by research output. This special pathway enables

the making of clinician scientists who can successfully advance research that spans basic, clinical and translational sciences.

The MD/PhD pathway consists of 2 years of pre-clinical course work, followed by 2-3 years of structured research training and full-time research work, culminating in the completion of a PhD thesis, followed by final two years of clinical attachments, totaling 6-7 years, and if we add up the pre-medical science-oriented undergraduate years, the required time to complete this pathway is 10-11 years post-secondary school.

D3. The Mainland pathway to the making of a clinician scientist

In HK, the basic medical school curriculum offers limited meaningful research training if any. HK medical graduates can choose to be a clinician or a clinician scientist, but they have often been discouraged from becoming a clinician scientist as a result of the 6-year specialty training, whose focus is the training of a clinician/specialist. The aspiring academic clinician scientist has to squeeze extra working hours for their research work and for their research grant proposal and research paper writing, etc. While their HA counterparts can progress steadily in rank and salary year after year, promotion for the academic clinician heavily relies on publication output. Most pragmatic medical graduates choose to stay with HA and shun the university posts.

A lesson can be learnt from the Mainland, where the medical trainees in major university hospitals, following medical school, internship and a year or two of specialty training, is given protected full time away from clinical work to develop their research skills and to work on a PhD thesis. The pendulum might have swung too far in the Mainland such that the quality of specialty training is under threat. The point remains that specialty training for the clinician scientist may take a pathway different from that of a non-academic clinician.

D4. How to apply the global experience to the HK scene

To groom fine clinician scientists in HK, the tasked university should

D4.1. Build a pre-medical programme for the

undergraduates with an interest in the sciences, especially biomedical sciences and bio-engineering; built-in liberal arts core curriculum ensures the broadening of the mind in these future medical leaders.

D.4.2. During the pre-medical undergraduates years, build basic knowledge and skills which facilitate the making of a clinician scientist: biostatistics, clinical trial design, epidemiology, pragmatic computer and AI skills, writing and presentation skills, etc.

D.4.3. Select 10-20 students from the pool of pre-medical undergraduates to go into a well-designed fully government-funded medical degree/PhD pathway, which will take 4 years of medical studies and 2-3 years of PhD work. Close supervision and mentorship by a selective cohort of clinician scientists and scientists throughout the 10-11 years post-secondary school is a must.

E. Proposed Vision and Mission of a Third Medical School

E1. To meet the medical manpower deficiency (but the proof of such need requires careful scrutiny).

E2. To offer a fully government-subsidised and carefully tailored pathway of a medical degree/PhD curriculum to train up clinician scientists. Structured research training and exposure to top-ranking research faculty at the pre-medical undergraduate level and during the medical degree/PhD programme will greatly facilitate the success of this pathway in producing top-tiered clinician scientists.

F. Conclusion

The Hong Kong Chinese Medical Association is in support of a third medical school as long as its vision and mission is clearly spelt out and training structure is carefully articulated. Top-rated clinician scientists in HK requires extensive prepping from undergraduate non-medical years through fully subsidised combined medical degree and PhD degree pathway. Protected time for research endeavors during post-medical school specialty training also needs further deliberation.

政策 (5) — 促進中醫及中藥發展

政策摘要

政府正與業界制定《中醫藥發展藍圖》，為中醫藥的長遠發展勾劃方向與策略，預計於 2025 年公布。主要措施包括：利用大數據推動中西藥相互作用的國際研究合作；加強中西醫協作服務，涵蓋更多病種如癌症治療；提升中醫藥在基層醫療的角色；推進首間中醫醫院及政府中藥檢測中心永久大樓的建設；舉辦「香港中醫藥文化節」推廣中醫藥文化；以及透過中醫藥發展基金支持國際性中醫藥活動在港舉行。



黃譚智媛教授

香港中華醫學會對政策 (5) 的回應

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香港中華醫學會榮譽顧問

政府會把握香港在醫療體制、規管制度、標準制訂、臨床研究及貿易等方面的優勢，發展香港成為中醫及中藥國際化的橋頭堡。政府現正與中醫藥界共同建構《中醫藥發展藍圖》，勾劃香港中醫藥長遠發展的願景、方向及策略，推動全方位及高質量發展。

中醫藥發展專員鍾志豪披露，《中醫藥發展藍圖》將涵蓋醫、教、研、產、管以及國際化等範疇，重中之重是完善中醫藥發展頂層設計，將中醫服務納入整體醫療框架，讓市民可以按照患病種類、病情發展不同時期的需要，獲得合適的中西醫服務，做到「應中則中、應西則西、應協作則協作」。可根據以下《中醫藥發展藍圖》涵蓋六個範疇方向立刻行動：1、醫療服務 2、人才培訓、3 創新科研 4、產業發展 5、標準制定及規管 6、推動香港經驗國際化。

中國工程院院士、中國中醫科學院名譽院長、天津中醫藥大學名譽校長張伯禮指出：人工智能與中醫藥結合是必然趨勢。近年來有不少與中醫藥行業深度融合的智能科技成果發佈，例如

海河一號、海河二號高通量的篩選系統，機器人篩選系統；中醫藥循證研究證據庫系統（EVDS）；「數智本草」大模型，它擁有 380 億個參數，能更好的完成中醫藥理論證據的挖掘和總結；「數智中藥」大模型，包含海量中醫藥數據，通過組方配伍、物質基礎、量時毒效、生產質控、臨床應用、消費認知等多方面數智化，達到用藥、生產、療效的新高度；「天河靈樞」大模型，構建了三維針灸數字人，加強了對中醫循證證據數據的挖掘和應用；新冠疫情期間，在經典名方、抗疫經驗、大數據及人工智能技術的支持下，篩選出 60 餘種可能對新冠有效的中成藥，並研製出「宣肺敗毒顆粒」及對新冠後遺症有治療作用的「清金益氣顆粒」，並用中藥解決抗菌、抗病毒耐藥性。

A. 創新科研

A1. 探索應用大數據，利用人工智能、海河一號、海河二號、數智本草、數智中藥、中藥多靶點網絡作用機制（大模型）和王喜軍教授（黑龍江中醫藥大學教授）的中藥組學驅動的中醫藥臨床療效闡釋，通過國家重點實驗室、臨床試驗中心對藥物進行二次開發。

A2. 以一人一病例，醫健通（eHRSS+）、HAGO、遙距醫療（Telemedicine）、真實世界數據（Real world data）、大數據以及中醫藥循證研究證據庫系統 EVDS 和大灣區國際臨床試驗所推動中西藥共享平臺國際研究合作。



A3. 利用醫管局大數據，由香港首間中醫醫院夥拍內地中醫醫院統籌在香港、內地及海外地區伙伴機構，就中西藥相互作用發掘更多具臨床意義的證據，推動中醫藥國際化；

B. 醫療服務

B1. 加強中西醫協作服務及探索涵蓋更多中醫優勢病種範圍，包括「癌症治療」、「呼吸科疾病」、「膝骨關節炎」、「中風」、「慢性疼痛」、「慢性阻塞性氣道疾病（COPD）」、「神經系統疾病」、「消化科疾病」、「代謝性疾病」、「免疫系統疾病」以及「婦科疾病」等。

B2. 使中西醫協作服務 2024 年增至 53 個服務站，能用中西結合診療方案，由專家共識致臨床科研一體化。

B3. 提升中西醫協作服務的服務水平，加強 18 區中醫醫教研中心的政府資助達 100%（2023 年逾 160 萬人次）

C. 基層醫療

發展中醫藥在基層醫療服務網絡的角色，繼續加強地區康健中心與中醫藥業界的協作；以「一人一中西醫配對」共同治理。

D. 人才培訓

D1. 持續推展首間中醫醫院及政府中藥檢測中心永久大樓的建設及籌備工作，以期於 2025 年內落成及分階段投入服務，香港中醫藥要強勢發展遙距醫療（Telemedicine）服務，在發展全世界病人看中醫方面起到樞紐作用。

D2. 發展專科培訓課程及資格考核，仿效西醫香港醫學專科學院（HK Academy of Medicine）及其屬下的專科學院（specialty college）。並到內地規培，提升臨床技能。

D3. 香港三所大學中醫學院撥款計算機制需同西醫學院看齊。

D4. 人才庫——中學西，西學中，中西共學，課程體系改革，特式規培基地。

E. 文化旅遊藥食同源

舉辦首屆「香港中醫藥文化節」，夥拍中醫藥界推廣中醫藥文化普及和公眾教育，發展香港涼茶文化、中藥園旅遊景點、中醫義診、「南北行」探索行、中藥製作工作坊、利用 AR、VR 展示中醫藥國家各地名勝相關地點和博物館、鼓勵旅遊業進行預防保健體驗和「藥食同源」大型活動，將中醫藥作為聯合國教科文組織非物質文化遺產。

F. 產業標準國際化

透過中醫藥發展基金資助及鼓勵更多國際性及區域性中醫藥大型會議、展覽及盛事在香港舉辦。

F1. 例如同現代化中醫藥國際協會（MCMIA）和香港貿易發展局（HKTDC）合作發展的國際現代化中醫藥及健康產品會議（ICMCM），要加強 B2B 的展覽，重拾廿三年前的風光，成為中藥貿易的樞紐，重點發展「一帶一路」推廣。

F2. 由梁振英副主席首創的守創中藥貿易平台也可以利用此中藥展覽，作國際化的窗口，發展期貨市場及質量標準（全供應鏈質量標準，包括中國藥典、ISO 標準、香港標準以及各國特定要求，形成國際貿易平臺）。

F3. 世界衛生組織 11 月 5 日在香港召開為期三日的會議，討論及制訂了國際草藥藥典的路線圖、大綱草案、範圍和框架。香港衛生署中醫藥規管辦公室自 2012 年已經是世衛傳統醫藥合作中心，我們定必領導制定草藥的安全和品質標準提供技術支援。



The Policy - Section 6. Promote Mental Health

The Policy Address Says

The government will enhance mental health services through an integrated medical-education-social collaboration model and develop a stepped care framework with the Mental Health Advisory Committee. This model will clearly define the roles of professionals from teachers to healthcare workers to enable coordinated care across different levels of need. To raise awareness, the Government will also introduce annual themes for the Mental Health Workplace Charter, recognizing organizations that meet mental health promotion targets. Additional mental health initiatives will also be implemented by various government departments.



Dr. Daniel WS Chu

HKCMA response to Section 6

Dr. Daniel WS Chu
HKCMA Vice-President

A. Introduction

In recent years, there have been more reported cases of our younger generations suffering from various kinds of emotional stress leading to various degrees of mental disturbance, sadly even taking the route of ending their own lives. The HKCMA supports the Government's initiative to "promote mental health", reflecting such a need in the Hong Kong community. However, such promotion should not be an end in itself; it should lead to efforts in achieving the ultimate goal of building a more positive and healthy population with stronger resilience towards adversity and competition, both of which will be more fierce in the coming years.

B. How to Promote Mental Health

The HKCMA supports the government's suggestion that in making a meaningful promotion on mental health, an integrated model is crucial as the development of a human mind is influenced by the environment he/she is placed into. However, one should be aware of all research evidence demonstrating that childhood development is the most important fundamental period during which one's mental capacity is constructed. (<https://www.unicef.org/early-childhood-development>) Hence, the family, the fundamental supportive environment for childhood development, plays the most important role of being the foundation for the child's mental construction, and cannot be ignored.

C. Concrete Enhancement of Relevant Services: Our Proposal

C1. The integrated services should not only be based on a medical-education-social collaboration, but also be expanded to a family-medical-education-social collaboration.

C2. The step care model for mental health aims at role delineation for various team members who have come together to handle cases with emotional problems but this step care model is a passive/reactive model which awaits the "problem" to emerge. The mental health "crisis" we are facing is usually only the tip of the iceberg and more proactive measures to actively seek out early mild cases are needed so that early prevention and intervention will be more economical and effective.

C3. Broad application of the screening and stratification tools such as PHQ-9 and GAD-7 on regular basis in schools, community centres, clinics, and District Health Centres. Such measure is taking reference from the Integrated Mental Health Programme implemented in the General Out-patient Clinics since 2019.

C4. Inclusion of the family doctors in the collaboration network is pivotal as the family doctors in the community are the professionals in the community who know the family unit and who possess adequate mental health handling skills in tackling common mental health problems.

D. Conclusion

Hong Kong is in urgent need to establish a stronger and healthy mental health environment. An integrated model involving all levels of community including family is an important approach to achieve this goal. The programme needs to take a proactive approach rather than just awaiting a case to happen. Active screening using PHQ-9 and GAD-7 at the primary doctor's clinic and at community centres on a continuous manner needs to be considered.

