立法會
Legislative Council

LC Paper No. CB(2)1671/14-15(08)

Ref : CB2/PL/HS

Panel on Health Services

Updated background brief prepared by the Legislative Council Secretariat for the meeting on 15 June 2015

Drug Formulary of the Hospital Authority

Purpose

This paper summarizes the concerns of the members of the Panel on Health Services ("the Panel") on issues relating to the Drug Formulary of the Hospital Authority ("the Formulary").

Background

2. The Hospital Authority ("HA") has implemented the Formulary since 2005 with a view to ensuring equitable access by patients to cost-effective drugs of proven safety and efficacy by standardizing the drug policy and drug utilization in all public hospitals and clinics. HA appraises new drugs and reviews the prevailing drug list in the Formulary regularly through an established mechanism.

3. At present, there are around 1 300 standard drugs in the Formulary. These drugs are provided within the standard fees and charges at public hospitals and clinics when prescribed under specified clinical conditions. Standard drugs can be classified into two categories, namely, General Drugs which have well-established indications and cost-effectiveness, and are available for general use by doctors of public hospitals and clinics; and Special Drugs which have to be used under specified clinical conditions with specific specialist authorization. For patients who do not meet the specified clinical conditions but choose to use Special Drugs, they will have to pay for the drugs. HA's expenditure on General Drugs and Special Drugs prescribed to patients at

standard fees and charges is $4,078 million and $4,277 million in 2013-2014 and 2014-2015[1] respectively. As at January 2015, there are 897 General Drugs and 338 Special Drugs in the Formulary[2].

4. For those drugs which are not standard drugs in the Formulary, patients have to purchase these drugs at their own expense. These self-financed items are categorized into those with safety net and those without safety net. The former are drugs which are proven to be of significant benefits but extremely expensive for HA to provide as part of its subsidized service. Patients who need these drugs but have financial difficulties can receive subsidy from the Samaritan Fund[3] to fully or partially cover their expenses on these drugs. At present, 21 self-financed drugs are covered in the scope of the Samaritan Fund. Self-financed drugs without safety net include (a) drugs which have preliminary medical evidence only; (b) drugs with marginal benefits over available alternatives but at significantly higher costs; and (c) lifestyle drugs (e.g. weight loss drugs). At present, HA supplies three categories of self-financed drugs at cost for purchase by patients. These include items not easily accessible in the community; items covered by the safety net of the Samaritan Fund; and items that need to be supplied for operational convenience (e.g. injection drugs).

Deliberations of the Panel

5. The Panel held a number of meetings between 2005 and 2014 to discuss issues relating to the Formulary and received the views of deputations at four meetings. The deliberations and concerns of members are summarized in the following paragraphs.

Management of the Formulary

6. Noting that a high-level Drug Management Committee ("DMC") was set up by HA in 2013 to replace the former Drug Utilization Review Committee, members were concerned about the overall drug management and governance in the Formulary. HA advised that DMC took charge of the Formulary management at the policy level and oversaw the Drug Advisory Committee

---

[1] The projection in 2014-2015 is based on expenditure figure as at 31 December 2014.

[2] A drug may fall in more than one category due to different therapeutic indications or dose presentations.

[3] Established in 1950, the Samaritan Fund is a charitable fund to provide financial assistance to needy patients to meet expenses on designated privately purchased medical items (including drugs) or new technologies required in the course of medical treatment which are not covered by hospital maintenance or outpatient consultation fees in public hospitals and clinics. In June 2012, the Finance Committee of the Legislative Council approved a commitment of $10 billion for a grant to support the continued operation of the Fund for the next 10 years or so.

("DAC") and the Drug Formulary Committee ("DFC"), which was respectively responsible for regular appraisal of new drugs every three months and review of the prevailing drug list of the Formulary every 18 to 24 months. In discharging their functions, DAC and DFC were supported by multiple expert panels which provided professional views for the review of drugs in related specialty areas.

Introduction of new drugs and review of existing drugs in the Formulary

7. Members noted that the evaluation of new drugs and review of existing drugs followed an evidence-based approach, having regard to the principles of efficacy, safety and cost-effectiveness and taking into account various factors, including international recommendations and practices, changes in technology, pharmacological class, disease state, patient compliance, quality of life, actual experience in the use of drugs, comparison with available alternatives, impacts on healthcare costs and views of professionals and patients groups. Noting that cost-effectiveness was one of the principles for assessing the drugs, members were concerned about whether HA would compromise patients' interests to save money. Question was also raised about the weighting of the factors of efficacy, safety and cost effectiveness in evaluating the new or existing drugs.

8. HA advised that public resources should be utilized with maximal effect of healthcare to ensure equitable access by patients to cost-effective drugs. This notwithstanding, the evaluation of drugs would foremost be based on the latest scientific evidence on the safety and efficacy of drugs. The factor of cost-effectiveness would only come into play when a drug was proved to be of benefits to patients. In general, HA made reference to the National Institute for Health and Care Excellence of the United Kingdom for consideration of the cost-effectiveness of some self-financed drugs under review.

9. Some members considered that HA should accord a higher priority to drugs with same efficacy but fewer side effects. More new psychiatric drugs and target therapy drugs for treating cancers should also be included in the Formulary as General Drugs and Special Drugs. There was also a call for HA to reposition more Special Drugs for chronic diseases in the Formulary as General Drugs. The Administration advised that HA had introduced a number of new drugs to the Formulary, repositioned self-financed drugs as Special Drugs and expanded the clinical applications of Special Drugs in the Formulary in recent years. With the increased funding from the Government, HA would reposition most oral anti-psychotic drugs from the Special Drugs to General Drugs in the Formulary in 2014-2015.