政策 (7) — 改革藥械審批制度

政策摘要

政府推動改革藥械審批制度，措施包括：擴展「1+」機制至所有新藥，加快註冊流程，讓治療嚴重或罕見疾病的新藥更快上市；成立「香港藥械監管中心」籌備辦公室，預計於2025年提出成立時間表及「第一層審批」路線圖，促進藥械研發和測試產業發展；以及推進醫療器械規管立法，確保安全、品質及性能，配合監管中心的成立。



郭子熹醫生

香港中華醫學會對政策 (7) 的回應

「1+」新藥審批機制：機遇與挑戰 — 一個臨床腫瘤專科醫生的視角

郭子熹醫生

香港中華醫學會理事

A. 「1+」機制的由來

A1. 過往，香港採用「第二層審查」方式來審批新藥註冊申請

一直以來，香港採用「第二層審查」方式來審批新藥註冊申請。根據這一制度，藥物必須在指定三十二個國家和地區中，至少獲得兩個地方頒發的《藥品註冊證明書》（Certificate for Pharmaceutical Products, CPP）才能在本港註冊。此名單（註1）包括美國、德國、法國和日本等先進製藥國家，而中國不在名單之內。近年，隨着綜合國力的提升，中國在醫療衛生和科研能力等各方面有很大的進步，與西方國家的差距明顯縮小，甚至在某些方面取得突破。在癌症藥物的研發方面亦取得令人觸目的成績。另一方面，目前香港大多數採用的藥物均來自歐美，亦有部分日本藥物。臨床研究對象以歐美的白人為主，研究所得的結果可否套用在華人身上呢？綜

合各種因素，相關人士認為舊有的藥物註冊制度非常不合理，故此提出「國藥港用」，後來再改為「好藥港用」，不單是中國藥物，任何優質藥物都值得引入香港。在各方努力爭取後，香港藥劑業及毒藥管理局通過新藥審批機制，由2022年11月1日起，《藥品註冊證明書》的要求由最初的三十二個國家，額外增加中國、巴西、南韓及新加坡這四個國家。此舉確認了中國在藥物研製和質素控制方面的能力。但是，新增的四個國家必須與第一組三十二個國家中的至少一個國家捆綁，即進口藥物最少須獲得三十二個國家中其中一個國家的認證，以及新增四個國家的其中一個國家認證。

A2. 特區政府於二〇二三年十一月一日實施全新的「1+」新藥審批機制

特首在《行政長官2023年施政報告》首次公布，政府會發揮香港特別行政區的醫療優勢，長遠目標是建立「第一層審批」的藥物及醫療器械（藥械）註冊機構，即可不參考其他藥物監管機構註冊許可，而直接根據臨床數據在本港審批藥物，同時也開啓審批醫療器械的註冊申請，藉此加快新藥械臨床應用以提升醫療水平，並帶動建設藥械研發和臨床測試的產業發展，發展香港成為國際醫療創新樞紐。

《施政報告》提出設立全新「1+」機制，容許治療嚴重或罕見疾病的新藥，在符合本地臨床數據要求並經相關專家認可後，只須提交一個（而非原來的兩個）參考藥物監管機構許可（例

如國家藥品監督管理局），便可以在香港有條件註冊使用，以促進本港臨床試驗發展及新藥使用。（註2）

終於在二〇二三年十一月一日，特區政府邁出新的一步，實施全新的「1+」新藥審批機制（「1+」機制），亦即所有國家不再分為兩組，只要藥物有三十六個國家當中任何一個國家的《藥品註冊證明書》，若能提供符合要求的本地臨床數據，以及經本地專家認可，便可申請註冊該藥在香港使用。

在今年的《施政報告》，特首公布為加快病人獲得先進診療，推動生物醫藥技術新質生產力，政府會以制度創新配合科技創新，發展香港成為國際醫療創新樞紐。政府會加快改革藥械審批制度，包括：擴展「1+」審批機制至所有新藥，包括疫苗及先進療法製品，完善評審制度以加快註冊，體現「好藥港用」；落實「香港藥械監管中心」成立時間表和邁向「第一層審批」路線圖，制訂藥械研發支援策略和措施；及推進規管醫療器械立法準備工作。（註3）

自「1+」機制生效以來，到目前為止，共有七款新藥按此機制獲批准註冊。包括兩款治療轉移性結直腸癌症、一款用於治療陣發性睡眠性血紅蛋白尿症，兩款用作治療副甲狀腺癌患者和某類原發性副甲狀腺功能亢進症患者的高血鈣症的新藥，以及兩款不同劑量用於治療慢性腎病引起的貧血的口服藥。值得一提的是，兩款治療轉移性大腸癌的新藥已納入醫院管理局（醫管局）藥物名冊的專用藥物類別。醫管局也成功進行採購議價，不單令藥物成本價下降近三成，在特定的臨床應用下獲處方這兩款藥物，病人只須支付標準費用15元，令財政負擔大為減輕，預計每年近300名癌症病人受惠。（註4）

B. 「1+」機制的機遇與挑戰

B1. 「1+」機制加快新藥註冊，引入新藥於公營服務仍面臨不少挑戰

癌症是本港的頭號疾病殺手，每年有逾3.5萬宗新症，導致1.5萬人死亡。（註5）對於癌症病人，尤其是已屆晚期的患者，能找到合適的治療藥物可能是他們最後的生機，新藥絕對是他們的治療曙光。每年都有很多創新藥物面世，但礙於註冊需時，致使不少病人「有藥無得用」，而即使新藥已然註冊，也因為未納入公立醫院藥物名冊及安全網，有需要的病人最終亦受限於高昂藥價而「有藥無得醫」。

一直以來，如要讓病人使用未註冊藥物（unregistered drug），便要透過「指定病人藥物使用計劃」（named patient programme），由醫生為病人提出申請，先獲得臨床部門主管的認可，再向聯網或醫院藥事委員會（The Hospital Drugs & Therapeutics Committee [DTC]）提出申請，再向衛生處申請藥品入口許可證（drug import licence），期間要填寫indent form，獲批准後才能開始採購藥物，申請手續相當繁複及費時。每一次的申請，藥物只能予指定病人。假若病人不再適合該藥或在治療期間去世，醫生也不能將剩餘藥物予其他適合的病人使用。代表病人必須單獨購買藥物，承擔高昂價格。根據醫管局現行的制度，即使藥物已獲正式註冊，但只要未納入藥物名冊，醫生仍需要向醫院的藥物委員會透過「指定病人」計劃申請才能為病人處方。

「1+」制度能幫助加快藥物註冊，但註冊只是「第一步」，新藥成功註冊後，仍有待納入醫院管理局的藥物名冊（HA Drug Formulary）方可為病人處方。傳統引入新藥於公營服務的機制是，藥物經註冊後，醫生於聯網提出申請採用該藥物，再交予醫管局總部經藥物諮詢委員會（Drug Advisory Committee）審批；決定該藥為「自費藥物」（Self-financed item）或成為「專用藥物」（Special drug）。如果此藥成為「自費藥物」，便要再用另一機制進入「安全網」（Safety net），合資格病人才可透過申請撒瑪利亞基金或關愛基金獲得資助購買藥物。即使新藥被納入藥物名冊，如該藥為「自費藥物」，公院病人初期

仍需要自費購買，待藥物進入安全網，病人才能在通過資產審查後獲得資助用藥，而直至有關藥物被列為專用藥物才能人人可用。因此，新藥要經歷註冊、納入藥物名冊、進入安全網，以及列為專用藥物等程序，而每一步均涉及資源的考慮，過程有快有慢，以往慢的可能要幾年才能進入安全網，近年速度有所加快，大部分具顯著成效及價錢合理的新藥都可於一、兩年進入安全網，但要成為專用藥物則通常需要數以年計的等候，甚至可能要藥物專利期過後、有副廠平藥供應，方能成為專用藥物。

B2. 癌症藥物十分昂貴，跨境求醫成為出路

近年，有賴醫藥科技不斷進步，用於治療癌症的藥物愈來愈多，效用亦愈來愈理想。但新藥往往價錢高昂，每月藥費動輒數萬元，普羅大眾難以負擔。現時內地部分進口藥物及科研新藥的售價只是香港的一成至三四成，部分藥物差價可達三至十倍。因此癌症患者選擇跨境到內地購買藥物，以減省財政壓力。但跨境買藥終究不是一個好辦法。病人每次都要拖著病體長途跋涉，不只花去休息時間，更要承受舟車勞頓。跨境就醫是病人的無奈，也令醫者痛心。兩地醫生跟進病人用藥劑量是否合適及處理副作用帶來困難。額外的病人亦加重當地醫療系統的承受能力。

B3. 治療癌症的財務可持續性對患者，家庭和社會都是一個重要挑戰

現時不少轉移性癌症的治療不再是短期性。它確實延長了患者的優質生活年限。晚期癌症變成慢性病，藥物治療對付款人的可負擔性有着極大的影響。以現在的市場價格，哪一個中產階級能輕而易舉負擔得起這樣的治療？這是患者，家庭和社會要面對的一個重要的財務挑戰。

C. 「1+」機制為癌症治療帶來機遇，我們應如何面對挑戰

「1+」機制實行後，新藥註冊只需提供一個國家的註冊證明，不再需要提供兩個國家，因此癌症新藥引入香港的時間有望縮短。但是註冊

只是第一步，後續的入藥機制仍需改善，否則公院病人要用已註冊的新藥仍是難事。香港醫療處於世界一流水平，但仍有病人特別是重症患者，無法及時獲得適切藥物，導致病情惡化。要真正「好藥港用」，必須體現新藥的可及性、可負擔性和可持續性。

C1. 繼續強化藥物審批功能，入藥機制有待加快

根據資料，新藥在香港由成功註冊到獲政府資助平均需時大約 23 個月，比德國、日本、英國及荷蘭等地只需 1.2 個月至 9.8 個月長得多。

最近衛生局盧寵茂局長在一個亞洲全球健康高峰會議上披露，今年內醫管局會加快將在「1+」新機制下註冊的新藥納入藥物名冊，旨在將新藥列入醫管局藥物名冊的處理時間縮短一半，至約五個月。這種精簡方法集中評審程序，並允許直接向醫管局藥物諮詢委員會提交資料。

對於各方加快入藥的訴求，在一個主題為「引入新藥的架構和機制」的「香港癌症策略論壇 2024」上，醫院管理局總藥劑師崔俊明稱，該局正優化入藥審批機制，計劃在年底前設立「藥物建議委員會」，一站式及中央處理所有入藥審批申請，同時亦會與藥廠「講價」，並邀請專家進行成本效益分析。他直言，只要「藥價夠合理」、「價錢能夠達到成本效益」，便可以直接進入安全網甚至納入為專用藥物，藉以讓「病人盡早有適切及長遠負擔得起的治療」。他稱，新機制的目標是把入藥審批時間由 10 個月縮減至 5 個月，而納入安全網的時間則由 18 個月減至 9 個月，整個審批時間將與澳洲睇齊。他又稱，過往入藥申請是由各間醫院提交，日後則容許藥廠、病人組織及醫生向委員會提出建議。

至於藥物註冊方面，與會的衛生署助理署長陳凌峯表示，衛生署是「好藥」的第一個把關人，著重藥物的安全及質素，所以必須嚴守把關，而署方亦從多方面改善及強化機制，例如在篩選申請時已啟動立法程序，令藥物獲批註冊後可即時應市。他強調，過去三年該署每年平均處理約

60 隻新藥註冊申請，所有申請均可於五個月完成審批。他又稱，以往由於資源有限，為免重審而採用第二層審批機制，為向第一層審批的發展邁進，未來該署會繼續強化審批功能，包括加入國際機構以標準化審批功能，以及會因應香港藥物及醫療器械監督管理中心成立，整合資源及理順相關規管和人力安排。

C2. 如何符合「1+」機制申請註冊時所需的「本地數據」定義？

要符合「1+」機制「+」的定義，要提供所要求的「本地數據」。首先若以臨床應用獲得本地數據，需時至少一年或更長時間才能完成，而「1+」機制初衷是加快引入藥物到港。如要同時搜集本地數據而不進行臨床研究計劃，港府需要幫助前線醫生簡化處方藥物程序之餘，也要讓藥廠更容易收集本地數據，才可發揮「1+」最大功效。若進行一個臨床研究項目，需時就更長。要符合「本地數據」，若果原始資料不是在中國人產生的，這樣的要求是絕對合理。海外監管機構也是要求從患者群體中產生可適用於當地人口的臨床數據。針對罕見病，本地個案非常有限，實難提供具說服力的數據。在這種情況下，是否可以採用華人數據例如內地數據作參考，接受中國患者臨床數據作為當地人群數據已經足夠？如不彈性處理這個問題，將無法達到「1+」機制初衷，即加快引入新藥。如果不考慮這種靈活性，許多創新療法將無法儘早註冊和無法加快將更多安全有效的治療方案引入藥物名冊內使用。那就白費了引進「1+」藥品註冊這新機制，亦會限制「1+」機制對市場產生價格競爭的潛力。

C3. 我們也可以建立適合本地的臨床指引

目前香港大多數採用歐美研發的藥物，亦有部分來自日本。不少藥物的臨床研究的對象以歐美的白人為主。近年不少外國的藥物研究在亞太地區有展開另一相似的臨床研究，旨在獲取相應的療效數據和副作用概況。而新藥註冊更強調本

地數據。有同業和患者家屬擔心，假如新藥只是憑在國內的研發數據審批，藥物尚未得到如美國食品藥物管理局，歐洲藥品管理局這些重要的藥物監管機構認可，是否會令本地醫生難以跟隨，因藥物的應用並未得到美國臨床腫瘤學會，歐洲腫瘤醫學會等權威指引的推薦。這方面我們相信本地的癌症專家有足夠的專業知識。我們一方面參考國際指引，與國際接軌，另一方面又善於利用國內同行的專業意見，互相借鑒，共同做好解說、監管，以確保藥物的質素服務水平。同時我們亦提供本地真實世界的數據，促進新藥在國外審批上市。香港有世界級的本地專家，憑藉我們的專業知識，為什麼我們不能透過進行本地臨床試驗、獲取本地數據，然後制定適合本地的臨床指引？

現時國內研發的新藥在中國境內以華人為主的臨床測試，由於患者數目眾多，不少研究在很短時間已經能收集足夠的數據，很快已經有研究結果，加上副作用的概況可直接作為參考，這一方面令中國研發的藥物具有一定的優勢。內地科研發展潛力十分強大，預計不久將來有很多新藥出爐，病人不僅有更多選擇，同類型藥物增多更能帶出競爭，從而令市場發揮出調控藥價的功能。然而部分市民對內地藥物質量有疑惑是事實，政府必須以正面態度破除市民的迷思，在確保藥物的療效、安全性和質量外，令政府在公營醫療藥物的開支上更具成本效益，更好利用國家在醫療產業發展中帶來的成果，以擴大醫藥供應領域，有效控制本地醫療成本，增加醫療服務競爭力。

執筆之時，河套深港科技創新合作區香港園區的「粵港澳大灣區國際臨床試驗所」正式開幕。（註 6）試驗所將統籌醫院管理局、私營醫療機構和大學等香港公私營界別的臨床試驗資源，為醫藥研發機構提供一站式臨床試驗支援平台。多項具體項目將分階段推出，包括建設香港臨床試驗數碼化平台、成立臨床試驗學院、與衛生署



和醫管局合作推出措施，將藥物審批及應用時間縮短至具國際競爭力水平。它會與同日開幕的深圳園區的「粵港澳大灣區國際臨床試驗中心」共同建立「大灣區臨床試驗協作平台」，拓展研發網絡，加快臨床試驗。協作平台將以大灣區逾 8,600 萬人口為基礎，為海內外醫藥研發機構提供支援，協調開展多中心跨境臨床試驗，務求有關臨床試驗可同時符合國家和國際標準。此舉一定能促進本地藥物研發，並與中國、國際更好的聯通合作和發展，獲得更快更直接的臨床數據，更好支援本地臨床應用。

C4. 要解決藥物高成本的問題需要各方共同努力

過去 20 年，藥物研發的重點主要集中於抗腫瘤藥物和罕見疾病的治療，這些以往未能有效解決的健康問題，經過多方面的合作研發，已獲得顯著突破，許多有效的藥物得以進入市場，從而惠及患者。不過，香港及全球仍面臨藥物成本高昂的問題。現有藥物名冊制度難以追上新藥發展。現行的藥物採購投標機制不能體現「好藥港用」的目標。採購不單只用投標形式滿足程序公義，議價不止基於用量，還需要以真實世界用藥數據來評估療效及應用效果，爭取具競爭性的價格。除了價格透明之外，我們還需要營造競爭氛圍，防止壟斷。引進東西方國家研發的創新好藥，始能防止壟斷，既有成效又合乎成本效益，

引文出處：

註 1: 32 個參考國家包括澳洲、奧地利、比利時、保加利亞、加拿大、塞浦路斯、捷克、丹麥、愛沙尼亞、芬蘭、法國、德國、希臘、荷蘭、匈牙利、愛爾蘭、意大利、日本、拉脫維亞、立陶宛、盧森堡、馬爾他、波蘭、葡萄牙、羅馬尼亞、斯洛伐克共和國、斯洛文尼亞、西班牙、瑞典、瑞士、英國及美國。巴西、中國、南韓及新加坡於 2022 年 11 年新增成為參考國家。

註 2: 《行政長官 2023 年施政報告》

註 3: 《行政長官 2024 年施政報告》

註 4: 2024 年 11 月 12 日香港特別行政區政府新聞公報

註 5: 香港癌症資料統計中心

註 6: 大灣區國際臨床試驗所開幕。2024 年 11 月 21 日。政府新聞網

部份內容參考和節錄自醫理說醫患倡導與公共事務總監及肺癌病人關注組召集人吳樂文先生，前醫管局癌症服務中央委員會主席，臨床腫瘤科專科鄭志堅醫生，前香港藥學會會長，「好藥港用」關注組召集人，資深藥劑師鄭耀深先生在醫理說 (Healthcare Thinkers) 發表的文章。

也有效減少因藥品短缺而造成的干擾。總之，要解決藥物高成本的問題需要政府、醫療機構、保險公司及社會組織各方共同努力，積極參與，為患者提供更加可負擔的醫療服務。要打破常規思考問題的框框，對現行藥品審批、納入藥物名冊、補貼機制等等進行系統性的改革，以解決如何確保現行公共醫療服務系統的可及性、可負擔性和可持續性問題。

最後，除了入藥程序受資源限制之外，病人能否適切有效地得到所需治療，也與醫生、護士和藥劑師等的人手和相關配套密切相關。現時公院醫護人手嚴重不足，必須以宏觀角度，從多方面入手解決。例如擴大公私營協作以減輕公院負擔，令公私醫療比重更趨均衡等等，令醫療系統更加穩健及可持續發展，病人得到更好的服務。

D. 結語

特首在施政報告中勾畫了發展香港成為國際醫療創新樞紐的藍圖，這是一個令本港的學術、醫療和藥業界振奮的願景。香港有享譽國際的專家、有達到國際級水準的醫護，本身有著優越的地理環境，背靠祖國、聯通世界。我們要有當家作主的思維，注重人才培訓，加快力度，提升本地醫藥科技創新的能力，推動新藥的研發和臨床研究，最終造福病人和社群。



The Policy - Section 8. Strengthen Biomedical Technology R&D and Translation

The Policy Address Says

With the establishment of the Greater Bay Area International Clinical Trial Centre, the government aims to strengthen clinical trial capabilities and accelerate the translation of innovative biomedical research into clinical applications. Key strategies include collaboration with the GBA to attract more clinical trials, leveraging real-world data from innovative drugs and medical devices to expedite new drug approvals in Hong Kong, the Mainland, and internationally, and enhancing support for R&D through improved inter-departmental collaboration within the GBA. These efforts aim to position Hong Kong as a hub for global innovation, attracting leading enterprises and research organizations to establish operations in the city.



Dr. Adrian YY Cheong

HKCMA response to Section 8

Dr. Adrian YY Cheong
HKCMA council member

A. Preamble

Hong Kong's role as an interlocutor between the vast market of mainland China and the rest of the world is ever more relevant. Healthcare technologies are a key component of the "new quality development forces" stipulated in the conclusions of the 2024 NPC and CPPCC two sessions meetings. Hong Kong's position as a key healthcare technology hub will depend on the correct government policy support and targeted communication with potential clients both from the mainland going out and from the rest of the world coming in to greater China.

B. Reforming the Approval Mechanism for Drugs and Medical Devices

Hong Kong's current approval mechanism is an excellent balance between meeting the needs of the population with safe and effective medical devices and pharmaceuticals and at the same time allowing innovation to thrive. For example, currently medical devices can be brought into HK's medical market for use after passing each individual institution's internal regulatory process. This creates a niche for companies to use HK as a testing ground for real-world use case scenarios

and use protocols, both in the university teaching hospital scenario and the private market. Attracting cutting-edge medical devices companies to HK has several potential benefits to the local community:

- Some of these companies will get a feel of HK, and by extension the GBA, as business-friendly places to base themselves for their regional and greater China operations.
- Local citizens will benefit from the use of the latest medical technologies.
- The availability of cutting-edge medical devices in HK will enhance its reputation as a medical tourism destination.
- HK is in dire need of fostering an ecosystem of entrepreneurs, scientists, professional service providers and financial professionals who are in-tune with the needs of medical technology companies. There is no doubt that we are currently behind many countries and territories in this respect, and attracting foreign talent in the medical technology field should be made a priority.

Creating an independent regulator of medical devices in HK will serve little to help the above objectives, while in fact this may cause damage to the nascent ecosystem by creating overly burdensome regulatory hurdles. We must face up to the fact that we are a city of 8 million or so people only, which is a miniscule market for medical devices, and that a HK regulator's decisions will hold little sway on the international medical device regulation scene. The strongest case for a survival path for Hong Kong is to be at the cutting-edge and high-end for medical technologies, and that means light-touch regulation.



C. Extending the 1+ Mechanism for Drugs, Vaccines and Advanced Therapy Products

The introduction of the 1+ system in 2023 was a revolutionary and absolutely correct step in recognising that there are well-run medical device and pharmaceutical regulators from territories with much larger markets than HK (e.g. mainland China), which thoroughly review each device and pharmaceutical product before marketing approval is granted and which continually survey the real-world effectiveness and safety of these products after their entry into routine clinical usage.

A crucial extension of this rule is to Advanced Therapy Products (ATP), which can be taken to include such fast-moving fields as cell therapies, gene therapies and antibody conjugates. Thus far few of these therapies have been introduced into clinical use in HK due to variety of reasons, allowing space for the growth of borderline and low-quality treatments with doubtful clinical evidence and evident safety concerns in the market, and the growing tendency of locals to go abroad to seek ATP abroad. This is HK's opportunity to grasp the opportunity presented to lead in this field.

D. Strengthening Biomedical Technology R&D and Translation

Creating a GBA clinical trial platform is a good idea in principle, leveraging the 80 million population of the GBA and the excellent higher education institutions of HK. An important point is to ensure that mechanisms for seamless and rapid cross-border data transfers are available; otherwise excessive bureaucratic hurdles will negate any advantages conferred by this GBA clinical trials platform.

In accelerating translation of research into clinical practice and produces, establishing a "Real-World Study and Application Centre" - a bureaucratic organisation - is far less important than enlisting the help and listening often to frontline entrepreneurs and professionals who are in the medical technology sphere, as they are driven by rapidly changing and cutting-edge market forces and have to bear real-world cost and regulatory pressures when considering if and how to invest in a new medical technology venture. Bridging the gap between the excellent research that comes out of our world-beating universities and

the finished product requires such seasoned professionals who move quickly and are, by nature, resource-efficient. The government should listen often and collaborate with this community to constantly adjust policy details to keep up with the market. Let the market shape and accelerate translation and support it in the process.

E. Supporting R&D, Clinical Trials and Applications of Advanced Biomedical Technology

Targeted government incentives are an effective way to help startup companies establish themselves and grow in HK. The process of selecting companies to which these incentives are distributed should involve not only academia and government officials, but also financial and healthcare technology industry professionals to select the companies with the best combination of a good product, good business plan and good human capital, which favour the growth of a successful company.

Attracting global top-notch innovation enterprises and research organisations to HK involves a deep reflection on what HK is and what it is not; HK is a high rental cost, high wage cost, high living cost territory which means that companies can only base the operations that will benefit the most from HK's unique environment and position to be the most productive. We must think from the perspectives of these companies and consider why they would want to land in HK. There are examples of such companies like contract research organisations that open just a token representative office in HK due to the lack of a market in HK. To a contract research organisation, maybe HK is more a source of strategic capital rather than a market for its core business; to a multinational pharmaceutical company, HK may be a source of early-stage companies that may provide pipeline products for future growth.

F. Conclusions

Hong Kong has great potential to foster growth of a vibrant and powerful medical technology ecosystem. The correct policy choices and good execution depends on close collaboration with industry frontline professionals. The government should consult regularly with these professionals to move closer in synchrony with a rapidly advancing field.



The Policy - Section 9. Scale up Medical Collaboration in the GBA

The Policy Address Says

Scaling up cross-boundary healthcare collaboration is key to enhancing both Hong Kong and the GBA's healthcare competitiveness internationally. Key initiatives include expanding the Elderly Health Care Voucher scheme to all nine GBA Mainland cities, improving cross-boundary medical record sharing for continuity of care, facilitating the use of data and medical resources to drive innovation, and promoting internationally aligned specialist training to strengthen the regional talent pool.



Dr. Christopher KM Hui



Dr. James YM Wong

HKCMA response to Section 9 Greater Integration of Healthcare Services Across the Greater Bay Area

Dr. Christopher KM Hui & Dr. James YM Wong
HKCMA council members

A. The Key Initiatives

A1. Expansion of the elderly healthcare voucher scheme

擴展「長者醫療券大灣區試點計劃」，以全面覆蓋大灣區九個內地城市

The plan to expand the "Hong Kong Health Care Voucher Scheme" to cover all nine mainland cities in the Greater Bay Area (GBA) represents a significant step towards integrating healthcare services across the region^{[1][4]}. This expansion aims to provide the Hong Kong's elderly population with more flexibility and choice in accessing medical services throughout the GBA. By allowing the use of healthcare vouchers in designated mainland facilities, the scheme addresses the needs of Hong Kong residents who frequently travel to or reside in the mainland, particularly retirees^[4].

This initiative not only enhances healthcare accessibility for Hong Kong's aging population but also promotes the development of a more

integrated healthcare ecosystem in the GBA. However, careful implementation will be crucial to ensure that the expanded scheme does not overwhelm mainland healthcare facilities or compromise the quality of care for local residents^[1].

A2. Enhancement of cross-border medical record sharing

繼續利用醫健通平台配合各項跨境醫療協作計劃，擴大及深化跨境醫療紀錄互通，支援市民跨境獲取更連貫醫療服務

The continued utilization of the eHealth platform to support various cross-border medical collaboration programs, with a focus on expanding and deepening cross-border medical record sharing, is a critical component of the GBA healthcare integration strategy^[1]^[2]. This initiative aims to create a more seamless healthcare experience for patients moving between Hong Kong and mainland GBA cities. By enabling authorized healthcare providers to access patient information across borders, this system has the potential to improve continuity of care, reduce duplicate tests and procedures, and enhance overall treatment efficacy^{[2][6]}. However, implementing such a system presents significant technical and regulatory challenges, including ensuring data security, protecting patient privacy, and harmonizing different healthcare information systems across jurisdictions^{[2][5]}. Overcoming these hurdles will require close collaboration between healthcare authorities in Hong Kong and mainland China, as well as substantial investments in secure, interoperable health information technology infrastructure.