10. On the question about whether DAC's decisions on new drug applications could be reviewed, HA advised that there was no limit on the number of applications. Unsuccessful applicants could re-submit their applications providing further information of the reviewed drugs for re-consideration of DAC. To enhance operational transparency, the outcome of each individual drug applications for inclusion in the Formulary, together with a list of references that had been taken into account in the process of considering each drug application, were uploaded to HA's internet and intranet websites after each DAC meeting.

Provision of drugs at individual cluster or hospital of HA

11. Members expressed grave concern about the variation in the provision of drugs across different clusters due to the difference in their size of budget for purchasing drugs; as well as the time lag between the inclusion of a new drug in the Formulary and the date the drug was included in the drug list of a cluster or hospital. There was a view that the prevailing arrangement to allow each cluster or hospital to decide on their own the drugs to be included in its drug list was at variance with the objective of introducing the Formulary.

12. According to the Administration and HA, given that not all public hospitals provided exactly the same range of clinical services, mechanisms were in place for public hospitals to formulate their local drug formulary by selecting suitable drugs from the Formulary in light of service needs. HA clinicians would prescribe suitable treatments having regard to patients' clinical needs and established clinical guidelines. The financial position of hospital clusters would not affect the prescription of appropriate treatment for patients.

Engagement with patient groups in the development of the Formulary

13. Members noted that HA had established a formal consultation mechanism with patient groups on the Formulary, under which two consultation meetings would be held every year to inform patients of the latest developments of the Formulary, understand their major concerns, and solicit their views and suggestions on introduction of new drugs and review of existing drugs in the Formulary. The patient groups would be given two months' time after the consultation meetings to submit their views to HA. Question was raised as to whether HA would invite representatives of the patient groups to become members of DAC and DFC.

14. HA advised that the views and suggestions submitted by patient groups under the consultation mechanism would be presented to the relevant drug committees for consideration. In addition, the Chief Executive of HA would regularly meet with patient representatives to collect their views on various

areas of patient services, including matters related to the Formulary, through the Patient Advisory Committee set up in 2011. Ad hoc meetings would also be convened with individual patients groups to discuss specific issues of concerns where necessary. There was a suggestion that an independent mechanism should be set up to review the Formulary and to receive complaints from patients concerning the use of drugs at public hospitals and clinics.

Financial assistance to needy patients

15. Members were concerned about the financial burden imposed by the extremely expensive self-financed drugs on patients, especially those suffering from cancers and chronic diseases. Question was raised as to whether the expenses borne by each patient for purchasing self-financed drugs could be capped at, say, $100,000 each year, and the amount exceeding the cap would be covered by HA as part of its subsidized services. There was also a view that patients' expenditure on self-financed drugs should be tax deductible.

16. The Administration stressed that it was its long-standing policy that no patients would be denied adequate medical treatment due to a lack of means. Needy patients could apply for assistance from the Samaritan Fund to meet expenses on self-financed drugs or seek fee waiver from HA. The First Phase Community Care Fund Medical Assistance Programme would also provide financial assistance to needy HA patients for the use of specified self-financed drugs which had not been brought into the safety net of the Samaritan Fund but had been rapidly accumulating medical scientific evidence and with relatively high efficacy.

17. Some members remained of the view that drugs which were proven to be of significant benefits should be covered by the standard fees and charges in public hospitals and clinics, rather than being classified as self-financed drugs with safety net. To ensure an efficient use of the $10 billion grant to the Samaritan Fund, there was a suggestion that HA should review the Formulary and expand the scope of the Fund to cover more self-financed drugs such as cancer drugs.

Recent developments

18. The Financial Secretary announced in his 2015-2016 Budget Speech that more drugs with proven efficacy would be incorporated into the Formulary. The additional recurrent financial requirements for widening the therapeutic application of interferon beta (i.e. a Special Drug in the Formulary) for treating multiple sclerosis, and introducing five new drugs classes for specified clinical

conditions into the Formulary for treating cancer, chronic Hepatitis C and Crohn's Disease is $44.5 million. It is estimated that more than 4 000 patients would be benefit each year.

Relevant papers

19. A list of the relevant papers on the Legislative Council website is in the **Appendix**.

Council Business Division 2
Legislative Council Secretariat
9 June 2015

Appendix

Relevant papers on the Drug Formulary of the Hospital Authority

Committee	Date of meeting	Paper
Panel on Health Services	31.1.2005 (Item I)	Agenda Minutes CB(2)1049/04-05(01) *(Chinese version only)*
Panel on Health Services	8.3.2005 (Item I)	Agenda Minutes
Panel on Health Services	13.6.2005 (Item V)	Agenda Minutes CB(2)2705/04-05(01)
Panel on Health Services	10.7.2006 (Item IV)	Agenda Minutes CB(2)3090/05-06(01) CB(2)747/06-07(01)
Panel on Health Services	25.9.2006 (Item I)	Agenda Minutes
Panel on Health Services	8.1.2007 (Item VI)	Agenda Minutes
Panel on Health Services	23.1.2007 (Item I)	Agenda Minutes CB(2)1894/06-07(01)
Panel on Health Services	12.2.2007 (Item III)	Agenda Minutes
Panel on Health Services	24.6.2008 (Item I)	Agenda Minutes CB(2)23/08-09(01)
Panel on Health Services	8.6.2009 (Item VI)	Agenda Minutes

Committee	Date of meeting	Paper
Panel on Health Services	19.6.2009 (Item I)	Agenda Minutes
Panel on Health Services	14.2.2011 (Item VI)	Agenda Minutes CB(2)1602/10-11(01)
Panel on Health Services	14.6.2011 (Item I)	Agenda Minutes
Panel on Health Services	17.3.2014 (Item III)	Agenda Minutes CB(2)2053/13-14(01)

Council Business Division 2
Legislative Council Secretariat
9 June 2015