A3. Acceleration of medical innovation industry development

探索以河套深港科技創新合作區的「大灣區臨床試驗協作平台」及「真實世界研究及應用中心」，打通數據、生物樣本、創新藥械的跨境流動及應用，加速醫療創新產業發展

The exploration of using the "Greater Bay Area Clinical Trial Collaboration Platform" and the "Real World Research and Application Center" in the Hong Kong-Shenzhen Innovation and Technology Cooperation Zone to facilitate cross-border flow and application of data, biological samples, and innovative drugs and devices is an ambitious initiative to boost the region's medical innovation ecosystem^{[1][3]}. This approach would leverage the unique strengths of Hong Kong and Shenzhen in biomedical research and development, potentially accelerating the development of new treatments and medical technologies. By creating a more integrated research environment, this initiative could attract more international pharmaceutical and biotech companies to conduct clinical trials and research in the GBA, enhancing the region's global competitiveness in the life sciences sector^[3]. However, successful implementation will require addressing complex regulatory issues related to cross-border data sharing, harmonizing clinical trial protocols, and ensuring ethical standards are maintained across different jurisdictions^[5].

A4. Promotion of internationally aligned specialist training

加強協作在大灣區內推動與國際接軌的專科培訓，為本地及大灣區擴大專科人才庫，滿足醫療服務需要

The initiative to strengthen collaboration in promoting internationally aligned specialist training within the GBA aims to expand the pool of specialist talent for both Hong Kong and the broader GBA region^{[1][6]}. This approach recognizes the importance of developing a high-quality healthcare workforce to meet the growing medical service needs across the

region. By aligning training standards with international benchmarks, this initiative could enhance the quality and consistency of specialist care throughout the GBA, making the region more attractive for both patients and healthcare professionals^[6]. Furthermore, this collaborative approach to specialist training could facilitate greater professional mobility within the GBA, helping to address workforce shortages in specific areas and promoting knowledge exchange between different healthcare systems^[4]. However, implementing such a program will require careful coordination to ensure that training standards and qualifications are mutually recognized across different jurisdictions within the GBA, which may necessitate changes to existing regulatory frameworks governing medical education and professional certification^[5].

Citations:

- [1] <https://ppl-ai-file-upload.s3.amazonaws.com/web/direct-files/40375312/ae9bd47e74ce-49b1-b6e6-6a0dd6bc69da/Integration-of-Healthcare-Services-Across-theGreater-Bay-Area-EN-CN.docx>
- [2] <https://www.pwccn.com/en/research-and-insights/greater-bay-area/integrationhealthy-sep2024.pdf>
- [3] <https://www.nature.com/articles/s41599-024-04105-y>
- [4] <https://www.chinadaily.com.cn/a/202211/18/WS637721e1a31049175432a916.html>
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B. Current State of Healthcare Integration in the GBA

The GBA has made significant progress in recent years towards integrating healthcare services across Hong Kong, Macau, and the nine mainland cities in Guangdong province.

Some key achievements include:

- Implementation of the "Hong Kong and Macau Medicine and Equipment Connect" policy, allowing approved drugs and medical devices from Hong Kong/Macau to be used in designated healthcare institutions in the GBA mainland cities^[1].
- Launch of cross-border healthcare programs like the "Hong Kong Health Care Voucher Scheme", enabling Hong Kong residents to use healthcare vouchers at designated mainland facilities^[3].
- Establishment of "Hong Kong-Macau Residents Healthcare Services Centers" in several public hospitals in mainland GBA cities to provide Hong Kong-style medical services^[6].
- Formation of strategic partnerships between Hong Kong/Macau hospitals and mainland healthcare groups to provide cross-border outpatient and inpatient services^{[4][6]}.
- Pilot programs to explore the use of digital identities and Legal Entity Identifiers (LEIs) to facilitate cross-border verification of medical credentials and records^[5].

However, challenges remain in areas such as insurance coverage, data-sharing, and regulatory alignment across jurisdictions.

C. Plan for Greater Healthcare Integration

To further integrate healthcare services across the GBA, the following initiatives are recommended:

C1. Expand cross-border insurance coverage

C1.1. Work with insurers to develop more comprehensive cross-border health insurance plans that provide seamless coverage across GBA cities^{[2][4]}.

C1.2. Explore innovative insurance models like value-based care propositions in partnership with hospitals across borders^[6].

C1.3 Streamline claims and payment processes for cross-border medical services.

C2. Enhance data sharing and interoperability

C2.1. Establish a unified electronic health record system accessible by authorized providers across the GBA^[4].

C2.2. Implement robust data security and privacy protection measures compliant with regulations in all jurisdictions.

C2.3. Enable mutual recognition of laboratory tests, imaging studies, and other diagnostic results to avoid duplication^[7].

C3. Align regulatory standards

C3.1. Harmonize drug and medical device approval processes across GBA jurisdictions to expand access to innovative treatments^[1].

C3.2. Develop common accreditation standards for healthcare facilities and professionals to ensure consistent quality of care.

C3.3. Create mechanisms for cross-border practice by qualified healthcare professionals.

C4. Strengthen cross-border referral networks

C4.1. Establish formal referral pathways between primary care providers and specialists across borders^[6].

C4.2. Develop telemedicine platforms to facilitate remote consultations between patients and providers in different GBA cities.

C4.3. Create a centralized appointment booking system for cross-border medical services.

C5. Promote collaborative research and innovation

C5.1. Establish joint research centers and clinical trial networks spanning multiple GBA institutions^[6].

C5.2. Facilitate sharing of biospecimens, genomic data, and other research assets across borders.

C5.3. Create funding mechanisms to support collaborative R&D projects in priority areas like chronic disease management.

C6. Enhance public health coordination

C6.1. Develop integrated disease surveillance and outbreak response systems across the GBA.

C6.2. Coordinate health promotion and disease prevention campaigns targeting the broader GBA population.

C6.3. Align public health policies and regulations where feasible.

D. Implementation Roadmap

D1. Form a high-level GBA Healthcare Integration Steering Committee with representatives from all jurisdictions.

D2. Conduct a comprehensive assessment of regulatory, technological, and operational barriers to integration.

D3. Develop detailed implementation plans for each initiative, with clear timelines and accountability.

D4. Launch pilot programs to test new integration models before broader rollout.

D5. Establish robust monitoring and evaluation mechanisms to track progress and impact.

D6. Regularly engage stakeholders including healthcare providers, insurers, patient groups, and technology companies to gather feedback and refine approaches.

By systematically addressing barriers and leveraging existing momentum, the GBA can create a world-class integrated healthcare ecosystem that provides seamless, high-quality care to its 86 million residents. This will not only improve health outcomes but also drive economic growth and innovation across the region.

Citations:

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[7] <https://www.hkmj.org/abstracts/v29n3/268.htm>

E. What Are the Main Challenges in Integrating Healthcare Services Across the GBA?

Based on the search results, some of the main challenges in integrating healthcare services across the Greater Bay Area (GBA) include:

E1. Regulatory differences

There are significant disparities in regulatory regimes across the "one country, two systems, three jurisdictions and customs territories, and three currencies" of the GBA^[2].

E2. Differences in medical systems

There are variations in physician training, medical payment mechanisms, and medical insurance systems across the regions^[2].

E3. Lack of unified cross-border medical payment and insurance claim schemes

The absence of standardized payment and insurance systems poses challenges for seamless healthcare integration^[2].

E4. Data management and sharing issues

Medical records, diagnoses, and test results are managed differently across the three regions, leading to challenges in sharing and recognizing medical information^[2].

E5. Language barriers

Communication can be difficult due to language differences between healthcare providers and patients from different regions^[5].

E6. Cultural differences

Varying cultural backgrounds and approaches to healthcare can create challenges in providing consistent care^[5].

E7. Governance differences

The healthcare systems in Hong Kong, Macau, and mainland China have different governance structures and practices^[5].

E8. Human resource shortages

There is a lack of qualified healthcare professionals able to work across the different systems^[5].

E9. Funding issues

Securing adequate funding for integrated healthcare initiatives can be challenging^[5].

E10. Technical challenges

Implementing interoperable systems for identity verification and professional qualifications recognition across cities requires overcoming technical hurdles^[3].

E11. Limited scope of existing integration programs

Current initiatives like the Hong Kong-Shenzhen hospital collaboration have a relatively narrow focus, indicating the need for broader integration efforts^[5].

Addressing these challenges will be crucial for achieving greater healthcare integration across the Greater Bay Area and providing seamless,

high-quality care to residents throughout the region.

Citations:

- [1] <https://upload.s3.amazonaws.com/web/direct-files/40375312/819e05b1-f88b-4b47-aa94-88496cd7da29/Yi-Wu-Wei-Sheng-Ju-De-Zheng-Ce-Cuo-Shi.docx>
- [2] <https://www.pwccn.com/en/research-and-insights/greater-bay-area/integration-healthy-sep2024.pdf>
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立法會會議：2024 年施政報告議案辯論： 打造國際高端人才集聚高地，惠民生 添幸福（二） — 林哲玄發言片段（2024 年 11 月 06 日）



林哲玄醫生
立法會議員

施政報告在醫療深改涵蓋面廣，全盤考慮。

方向、政策、策略

方向上，香港從“重治療”轉變，做到防治並重，把發展重點適度向社區、向基層轉移，要紮實的基層醫療結合高端的上層醫療建成立體的醫療體系，全方位服務市民，方向清晰。

政策上，施政報告明言重整三大公營醫療板塊：

- 一、衛生署繼續負責疫情和重大醫療風險防控，以及醫藥監管工作；
- 二、基層醫療處負責基層醫療發展和管治；
- 三、醫管局負責專科和醫院服務，按公立醫院系統管理檢討委員會的報告深度改革。

第四個板塊是策略採購辦公室，制定政策向私營醫療單位採購公營服務。第五個板塊是中醫體系，包括中醫醫院、中藥檢測中心、數碼化標本館、18 區中醫診所暨教研中心以及中醫藥發展專員領導的中醫藥處。我們可以看到，每個板塊都有深度改革和巨大發展。

策略上，中醫藥發展藍圖的籌劃，基層醫療健康藍圖進一步落實，中西醫學協調發展、生命科學研發、藥物和醫療器械向第一層審批邁進，以及加強和擴大醫學教育、設立第三所醫學院都有具體的著墨。下面聚焦討論。

執行項目

一、地區康健中心

地區康健中心在社區的醫療統籌角色已在逐步加強。

統籌的意思就是地區康健中心不會提供所有服務，而是善用社區資源，與志願機構和私人執業醫護人員合作，通過策略採購提供全面服務。

二、醫健通

醫健通有無限的發展空間：

1. 是連結各醫護人員的溝通平台，方便轉介和個案討論；
2. 是提供服務的副機師 (co-pilot)，提醒醫生有關病人的醫療警示和實時提供臨床指引以供參考；
3. 是一人一病歷的紀錄系統；
4. 更是市民的健康一站通 Apps。

醫健通要有效使用，私家醫院和醫生的參與十分重要，因此我過去多年來一直與局方溝通不斷，交換意見，闡述私家醫生使用系統時遇到的實際難題，商討解決方案。今天，私家醫生診所的醫療紀錄系統可後台上載有知情同意病人的病歷紀錄，就是多年來討論的成果。事實證明，與持份者溝通能有效排除萬難、理順操作、推進政策。我希望政府繼續就推進醫健通的使用與業界保持密切溝通。

三、慢病共治

慢性疾病共通治理先導計劃 (CDCC) 是提倡家庭醫生的關鍵措施。計劃連結市民、家庭醫生與地區康健中心；我樂見計劃推行。家庭醫生以家庭，亦以個人為服務對象。家庭醫生是市民的健康總經理，為市民制訂全人生週期健康規劃，

並且複檢病人對上一次覆診後所接受的各項醫療專業服務。家庭醫生為市民防治疾病：提供疫苗接種、疾病篩查，也處理穩定的慢性疾病以及偶發性疾病。家庭醫生與市民的關係是長遠的，個人化的，因此不宜隨意更換。

慢病共治計劃也可考慮加入臨床藥劑師為病人解答藥物服用疑難、鼓勵服藥依從性、及早發現副作用和評估療效等。慢病共治計劃也應該根據病人個別需要加入其他醫護人員，例如糖尿病人每年見視光師和營養師。

四、基層醫療名冊

《基層醫療指南》列載參與公私營協作醫療服務的私人執業中醫、西醫、牙醫。據了解，政府將進一步把指南發展成為名冊，也將擴充專業至涵蓋藥劑師、護士、物理治療師、職業治療師以及牙專人員等。在名冊上面的專業人員參與基層和公共醫療服務、共用醫健通，按參考概覽協同護理病人，組成一個一個以病人為本，以家庭醫生為主要服務責任人的團隊。

醫護人員之中，脊醫滿足了不少市民的醫療需要，對市民健康貢獻良多。脊醫人數不多，默默耕耘，希望政府為脊醫在醫療體系的角色定位，讓專業得以健康發展。

五、社區藥物名冊

社區藥物名冊相信是未來一年政府銳意發展的項目。名冊上通過集中採購的藥物，可考慮先統一價格，明碼實價，增加藥物價格透明度。一些常用藥物，包括抗生素、咳藥水不時斷貨，集中採購如能保障藥源充足，相信會受私家醫生的歡迎。我希望社區藥物名冊擴充範圍，例如讓指定病人在家庭醫生診所或社區藥房取得較新的專科藥物，避免病人因為在社區得不到較新的專科藥物而繼續在公立醫院專科門診覆診。處理好專科藥物，慢性疾病穩定患者從公立醫院專科門診大量轉診家庭醫生的障礙相信得以掃除。

六、社區藥房

公立醫院藥物浪費嚴重，問題源於每次出藥

量過大，動輒發出半年或一年藥量，病人病情有變或出現副作用，藥物隨時報廢。以專業藥劑師主導的社區藥房的出現，無疑是從源頭解決問題踏出的重要一步。我樂見社區藥房不只是面對市民，也服務安老院舍。這是業界多年來的建議，我感謝政府從善如流，相信措施定必讓院舍派藥更加精準快捷。

七、中醫藥發展

中醫藥是我國文化瑰寶，我期待中醫藥發展藍圖的制訂。中醫藥的進一步發展，尤其與西方醫學的對接關鍵在於循證醫學。我期待中醫藥處主動協調大學和業界針對性推行醫藥成效的科研，尤其是純中醫藥、純西醫藥以及中西醫藥並用的對比性研究，作為中醫中藥寫入參考概覽或治療指引的科學基礎，務實開啟中西醫相互轉介、協同發展。

八、口腔健康

沒有口腔健康就沒有健康，香港醫療體系始終是市民口腔健康的主要責任人。今年衛生署聘任了過半新畢業牙醫，隨著牙醫實習的落實以及市民求醫習慣的改變，來年加入公共醫療體系的牙醫估計將進一步增加。除了增加公共牙科服務外，開拓牙科公私營協作、策略採購口腔健康服務相信可為香港基層市民和長者逐步解決看牙醫的難題。

九、精神健康、醫療專業註冊計劃過渡法定註冊

同樣，沒有精神健康就沒有健康。我樂見政府強化醫、教、社精神健康協作服務，以及制訂「精神健康分層護理模式」等措施。

專業人員的水平達標是保障市民的重要舉措，關鍵在於有法律基礎的有效監管。

法定註冊不在於是否由政府成立法定機構負責註冊，重點在於法例賦予權力由指定機構負責單一專業名冊，冊上無名者不得在港以該專業名義執業。律師和大律師的註冊就是例子。只有法定註冊才能有效保證從業員水平和操守，才能保障市民得到達標的專業服務。我期待政府推進



《認可醫療專業註冊計劃》，過渡到法定註冊。

十、大灣區醫療合作

隨著越來越多港人在大灣區就業和退休，港人在內地城市的醫療需求將日益增加。廣東院舍計劃連居民醫保、住院及門診補貼以及指定醫療設施可以報銷長者醫療券都是利民惠民措施，值得支持。

十一、藥物資助措施

那邊廂，在港求醫的市民越來越擔心因藥物昂貴帶來的財政壓力。雖然醫管局藥物名冊正加速列入新藥，而合資格人士也可通過撒瑪利亞基金或關愛基金得到自費藥物的資助，但是，費用達到數萬甚至數十萬的超昂貴的罕見疾病和癌症自費藥物即使中產家庭也望而卻步。如果我們不可以參與國家集中採購藥物，那麼與內地醫院共同治理個別病人，讓病人在內地診治時取藥也許可行，希望政府探討。局方曾經提過為市民的昂貴藥物開支封頂也是我期待得到落實的措施。

藥物昂貴之外，罕見疾病患者所需的特別食品也成為病人和家庭的財政負擔。苯丙酮尿症(PKU)是罕見的胺基酸代謝障礙，患者不可進食含有苯丙氨酸(Phenylalanine)的蛋白，否則有生命之虞。適合PKU病人食用的營養液價格高昂，需要從海外購買，一年每個患者所費高達10萬港元。據悉，國外一些地方有全費資助特別需要食品計劃。我希望政府探討因指定疾病所需的特製食品得到有如藥物一般資助。

十二、第三所醫學院

根據醫療人力推算，醫生到2040年將持續短缺，缺口人數過千。

推算面對不少變數：公立醫院醫生離職率的變化以及醫療改革亦將改變人力配置和需求。

醫生人手可以外求，也可以自己訓練；前者多變、難於預測，後者比較穩定。因此，香港醫生主要還應由自己訓練，外來者可作為補充。從鞏固本地醫療服務角度出發，我歡迎香港成立第三所醫學院。

不過，前事不忘，後事之師。2002年醫生對香港人口比例每千人1.65名醫生，但當時醫生過多，兩大醫學院亦把學生人數逐步遞減。醫科畢業生不一定找到公立醫院工作。我們要為人手需求變化做好準備。

到我們有第三所醫學院時，我希望醫學院多收海外生，增加同學文國際化交流機會。國際學生來港讀醫既顯示出我們的軟實力，也可為香港打造成為國際教育樞紐打下多一層堅實基礎。

十三、生命科技研發

今天，香港不能再單靠我們是世界最長壽的地方就可以站在世界醫療前緣。我們有否能力研發新藥、新醫療科技、帶領全球才是香港領先地位的試金石。

我們的兩所醫學院以及各大學在生物醫學、醫學工程方面已有卓著的科研成就。多一所醫學院，必然為生命科學研究注入新動力。

科研要靠全球吸引人才，亦要全球頂尖的科研製藥企業落戶香港。河套深港科技創新合作區是香港創科的新基地，讓科研人員善用大灣區以致全國巨大的病人數量為臨床科研提質增速。科研是必由之路。

十四、醫療融資改革

最後，我提一提醫療融資。醫療融資的目標是讓公帑公平配置，讓有經濟需要的人得到有醫療需要的治療，同時增加用者責任意識。我期待在這方面繼續與政府溝通。

總括而言，2024年施政報告是醫療深改的宏觀規劃，全面而具體。業界期待繼續與局方密切溝通，共同譜寫醫療新篇章。



Role of immunotherapy in non-small cell lung cancer (NSCLC)

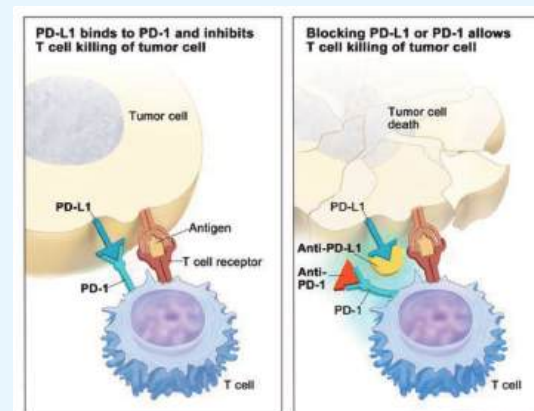


Dr. Carol CH Kwok
Specialist in Clinical Oncology

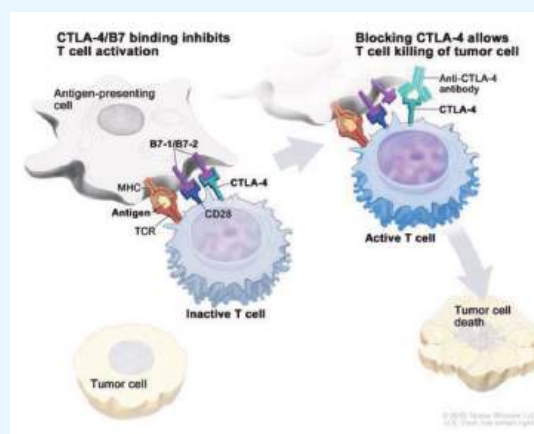
Introduction

Immunotherapy is a type of cancer treatment that helps the immune system fight cancer. Immune checkpoint inhibitor (ICI) is a form of immunotherapy. Immune checkpoints are a normal part of the immune system to prevent

an immune response from being so strong that it destroys healthy cells in the body.¹ Checkpoint proteins, such as Programmed Cell Death Ligand 1 (PD-L1) are present on tumour cells and Programmed Death-1 (PD-1) on T cells. The binding of PD-L1 to PD-1 keeps T cells from killing tumour cells in the body. ICIs are antibodies directed against PD-1 (pembrolizumab, nivolumab and cemiplimab) and PD-L1 (atezolizumab and durvalumab); they block the binding of PD-L1 to PD-1, releasing the 'brakes' and allows the T cells to kill tumour cell. Anti-CTLA4 (Cytotoxic T-Lymphocyte-associated Antigen 4 (ipilimumab, tremelimumab) is another category of ICI; when it binds to CTLA4 on the T cells, the 'brakes' on the immune system are released and the ability of T cells to kill cancer cells is increased.



Immune checkpoint inhibitor.¹ Checkpoint proteins, such as PD-L1 on tumour cells and PD-1 on T cells, help keep immune responses in check. The binding of PD-L1 to PD-1 keeps T cells from killing tumour cells in the body (left panel). Blocking the binding of PD-L1 to PD-1 with an immune checkpoint inhibitor (anti-PD-L1 or anti-PD-1) allows the T cells to kill tumour cells (right panel).



Immune checkpoint inhibitor.¹ Checkpoint proteins, such as B7-1/B7-2 on antigen-presenting cells (APC) and CTLA-4 on T cells, help keep the body's immune responses in check. When the T-cell receptor (TCR) binds to antigen and major histocompatibility complex (MHC) proteins on the APC and CD28 binds to B7-1/B7-2 on the APC, the T cell can be activated. However, the binding of B7-1/B7-2 to CTLA-4 keeps the T cells in the inactive state so they are not able to kill tumour cells in the body (left panel). Blocking the binding of B7-1/B7-2 to CTLA-4 with an immune checkpoint inhibitor (anti-CTLA-4 antibody) allows the T cells to be active and to kill tumour cells (right panel).

Immunotherapy in the form of ICIs has led to a dramatic increase in the survival of patients with NSCLC across all stages. This article summarized the benefits and indications of immunotherapy in NSCLC. The pivotal trials all enrolled patients with WHO performance status (PS) 0-1, and no contraindication for ICI therapy.² All published phase III studies with ICIs excluded patients with PS ≥ 2 .²

A. Immunotherapy as first line treatment for metastatic NSCLC

1. Single-agent immunotherapy

The benefit of ICI monotherapy is shown in three pivotal phase III studies which compared immunotherapy with platinum-doublet chemotherapy (ChT). Pembrolizumab (**KEYNOTE-024**)^{3,4} and cemiplimab (**EMPOWER-Lung 1**)⁵ recruited patients with PD-L1 $\geq 50\%$ on tumour cells (TCs). ICI monotherapy showed superior for all efficacy endpoints: overall response rate, progression free survival (PFS) (median PFS from 5.5 months to 7.7m) and overall survival (OS) (median OS from 13.4m to 26.3m).⁴ In **IMpower110**, atezolizumab showed OS improvement in the subgroup of patients with high PD-L1 ($\geq 50\%$ on TCs or $\geq 10\%$ on immune cells [ICs]).⁶

Based on the results of these three pivotal trials, single-agent ICI (pembrolizumab, cemiplimab and atezolizumab) has become the standard treatment for patients with squamous-cell as well as nonsquamous NSCLC and a high PD-L1 expression (TCs $\geq 50\%$, or $\geq 10\%$ on ICs for atezolizumab).² Pembrolizumab is considered a standard first-line option, alternatives are atezolizumab (also if ICs $\geq 10\%$) and cemiplimab.²

2. Single-agent immunotherapy combined with chemotherapy

a. Immunotherapy chemotherapy combination for non-squamous NSCLC

Immunotherapy in combination with chemotherapy were studied in **KEYNOTE-189** (patients were randomised to receive pemetrexed and platinum plus either pembrolizumab or placebo, followed by pemetrexed-pembrolizumab or pemetrexed-

placebo maintenance therapy),⁷ **IMpower150** (patients were randomized to carboplatin-paclitaxel-bevacizumab vs carboplatin-paclitaxel-atezolizumab vs carboplatin-paclitaxel-atezolizumab-bevacizumab),⁸ and **IMpower130** (carboplatin-nab-paclitaxel with or without atezolizumab).⁹ OS was substantially improved by the addition of immunotherapy.^{9,10,11} There was improved survival compared with ChT across each of the PD-L1 strata as well. Based on the results from **KEYNOTE189**, pembrolizumab in combination with pemetrexed and platinum ChT is considered a standard treatment option in metastatic non-squamous NSCLC.² Results from **IMpower150** place the combination of atezolizumab-bevacizumab-carboplatin-paclitaxel as a therapeutic option and atezolizumab with carboplatin-nab-paclitaxel (**IMpower130**) as another option in patients with metastatic non-squamous NSCLC.²

b. Immunotherapy chemotherapy combination for squamous NSCLC

For advanced squamous mNSCLC, **KEYNOTE-407** randomised patients to receive carboplatin-(nab)-paclitaxel plus pembrolizumab or placebo, followed by pembrolizumab or placebo maintenance.¹² The trial met its primary endpoints for PFS and OS.¹³ Results from **KEYNOTE-407** place the combination of pembrolizumab-carboplatin-(nab)-paclitaxel as the standard choice in patients with metastatic squamous NSCLC.²

3. Dual Immunotherapy without chemotherapy

Dual Immunotherapy without chemotherapy is tested in the phase III trial **Checkmate 227**, which comprised patients across all PD-L1 expression subgroups and compared ipilimumab/nivolumab vs. chemotherapy. OS benefit was positive. Patients on ipilimumab/nivolumab had better long-term survival with a 4-year OS rate of 29%, compared to 18% for patients on chemotherapy.¹⁴ Benefits were observed in both squamous and nonsquamous histologies. Nivolumab-ipilimumab is a FDA approved option for PD-L1 $\geq 1\%$ tumours regardless of histology but is not EMA approved.²

4. Dual immunotherapy combined with chemotherapy

The phase III **Checkmate-9LA** trial evaluated ipilimumab/nivolumab with an abbreviated course of ChT (two cycles) vs. standard ChT alone. It recruited N = 719 patients; n = 495 non-squamous non-small-cell carcinoma, n = 224 squamous-cell carcinoma patients are included.¹⁵ With a 47.9- month follow-up for OS, nivolumab plus ipilimumab with chemotherapy continued to prolong OS over chemotherapy in all randomized patients regardless of tumor PD-L1 expression or histology. The benefit was enriched in patients with squamous-cell [squamous, HR 0.64 (0.48 to 0.84) and non-squamous, 0.80 (0.66 to 0.97)].¹⁶

In summary, in PD-L1 1-49% or $<1\%$ patient groups, ICI confers a survival benefit when combined with chemotherapy. A combination of platinum-based ChT plus anti-PD-(L)1 is the most common treatment approach for a patient with newly diagnosed stage IV NSCLC.² These included, for nonsquamous cell carcinoma: pembrolizumab with pemetrexed-platinum,^{7,10} atezolizumab-paclitaxel-carboplatin with or without bevacizumab;^{8,11} for squamous cell carcinoma: pembrolizumab with carboplatin-paclitaxel (or nab-paclitaxel),^{12,13} and nivolumab-ipilimumab with 2 cycles of chemotherapy for non-squamous and squamous NSCLC and others.^{2,15,16}

B. Single-agent immunotherapy in later lines treatment for mNSCLC

Checkmate-017,¹⁷ **Checkmate-057**¹⁸ and **Keynote-010**¹⁹ were the first trials for anti-PD-(L)1 monotherapy in the second-line or third-line setting, with encouraging results demonstrating response rates of around 20%, compared to 9-13% for docetaxel. Similar result for atezolizumab was also seen in the **OAK** trial,²⁰ All phase III randomised controlled trials with these agents demonstrated an OS benefit for monotherapy ICI over monotherapy ChT.^{17,18,19,20} Monotherapy nivolumab, pembrolizumab and atezolizumab have been approved by regulatory bodies and are the treatment of choice for most patients (except for never smokers OS favored nivolumab was not shown in the subgroup who had never smoked) with advanced, previously treated with a platinum doublet in the first line,

PD-(L)1 inhibitor-naive mNSCLC, irrespective of PD-L1 expression (pembrolizumab only in PD-L1 $\geq 1\%$).^{2,17,18,19,20}

C. Consolidation immunotherapy after chemoradiotherapy in unresectable, stage III NSCLC

The phase III **PACIFIC** trial randomised patients with unresectable, stage III NSCLC without disease progression within the first 42 days after concurrent chemoradiotherapy, to consolidative durvalumab for 1 year or placebo.²¹ Updated analyses demonstrate robust and sustained OS and durable PFS benefit with durvalumab after chemoradiotherapy. Based on the findings of the **PACIFIC** trial, consolidation durvalumab following platinum-based chemoradiotherapy is a standard of care for patients with unresectable, stage III NSCLC.²²

D. Perioperative/neoadjuvant setting

Checkmate-816, a phase III trial of patients with stage IB to IIIA resectable NSCLC, randomized patients to receive neoadjuvant nivolumab plus platinum-based chemotherapy or platinum-based chemotherapy alone, followed by resection.²³ The addition of nivolumab resulted in increased pathological complete response (pCR) rates (24% vs. 2%) and event free survival (EFS).²³ Based on **Checkmate-816**, the FDA approved **Nivolumab in 2022** as the first neoadjuvant checkpoint inhibitor for resectable NSCLC that is ≥ 4 cm or is associated with positive lymph nodes.

More recently, there are data from the **AEGEAN**²⁴ (durvalumab and chemotherapy), **Neotorch**²⁵ (toripalimab and chemotherapy), **Keynote-671**²⁶ (pembrolizumab and chemotherapy), and **Checkmate 77T**²⁷ trial (nivolumab and chemotherapy) which also showed improvement in EFS with perioperative/neoadjuvant immunotherapy.

E. Adjuvant setting

In the adjuvant setting, atezolizumab has demonstrated improvement in disease-free survival in the phase III **IMpower010**²⁹ trial and also with pembrolizumab in the phase III **Keynote-091** trial.³⁰ Adjuvant atezolizumab is an adjuvant therapy option for eligible patients

with completely resected (R0) stage IIB to IIIA, stage IIIB (only T3,N2), or high-risk stage IIA NSCLC and **with PD-L1 of 1% or more** who are negative for certain biomarkers—EGFR exon 19 deletions, EGFR exon 21 L858R mutations, and ALK rearrangements and who have previously received adjuvant chemotherapy based on clinical trial data and FDA approval.³¹ EMA approval is limited to patients whose tumours express PD-L1 on $\geq 50\%$ of tumour cells and who do not have EGFR- mutant or ALK-positive NSCLC.³²

Discussion

After diagnosis of mNSCLC, every effort is made to assess for oncogenic driver variants for which targeted therapies are available. After excluding driver mutation, **all stage IV NSCLC cases are recommended for PD-L1 immunohistochemistry (IHC) testing before first-line treatment, regardless of histology.** PD-L1 expression is reported as a tumour proportion score (TPS), which is defined as the percentage of tumour cells showing partial or complete PD-L1 membrane staining, versus all the tumour cells (both positive and negative for PD-L1) present in the specimen field. PD-L1 expression ranges from 0% to 100% on tumour cells. In pathology reporting, PD-L1 expression is generally reported as: high PD-L1 expression (a $TPS \geq 50\%$); PD-L1 expression (a $TPS \geq 1\%-49\%$); and no PD-L1 expression ($TPS < 1\%$).²

PD-L1 testing in the second-line or later setting is only necessary for treatment with pembrolizumab; treatment with either nivolumab or atezolizumab may proceed without PD-L1 testing. PD-L1 testing is not required for consolidation immunotherapy and in perioperative setting. In the adjuvant setting, adjuvant atezolizumab is indicated in tumours of PD-L1 of 1% or more by NCCN³¹ and $\geq 50\%$ by EMA.³²

References:
References would be provided upon request.

Treatment strategies for mNSCLC are based on histology, tumour genotype, PD-L1 expression, PS, comorbidities and patient’s preferences.² Contraindications to immunotherapy may include active or previously documented autoimmune disease and/or current use of immunosuppressive agents. PD-L1 inhibitors are less beneficial in patients with some oncogenic drivers (i.e., EGFR exon 19 deletions, EGFR exon 21 L858R mutations, ALK rearrangements).² Although PD-L1 expression can be elevated in patients with an oncogenic driver, targeted therapy for the oncogenic driver should take precedence over treatment with an ICI.^{2,31}

In most registered strategies in metastatic setting, **duration of ICIs treatment was limited to 2 years.** Trials with ipilimumab and nivolumab (e.g., CheckMate-9LA), the KEYNOTE trials with pembrolizumab (e.g., 024, 189, and 407) and the EMPOWER trials with cemiplimab (e.g, Lung 1 or 3) set a limit of two years, 35 cycles, and 108 weeks, respectively. Therefore these ICI can be discontinued after 2 years.² There was no limit in the IMpower trials (e.g., 130 or 150) with atezolizumab. Duration of treatment should be adjusted to clinical efficacy and tolerability.²

CME Questions

- 1. PD-L1 tumour proportion score (TPS) of 45% is regarded as high PD-L1 expression.
- 2. PD-L1 testing is important to guide the use of monotherapy immunotherapy in the treatment of patients with metastatic NSCLC. Single-agent pembrolizumab, cemiplimab or atezolizumab is indicated as first-line if tumour PD-L1 $\geq 50\%$ (or ICs $\geq 10\%$ for atezolizumab).
- 3. Monotherapy immunotherapy is indicated in tumours with PD-L1 1%-49% in first line treatment of mNSCLC.
- 4. Tumour histology, e.g. whether it is nonsquamous or squamous cell does **not** impact the choice of chemotherapy regimen to combine with immunotherapy in first line treatment of mNSCLC with PD-L1 1%-49%.
- 5. A patient with mNSCLC who suffers from systemic lupus erythematosus and is on steroid therapy should be considered as contraindication for treatment with PD-1/PD-L1 inhibitors..
- 6. Immunotherapy in combination with chemotherapy is the treatment of choice for patient who suffers from mNSCLC with tumour tested positive for EGFR mutation.
- 7. PD-L1 testing is required with nivolumab or atezolizumab use in **second line** setting.
- 8. The optimal duration of ICI therapy in mNSCLC is one year.
- 9. PD-L1 testing is required for adjuvant use of atezolizumab.
- 10. Immunotherapy is beneficial in patients with PS 4 in first line treatment of mNSCLC.

Answer Sheet HKCMA Bulletin Issue 02 January 2025

Doctors are most welcome to answer the self-assessment questions to attain the CME point for respective authorities if 5 answers out of the 10 short questions are correct by returning the completed answer sheet via fax 3007 1019 or by email to info@hk-cma.org.hk on or before 28 February 2025 for documentation. Answers to questions will be provided in the next issue of the HKCMA Bulletin.

Role of immunotherapy in non-small cell lung cancer (NSCLC)

By Dr. Carol Kwok, Specialist in Clinical Oncology

Self-assessment Questions 1-10: Please answer T (true) or F (false)

1	2	3	4	5	6	7	8	9	10

Full Name (block letters): _____ Signature : _____

HKID No. : _____ () MCHK No: _____

HKMA No: _____ OR HKDU No: _____

College: _____ Fellowship No: _____

Answers to Issue 01 October 2024

Diagnosis and Treatment of Mild Cognitive Impairment and Early Alzheimer’s Disease

By Prof. Lawrence Ka-sing Wong

Emeritus Professor, Department of Medicine & Therapeutics, CUHK

1. True 2. True 3. True 4. False 5. False

The Dermatology Quiz

Contributor:

Dr. CHAN Yung Davis

A 78-year-old Chinese patient presented with a itchy erythematous plaque over scrotum as well as penile base for 1 year. It has been treated with various topical medications from multiple doctors without improvement.

Q1. What is the most likely diagnosis?

- A. Contact dermatitis
- B. Lichen sclerosus
- C. Extramammary Paget's Disease (EMPD)
- D. Bowen's disease
- E. Superficial fungal infection

Q2. What should be done to confirm the diagnosis?

- A. Skin scrapping for fungal culture
- B. Skin patch test
- C. Skin biopsy
- D. Computed Tomography (CT) scan
- E. Positron Emission Tomography (PET) scan



Skin biopsy confirmed this patient suffered from EMPD, which is a rare intraepithelial adenocarcinoma occurring in apocrine gland-bearing areas, like genital, perianal and armpits.

EMPD was found to be more prevalence in patient older than 50, and is more male predominant in Asian population.

Clinically it presented as eczema like lesions which may lead to delay in diagnosis. Skin biopsy should be considered with this kind of persistent recalcitrant plaque to exclude other serious skin conditions including skin cancer.

Lichen sclerosus usually presents as white, atrophic plaques with a crinkled texture, often with symmetrical plaques affecting the genital and perianal areas.

Bowen's disease appears as scaly erythematous plaques with well-demarcated borders, often found on sun-exposed areas.

Imaging studies like PET scan can be used for staging. Surgical excision remains the preferred treatment option for operable cases.

Reference: t. Claire, K., Hoover, A., Ashack, K., & Khachemoune, A. (2019). Extramammary Paget disease. Dermatology Online Journal, 25(4).

Answers: Q1: C and Q2: C

香港醫療衛生界慶祝中華人民共和國成立 75 週年晚會



楊超發醫生

香港醫療衛生界專業人員於 2024 年 9 月 14 日在香港會議展覽中心舉行隆重晚宴，慶祝中華人民共和國成立 75 週年。這場晚宴不僅是紀念歷史的重要時刻，也是展現全體醫療衛生界專業人員團結合作的平台。

活動當晚，會場佈置精美、莊重，洋溢著節慶氣氛。來自香港醫療衛生界的專業人士齊聚一堂，共同見證這一具有歷史意義的時刻。晚宴榮幸地邀請到香港特別行政區行政長官李家超先生及其他主辦方致辭，回顧中華人民共和國 75 年的發展歷程，強調醫療衛生界專業人員在推動社會進步方面的重要作用。

我們香港中華醫學會是這次晚宴的主要協辦單位和贊助單位之一。在 78 桌貴賓中，我們很



香港中華醫學會大家庭在台上合照

全體主禮嘉賓在台上唱國歌



幸運地為我們的會員預訂了 3 桌，以便當晚與其他醫療衛生界專業人士一起慶祝。

出席晚宴的成員有，包括：香港中華醫學會榮譽贊助人楊紫芝教授、榮譽顧問曹吳美齡醫生、養和醫院副院長曹延洲醫生、會長陳真光醫生、副會長楊超發醫生、副會長朱偉星醫生、理事及會員。

現場安排了豐富的節目，包括莫華倫夫婦的歌唱表演和舞蹈。整個活動在溫馨歡樂中圓滿結

束，加深了與會者對國家發展的認識，增強了香港醫療衛生界的凝聚力。這次晚宴譜寫了慶祝中華人民共和國成立 75 週年的精彩篇章，為未來的合作發展奠定了堅實的基礎。

中華人民共和國成立 75 週年慶祝晚宴籌委會委員楊超發醫生作報告。



主禮嘉賓香港特別行政區首長李家超先生致開幕詞



香港中華醫學會理事與楊紫芝教授合照



台上與四位司儀合照



莫華倫夫婦在場精彩歌舞表演



香港中華醫學會會長陳真光醫生與醫務衛生局局長盧寵茂教授及一眾嘉賓合照



西醫界別嘉賓大合照

超過千位嘉賓參加慶祝建國盛大晚會



香港醫療衛生界慶祝國慶籌委會主要成員國慶前奏北京之行



陳真光醫生

正值新中國成立 75 周年普天同慶之際，國家邀請了香港醫療衛生界慶祝籌委會主要成員，也就是醫衛界別各組織代表到北京交流。今年 9 月 28 日我們一團大約 20 多人（包括西醫、牙醫、護士、藥劑師、物理治療師和脊醫）在梁智鴻醫生為團長、高永文醫生和林哲玄為副團長帶領下，浩浩蕩蕩的從香港飛到北京，入住酒店後便立刻準備起程到人民大會堂參加國家招待的國慶晚宴。

行程中最耀眼的是在北京大街的建築物閃亮的燈色，和在大路中間和兩旁的各種裝飾，包括鮮花擺設、燈籠、國旗，北京顯得非常美麗。天安門的擺設也是非常出色，有一個巨大立體的花籃，襯托着整所大廈光亮起來的人民大會堂，實在雙輝互映！

代表著香港中華醫學會的我不禁雀躍起來，和同僚拍照留念，和期待着人生第一次在人民大會堂與國家領導人共宴的難得機會！

進入人民大會堂後最吸引我的是在牆上的一幅巨型國畫，是關山月與李可染合作的，引用毛主席詞：沁園春·雪：“江山如此多嬌，引無數英雄競折腰”。這句話用上新中國真是非常恰當。我們看到的北京面貌，看到國家的嬌美，這是我們這一代人的幸福，令我想起年初看的一套內地電影「我和我的父輩」，講出了就是因為父



在人民大會堂上香港代表和我們那桌的主家國務院港澳辦五局趙旭東局長合照



香港代表團和中華醫學會領導人合照（前排右四為中華醫學會王健副會長及秘書長）



香港代表團在往北京人民大會堂的集合地方合照

輩他們的努力，我們才能享受到國家繁榮安定；因為有他們的苦，為我們這一代建設了富強美麗的國家！

第二天和第三天我們拜訪了衛生健康委員會、中華醫學會和協和醫院，感謝國家衛健委劉金峰副主任、中華醫學會趙玉沛會長、及北京協和醫院張抒揚院長在百忙之中抽空接見招待我們！

多年來都希望能在北京過國慶，這行總算如願以償！看到國家首都的宏偉嬌美，更是令人讚嘆不已！

未來，中華醫學繼續與其他香港醫衛界同道共同參與，為健康中國、健康香港做出新貢獻。

劉金峰肯定是兩地持續交流合作成果，並簡要介紹了近期國家深化醫藥衛生體制改革特別是公立醫院改革重點任務。在發展貢獻的同時，繼續推動兩地醫療衛生界共同參與國際事務，在國際舞台積極展示中國形象，推動建構人類健康健康社區。202409/ec2867eb6df74577a2f077f119082f50.shtml)



香港代表團和國家衛健委劉金峰副主任（前排中間）及其他領導人合照



中華醫學會晚宴盛情款待香港代表團

趙玉沛會長肯定了長達兩地在醫學交流合作方面的成果，並簡要介紹了中華醫學會與香港醫務界的歷史淵源。他表示，中華醫學界繼續與香港醫務界保持緊密的聯繫和持續的學術交流，促進兩地醫家情誼，共同為兩地醫學交流和人民健康福祉作出新的貢獻。(https://mp.weixin.qq.com/s/lv2zX74VbZBLUFmhYNaKag)

代表團一行人觀看了北京協和醫院介紹短片《百年協和一切為民》、新華社微紀錄片《三位大醫生》，參觀了院史館、病歷展、曾憲九教授誕辰 110 週年暨外科發展專題展，以及位於轉化醫學國家重大科技基礎設施的臨床試驗病房、臨床生物樣本庫和罕見疾病聯合門診，在罕見病醫學科病房與醫護人員親切交談。代表團成員對北京協和醫院百餘年來在醫學科學領域所取得的輝煌成就表示高度讚賞，充分肯定了協和在中國乃至世界醫學界的地位和影響力。



香港中華醫學會會長陳真光醫生向國家衛健委劉金峰副主任致紀念旗致謝



香港代表團和北京協和醫院張抒揚院長（前排右 5）合照

東莞康華醫院訪問小記



王裕民醫生



江炎輝醫生撰稿

11月24日星期日，一個初冬天氣清涼的下午，在香港中華醫學會陳真光會長帶領下，我們一行50人踏上了前往東莞康華醫院的旅程，隨後在苗圃會所享受了一頓難忘的晚餐。這半天的經歷，不僅讓我們對東莞的醫療服務有了全新的認識，也讓我們體驗到了東莞獨特的餐飲文化，品嚐了馳名的厚街燒鵝瀨粉。

從福田口岸乘坐巴士，大概一小時，我們便抵達了東莞康華醫院。這是一家集醫療、教學、科研於一體的現代化三甲私人民營醫院，規劃床位有2000張，以其先進的醫療設備和專業的醫療團隊而聞名。醫院佔地563畝，我們被其寬敞綠化的環境所吸引，現代化的裝備和溫馨的氣氛讓人感到舒適和安心。

其獨具匠勝的VIP病房，設備齊全、環境優雅、配備有先進的醫療設備，24小時專業醫護人員貼心照顧，提供了私密性極強的個人空間，

可以媲美香港私營醫院的病房。除了VIP病房外，港式設計的VIP門診服務同樣令人稱讚。內裏設置多個專科門診科室，涵蓋了內科、外科、婦產科及兒科多個領域，滿足不同的類別病患者需求。門診環境整潔明亮，醫護人員態度親切，流程簡易清晰，讓病患者在輕鬆愉快的氣氛中完成就診。他們分享了醫院的最新醫療技術，在參觀過程中，我們有幸與兩位院長進行了交流，他



晚飯前與院長合照



於醫院演講廳大合照

們不僅分享了醫院的最新醫療技術和研究成果，還詳細介紹了醫院在患者護理方面的創新實踐。通過這次交流，我們對康華醫院的醫療服務水平有了更深入的了解，也對內地醫療行業的未來發展充滿了期待。

現時長者醫療卷計劃已經在內地啟動，標誌著大灣區醫療融合正式開始，港人北上求醫數目日漸增加。期望香港優質醫療專家及先進的醫療管理經驗，能夠和內地醫療資源互補優勢，互動互惠，促進粵港澳大灣區醫療水平，為內地及港澳居民享受多樣化優質醫療健康服務提供便利，以大灣區居民健康福祉為依歸。

整個行程充滿了代表聯誼團結歡樂交流體驗學習及旅遊的元素。晚上會長陳真光醫生率領全

體參加者出席在康華醫院會所苗圃之豐富晚宴，享受著名的土產菜餚。回港時每人除了帶了興奮的心情還有一些土產紀念手信，盡興而歸。在此陳會長帶領各會員再次感謝康華醫院領導及各部門員工的盛情招待，及王裕民醫生夫婦的妥善安排，使本會與內地交流更進一步，享受了一個難忘的假期。



會長致送錦旗給周子權副院長



於台上與醫院院長及主任合照



會長於晚宴中致送紀念品給賈文霄院長



到步大合照



參觀院中私家病房



參觀醫院模型 (1)



Galaxy S25 Ultra



參觀醫院模型 (2)

KEYTRUDA®
(pembrolizumab) Injection 100 mg

**From Metastatic Legacy to
New Indications in
Early-Stage Resectable NSCLC¹**

**DON'T
LEAVE
THE**

KEY PLAYER

**ON THE
SIDELINE**

When Treating Your Indicated
Early-Stage Resectable NSCLC Patients¹
with **Multidisciplinary Approach**

KEYNOTE-671 Perioperative KEYTRUDA

**Neoadjuvant
Treatment**



**KEYTRUDA
and chemotherapy**

Surgery



**Adjuvant
Treatment**



KEYTRUDA Alone

KEYTRUDA is indicated for the treatment of patients with resectable (tumors ≥ 4 cm or node positive) NSCLC in combination with platinum-containing chemotherapy as neoadjuvant treatment, and then continued as a single agent as adjuvant treatment after surgery.¹

Selected Safety Information for KEYTRUDA (pembrolizumab):

Contraindications: None. **Precautions:** •Immune-mediated pneumonitis •Immune-mediated colitis •Immune-mediated hepatitis and hepatotoxicity •Immune-mediated endocrinopathies •Immune-mediated nephritis and renal dysfunction •Immune-mediated Dermatologic Adverse Reactions •Other immune-mediated adverse reactions •Infusion-related reactions (including hypersensitivity and anaphylaxis) •Complications of allogeneic HSCT in patients after or prior to treatment with KEYTRUDA treatment •Increased mortality in patients with multiple myeloma when KEYTRUDA is added to a thalidomide analogue and dexamethasone •Embryo-fetal toxicity. **Adverse Events:** Most common adverse reactions (reported in $\geq 20\%$ of patients) were: •KEYTRUDA as a single agent: fatigue, musculoskeletal pain, rash, diarrhea, pyrexia, cough, decreased appetite, pruritus, dyspnea, constipation, pain, abdominal pain, nausea and hypothyroidism. •KEYTRUDA in combination with chemotherapy: fatigue/asthenia, nausea, constipation, diarrhea, decreased appetite, rash, vomiting, cough, dyspnea, pyrexia, alopecia, peripheral neuropathy, mucosal inflammation, stomatitis, headache, weight loss, abdominal pain, arthralgia, myalgia, insomnia, and palmar-plantar erythrodysesthesia. •KEYTRUDA in combination with chemotherapy and bevacizumab: peripheral neuropathy, alopecia, anemia, fatigue/asthenia, nausea, neutropenia, diarrhea, hypertension, thrombocytopenia, constipation, arthralgia, vomiting, urinary tract infection, rash, leukopenia, hypothyroidism, and decreased appetite. •KEYTRUDA in combination with atezolizumab: fatigue/asthenia, hypertension, hepatotoxicity, hypothyroidism, decreased appetite, palmar-plantar erythrodysesthesia, nausea, stomatitis/mucosal inflammation, dysphonia, rash, cough, and constipation. •KEYTRUDA in combination with lenvatinib: hypothyroidism, hypertension, fatigue, diarrhea, vomiting, stomatitis, weight loss, abdominal pain, urinary tract infection, proteinuria, constipation, headache, hemorrhagic events, palmar-plantar erythrodysesthesia, dysphonia, rash, hepatotoxicity, and acute kidney injury.

For detailed precautions and adverse events, please consult the full prescribing information.

¹ KEYTRUDA® (pembrolizumab) [prescribing information]. Hong Kong: MSD; 2024.



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HK-KEY-00923 Jan/2025



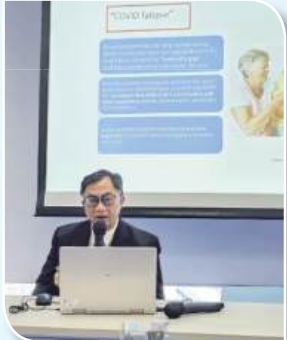
HKCMA CME Activities

Date	Topic	Speaker/s	Time & Venue
7 October 2024 (Monday)	Recent Advances in The Management of Alzheimer's Disease	Prof. Lawrence Ka-sing WONG Specialist in Neurology	Time: 1:00 pm - 3:00 pm Venue: Queen Victoria 8, Central
 Jane Chan, Dr. Law Yim Kwai and Dr. Henry Yeung presenting souvenir to Dr. Lawrence Wong, the speaker			
17 October 2024 (Thursday)	Breathing Easier: Modern Approaches to Asthma Management in Primary Care	Dr. Christopher Kim-ming HUI Specialist in Respiratory Medicine	Time: 1:00 pm - 3:00 pm Venue: Kwai Tsing District Health Centre (Core Centre)
 Kwai Tsing DHC after the talk  Dr. Henry Yeung presenting souvenir to sponsor representative  Dr. Christopher Hui giving the talk  Dr. Henry Yeung presenting souvenir to Mr. Chow Yick Hay, Chairman, Operator of Kwai Tsing DHC			

Date	Topic	Speaker/s	Time & Venue
19 October 2024 (Saturday)	CaReMe Forum: Unlocking Optimal Cardiorenal Care through Guideline-Driven Strategies	Prof. Cheuk-chun SZETO Professor of Department of Medicine & Therapeutics, The CUHK Prof. Ronald Ching-wan MA Professor of Department of Medicine and Therapeutics, The CUHK Prof. Navdeep TANGRI Professor, Division of Nephrology, Rady Faculty of Health Sciences, The University of Manitoba (Canada)	Time: 1:00 pm - 4:05 pm Venue: The Langham Hong Kong
 President Jane gave opening speech at the CaReMe forum  Panel discussion moderated by Dr. Ho Chung Ping (Right first)  Q & A session by President Jane Chan  Group photo with all the speakers and sponsor			

HKCMA CME Activities

Date	Topic	Speaker/s	Time & Venue
7 November 2024 (Thursday)	What can be achieved between Primary Care Doctors and DHC?	Dr. Daniel Wai-shing CHU Specialist in Family Medicine	Time: 1:00 pm - 3:00 pm Venue: Kwai Tsing District Health Centre (Core Centre)
 Group photo after the talk		 Dr. Daniel Chu giving the talk	
22 November 2024 (Friday)	Shielding the Fragile: Emerging Strategies to Protect High-Risk Older Adults from RSV	Dr. CHUNG Shiu-shek Specialist in Cardio-thoracic Surgery	Time: 1:00 pm - 3:00 pm Venue: Star Place, Xiqu Centre
 Dr. CHUNG Shiu-shek giving the talk		 Group photo after the talk	
28 November 2024 (Thursday)	New Insights in Cardio-Renal Disease Management	Dr. Andrew Kei-yan NG Specialist in Cardiology	Time: 1:00 pm - 3:00 pm Venue: Queen Victoria 8, Central
 President Dr. Jane Chan presenting souvenir to Dr. Andrew Kei-yan Ng, the speaker		 President Dr. Jane Chan presenting souvenir to sponsor representative	

Date	Topic	Speaker/s	Time & Venue
29 November 2024 (Friday)	Protecting the vulnerable elderly and cardiovascular patients from RSV - a matter of urgency	Dr. Adrian Piers Yan-yue CHEONG Specialist in Cardiology	Time: 1:00 pm - 3:00 pm Venue: Kwai Tsing District Health Centre (Core Centre)
 Group photo after talk by Dr. Adrian Yan-yue Cheong		 Dr. Henry Yeung and Dr. Adrian Cheong, the speaker, presenting souvenir to the sponsor representative	
5 December 2024 (Tuesday)	The Future of Obesity Pharmacotherapy: Matching Medication to Phenotype	Dr. Michele Mae-ann YUEN Specialist in Endocrinology, Diabetes & Metabolism	Time: 1:00 pm - 3:00 pm Venue: Queen Victoria 8, Central
 香港中華醫學會會長陳真光醫生致送紀念品給講者袁美欣醫生 (Hong Kong Obesity Society Founder and Council Member)		 香港中華醫學會會長陳真光醫生致送紀念品給贊助商代表	
3 January 2025 (Friday)	The Importance and Strategies of Prevention Against Respiratory Viruses Infections	Dr Mike Kwan Yat Wah President of Asian Society for Pediatric Infectious Diseases (ASPID)	Time: 1:00 pm - 3:00 pm Venue: Kwai Tsing District Health Centre (Core Centre)
 Dr. Mike Kwan giving the talk		 Dr. Henry Yeung and Dr. Mike Kwan presenting souvenir to sponsor	

HKCMA CME Activities

Date	Topic	Speaker/s	Time & Venue
21 January 2025 (Tuesday)	Hong Kong Obesity Society & The Hong Kong Chinese Medical Association Lunch Symposium (Hong Kong Side) New Perspectives and Solutions in Obesity Care	Dr. Michele Mae-ann YUEN Founder and Council Member, Hong Kong Obesity Society	Time: 1:00 pm - 3:00 pm Venue: Conrad Hong Kong
		Prof. Alice CHENG Endocrinologist, Associate Professor, University of Toronto, Canada	
		 Dr. Michele Yuen giving the talk on New Perspectives in Obesity treatment	
21 January 2025 (Tuesday)	Hong Kong Obesity Society & The Hong Kong Chinese Medical Association Lunch Symposium (Kowloon Side) New Perspectives and Solutions in Obesity Care	 Dr. Jane Chan leading the panel discussion on Obesity Management	Time: 1:15 pm - 3:15 pm Venue: The Cityview
		 Prof. Alice Cheng from Canada talking on New Solutions in Obesity Care	
		Dr. Tellus NG Immediate Past President, Hong Kong Obesity Society Prof. Thomas FORST Chief Medical Officer, Clinical Research Services Mannheim, University Mainz, Germany	
21 January 2025 (Tuesday)	Hong Kong Obesity Society & The Hong Kong Chinese Medical Association Lunch Symposium (Kowloon Side) New Perspectives and Solutions in Obesity Care	 Dr. Adrian Cheong leading the panel discussion with Prof. Thomas Forst and Dr. Tellus Ng	Time: 1:15 pm - 3:15 pm Venue: The Cityview
		 Group photo after the lunch symposium	
		 Prof. Thomas Forst from Germany giving the talk on newly available drugs for obesity management	

Date	Topic	Speaker/s	Time & Venue
5 March 2025 (Wednesday)	Impact of influenza and the need for better influenza vaccines in the older adults	Dr. Wong King Ying Specialist in respiratory medicine	Time: 1:00 pm - 3:00 pm Venue: The Chinese Bank's Association Ltd.
7 March 2025 (Friday)	Role of Immunotherapy in Non-Small cell Lung Cancer (NSCLC)	Dr. Carol Kwok Specialist in Clinical Oncology	Time: 1:00 pm - 3:00 pm Venue: Kwai Tsing District Health Centre (Core Centre)
22 March 2025 (Saturday)	Growth Disorders Management - Clinical approach to children with short stature (Dr. Sammy Wong) - Investigations for suspected growth hormone dysfunction (Dr. Yu Chak Man Aaron) - Growth hormone treatment for short stature (Dr. But Wai Man Betty)	Dr. Sammy Wong Dr. Yu Chak Man Aaron Dr. But Wai Man Betty	Time: 1:00 pm - 3:00 pm Venue: Sung Room, Sheraton Hotel, TST
14 September 2025 (Sunday)	2025 Annual Scientific Meeting Management of Chronic Diseases: Bridging Primary and Specialist Care		Time: 9:00 am - 4:50 pm Venue: Cordis Hong Kong

HKCMA Non-CME Activities

Public Education

Date	Topic	Speaker/s	Time & Venue
7 September 2024 (Saturday)	高血壓與腎病	Dr. HO Chung-ping Specialist in Nephrology	Time: 3:00 pm – 4:30 pm Venue: Sham Shui Po District Health Centre
 After health talk, Dr. Henry Yeung, Dr. Albert Kong and Dr. Ho Chung Ping presenting souvenir to Sham Shui Po DHC representative			
19 October 2024 (Saturday)	乳癌	Dr. Carol Chi-hei KWOK Specialist in Oncology	Time: 5:00 pm – 6:30 pm Venue: Sham Shui Po District Health Centre
 Group photo with audience before Dr. Carol Kwok gave her health talk			
9 November 2024 (Saturday)	糖尿病	Dr. Adrian Piers Yan-yue CHEONG Specialist in Cardiology	Time: 3:00 pm – 4:30 pm Venue: Sham Shui Po District Health Centre
  Dr. Adrian Cheong giving the health talk			

Community Service

Date	Activity	Time & Venue
10 November 2024 (Sunday)	慶祝中華人民共和國成立 75 周年 油尖旺區健康日	時間：下午 1 時 30 分至下午 5 時 30 分 地點：梁顯利油麻地社區中心禮堂
 Volunteer doctors gave free consultations at the event		
4 & 5 January 2025 (Saturday & Sunday)	2024 慶祝國慶 75 週年系列活動： 九龍城醫護同心顯關懷	時間：早上 10 時至下午 6 時 地點：九龍紅磡利街 42 號紅磡社區會堂
 Group photo with all participants		 Volunteer doctors in front of HKCMA stall
 Group photo on stage in opening ceremony		

Social Activity

Date	Activity	Time & Venue
24 November 2024 (Sunday)	Social Activity 會員同樂日	時間：下午 2 時至晚上 9 時 地點：參觀東莞康華醫院
9 February 2024 (Sunday)	Social Activity 會員同樂日	時間：上午 9 時至下午 5 時 地點：荔枝窩、吉澳、鴨洲一天遊



HELP YOUR PATIENTS DISRUPT

MODERATE TO SEVERE ATOPIC DERMATITIS



RAPID ITCH RELIEF^{*,1}

RINVOQ® 30 mg achieved significant itch reduction (vs placebo) as early as DAY ONE after treatment initiation¹



PROVEN SKIN IMPROVEMENT²

- EASI-90 at week 16: 62%¹ (RINVOQ® 30 mg) vs 7% (placebo)²
- EASI-75 at week 16: 76%¹ (RINVOQ® 30 mg) vs 15% (placebo)²

* Itch (≥ 4-point improvement in Worst Pruritus NRS from baseline assessed in patients with Worst Pruritus NRS ≥ 4 at baseline) at Day 1 for RINVOQ® 30 mg was a key ranked secondary endpoint
¹ Integrated data at week 16. p<0.001 vs placebo ITT (NRI-C) (placebo-controlled population)
² Data at week 16. p=0.007 vs dupilumab multiplicity-controlled analysis



SUPERIORITY OF RINVOQ® 30 MG VS DUPILUMAB³

- EASI-75 at week 16: 72.4%¹ (RINVOQ® 30 mg) vs 62.6% (DUPILUMAB 300 mg)³
- EASI-90 at week 16: 61.6%¹ (RINVOQ® 30 mg) vs 40.3% (DUPILUMAB 300 mg)³
- Mean improvement in Worst Pruritus NRS at week 16: 67.8%¹ (RINVOQ® 30 mg) vs 49.6% (DUPILUMAB 300 mg)³



EXPERIENCE IN MULTIPLE INDICATIONS^{4,5}

- Well-studied safety profile with long-term exposure (>15,000 patient-years)⁴
- RINVOQ® 15 mg is approved in moderate to severe AD for adolescents from 12 years of age⁵
- Similar safety profile in adolescents and adults using RINVOQ® 15 mg for AD⁵

³ Data at week 16. p<0.001 vs dupilumab multiplicity-controlled ITT (NRI-C)
⁴ Data at week 16. p<0.001 vs dupilumab 300 mg SC Q2W + placebo QD for RINVOQ® (n=342).
⁵ Patient-years of combined exposure to RINVOQ® 15 mg or 30 mg. Data are for RINVOQ® 15 mg in RA, PsA, AS and AD, and RINVOQ® 30 mg in AD only.⁵

For RINVOQ® Abbreviated Prescribing Information, please scan the QR code



Full prescribing information is available upon request. All adverse event should be reported drugsafety.pw@abbvie.com For Healthcare Professionals Only

NEW PERSPECTIVES AND SOLUTIONS IN OBESITY CARE

LUNCH SYMPOSIUM



Date: 21 Jan 2025 (Tue)

Time: 13:00 – 13:30 (Reception)

13:30 – 15:00 (Lunch Symposium)

Venue: Chatham Room, 7/F, Conrad Hong Kong,
Pacific Place, 88 Queensway, Hong Kong

Chairperson:

Speakers:



Dr. Jane Chan
President,
Hong Kong Chinese
Medical Association



Prof. Alice Cheng
Endocrinologist;
Associate Professor,
University of Toronto, Canada



Dr. Michele Yuen
Founder and Council Member,
Hong Kong Obesity Society

REGISTRATION

Scan the QR code



FIRST COME,
FIRST SERVED

AGENDA

Time (HKT)	Topic / Session	Chairperson / Speakers
13:00 – 13:30	Welcome Reception	
13:30 – 14:00	New Perspectives: Treating Obesity Beyond Weight Centricity	Dr. Michele Yuen
14:00 – 14:30	New Solutions: Updates on Latest Advancement in Obesity Care	Prof. Alice Cheng
14:30 – 15:00	Panel Discussion	Dr. Jane Chan Prof. Alice Cheng Dr. Michele Yuen

For enquiries, please contact Mr. Patrick Cheung at 2964 2977 or via waiyin.cheung@network.lilly.com

NEW PERSPECTIVES AND SOLUTIONS IN OBESITY CARE LUNCH SYMPOSIUM

Date: 21 Jan 2025 (Tue)
Time: 13:15 – 13:45 (Reception)
13:45 – 15:15 (Lunch Symposium)
Venue: Crystal Ballroom B & C, 2/F, The Cityview,
23 Waterloo Road, Yau Ma Tei, Kowloon

Chairperson:

Speakers:



Dr. Adrian Cheong
Specialist in Cardiology;
Council Member,
Hong Kong Chinese
Medical Association



Prof. Thomas Forst
Chief Medical Officer,
Clinical Research
Services Mannheim,
University Mainz, Germany



Dr. Tellus Ng
Immediate Past President,
Hong Kong Obesity Society

REGISTRATION

Scan the QR code



FIRST COME,
FIRST SERVED

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For enquiries, please contact Mr. Patrick Cheung at 2964 2977 or via waiyin.cheung@network.lilly.com

HKCMA is inviting private general practitioners and relevant specialists to participate in this highly impactful “Chronic Kidney Disease Screening Programme”!

Join Us!

HONG KONG CHINESE MEDICAL ASSOCIATION LTD.
香港中華醫學會

慢性腎病免費篩查計劃
Chronic Kidney Disease Screening Programme

醫生須知

篩查流程

諮詢醫生意見 → 即場蛋白尿快速測試

陽性病人會被轉介到指定化驗所抽取血液及尿液樣本以作進一步腎功能測試(eGFR及uACR)

3個工作天得知結果 → 家庭醫生致電解釋化驗報告及診斷結果

如確診腎病，病人可與家庭醫生預約收費診症，並安排合適的健康管理方案

蛋白尿快速測試

第1步：將試紙放入尿液樣本大約5秒，請留意尿液樣本的水平必須在兩條黑線之間

第2步：一分鐘後，觀察試紙顏色變化再與蛋白質標準色板比對，便可查出有否微蛋白尿。
陰性：沒有顏色變化/白色
陽性：淡粉色至紅色

此計劃之化驗項目由阿斯利康香港有限公司及拜耳醫療保健有限公司贊助

HONG KONG CHINESE MEDICAL ASSOCIATION LTD.
香港中華醫學會

慢性腎病免費篩查計劃
Chronic Kidney Disease Free Screening Programme

**香港中華醫學會舉辦
慢性腎病免費篩查**
Chronic Kidney Disease Screening Programme
spearheaded by Hong Kong Chinese Medical Association

計劃對象

年滿45歲至80歲人士及具有以下其中一個慢性腎病高風險因素：

糖尿病 高血壓 高血脂 心血管疾病 有腎病家族史 (患腎病者指數×10)

透過微白蛋白尿試紙，即場測試腎臟有沒有受損

請立即向醫生查詢

HONG KONG CHINESE MEDICAL ASSOCIATION LTD.
香港中華醫學會



Scan for registration
as participating doctor



HONG KONG CHINESE MEDICAL ASSOCIATION LTD.

香港中華醫學會有限公司

Tel: 2833 9907

E-mail: info@hk-cma.org.hk

Website: www.hk-cma.org.hk

Address: Room 1612, 16/F, Central Building,
1-3 Pedder Street, Central, Hong Kong

HKCMA Membership Application



For Doctor



For Associate Member