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Panel on Health Services

Background brief prepared by the Legislative Council Secretariat for the meeting on 8 June 2009

Drug Formulary of the Hospital Authority

Purpose

This paper gives an account of the past discussions by the Panel on Health Services (the Panel) on the Drug Formulary (the Formulary) of the Hospital Authority (HA).

Background

Need for introducing the Formulary

2. An HA-wide Formulary was implemented by phases between July and October 2005 to ensure equitable access to cost effective drugs of proven efficacy and safety, through standardisation of drug policy and utilisation in all public hospitals and clinics.

Drugs on the Formulary

3. The HA Formulary contains two categories of drugs, namely General Drugs and Special Drugs, both of which are provided within the standard fees and charges. General Drugs refer to drugs with well-established indications and effectiveness which are available for general use as indicated by the patients' clinical conditions. Special Drugs refer to drugs which are to be used under specified clinical conditions with specific specialist authorisation.

Drugs outside the Formulary

4. Four main types of drugs, guided by the principles of evidence-based medical practice, targeted subsidy and opportunity costs considerations, have not been included in the Formulary and patients have to purchase these self-financed item (SFI) drugs at their own expenses. They include -

(a) drugs proven to be of significant benefits but extremely expensive for HA to provide as part of its subsidised service;

(b) drugs which have preliminary medical evidence only;

(c) drugs with marginal benefits over available alternatives but at significantly higher costs; and

(d) life-style drugs.

Most of these drugs are already self-financed by patients before the implementation of the Formulary in HA.

Mode of supply of SFI drugs

5. Patients on SFI drugs would be referred to the private market for acquisition. SFI drugs will be supplied by HA to patients only when they are -

(a) items not easily accessible in the community (e.g. dangerous drugs as defined under the Dangerous Drugs Ordinance (Cap. 134); certain psychiatric drugs, oncology drugs and immunosuppressives);

(b) items covered by the Samaritan Fund; and

(c) items which have to be supplied for operational convenience (e.g. drugs needed by in-patients and day-patients, drugs to be administered by injection).

Support for patients who are unable to afford SFI drugs

6. Needy patients who require the use of drugs which are proven to be of significant benefits but with significant cost burden for HA to provide as part of its standard service may apply to the Samaritan Fund for partial or full subsidy. All SFI drugs with potential for safety net coverage are considered by the HA Board. The decision on whether safety net coverage should be extended to specific SFI drugs would be made on the basis of a number of factors, including safety, efficacy, effectiveness, cost effectiveness, health impact, equity and patients' choice, societal values and ethical factors, the overall provision of public health care services by HA and the potential financial impact on the Samaritan Fund. Currently, eight SFI drugs are covered by the Samaritan Fund.

Past discussions

Reason for introducing the Formulary and impact on patients

7. At the meeting on 31 January 2005, the Administration briefed the Panel on the proposed introduction of a Formulary in all HA hospitals and clinics. A special meeting was subsequently held by the Panel on 8 March 2005 to receive views from 14 patients groups and other organisations concerned on the subject matter.

8. Whilst members had no objection in principle to the policy of standardisation of drugs in all HA hospitals and clinics, concern was raised about its impact on patients and that the proposal represented a fundamental change in public health policy which had all along been that public hospitals provided the same medical treatment to patients with the same illness regardless of their means. Although a safety net would be available, some might fail to meet the eligibility criteria for subsidy by a narrow margin and had to exhaust their lifelong savings to pay for the necessary drug charges.

9. The Administration explained that the Formulary was a measure to ensure equity and fairness in access to drugs of proven clinical efficacy and therapeutic effectiveness. The Formulary included more than 1 200 types of drugs covering the majority of drugs required by patients, in particular the elderly and the chronically ill. More than 60 types of drugs included in the Formulary were for the treatment of cancer-related diseases. The Administration also pointed out that with increasing knowledge of patients on alternative therapeutic options, the choice of patients who wished to try options outside the Formulary should be respected.

10. The Administration further explained that at present some expensive drugs, such as Glivec, were already self-financed by patients. One important aspect of the Government's healthcare policy was that patients who could afford to pay should contribute to the drug expenses, whereas those in genuine hardship were given assistance under the targeted subsidy principle.

11. At the meeting on 13 June 2005, the Administration briefed the Panel on the views received from the three-month consultation exercise on the proposed Formulary. Members were advised that there was general support for HA's proposal to standardise the Formulary at public hospitals and clinics and HA was planning to roll out the Formulary by phases starting with the New Territories East Cluster in mid-July 2005, with other hospital clusters following in the ensuing months. HA would take a gradual approach in implementing the Formulary to minimise the impact on patients.

12. Some members, including Hon LEUNG Kwok-hung and Hon Albert HO, maintained the view that all drugs with significant clinical efficacy, regardless of their prices, should be included in the Formulary.

13. The Administration stressed that the purpose of developing the Formulary was to standardise the drug list and not to cut down on HA's drug expenditure. It was pointed out that no public sector or health insurance system could afford to supply or reimburse all medicines that were available in the drug market for the patients. In places elsewhere, such as the United Kingdom, a drug formulary was in place concurrently with healthcare financing strategies and medical insurance, as it helped to ensure high standard of medical practice, delivery of effective treatment and rational use of resources. The vast majority of drugs which were of benefit to patients were included in the proposed Formulary, and most of the expensive drugs which were of significant benefit to patients were covered under the safety net. The number of patients taking expensive drugs not covered by the safety net was not great. With clear guidelines and assessment criteria for determining eligibility of applicants seeking assistance, the vetting process would be expedited.

Introduction of new drugs into the Formulary

14. The Administration briefed the Panel on the results of its review on the Formulary on 10 July 2006, which proposed, inter alia, to draw up a set of more explicit evaluation criteria for the introduction of new drugs into the Formulary. The criteria included (a) efficacy versus alternatives; (b) efficacy versus placebo; (c) efficacy (no comparator); (d) safety; (e) drug cost versus alternatives; (f) cost impact to HA; (g) overseas reimbursement status; and (h) other considerations (e.g. patient compliance and cost effectiveness studies).

15. Noting that two of the evaluation criteria were drug cost versus alternatives and cost impact to HA, concern was raised as to whether HA would compromise patients' interests to save money.

16. HA explained that in the development of the Formulary, HA was guided by the principle that public resources should be utilised with maximal effect of healthcare, and had equitable access by all patients. Other core values included evidence-based medical practice, rational use of public resources, targeted subsidy and opportunity cost considerations, and facilitation of patient's choice.

17. On the suggestion that the decision of introducing new drugs into the Formulary should be made by a committee comprising people from outside HA, such as representatives from patient groups and the academia, HA did not see the need for such as HA had already set up an Expert Panel comprising

professionals, such as pharmacists and academics in pharmacology from outside HA.

18. In response to members' enquiry about the time taken to introduce new drugs into the Formulary, HA advised that with the evaluation criteria being made more explicit to the pharmaceutical industry, the time taken to do so could be shortened from the present some six months to three months.

Mode of supply of SFI drugs

19. At the meeting on 10 July 2006, members were advised about HA's proposal to expand the supply of SFI drugs at HA pharmacies to cover all SFI drugs prescribed to patients by HA doctors. HA explained that the proposal was made having regard to the feedback gathered from many patients about their difficulties in verifying the authenticity of drugs and in identifying their source. Some chronic patients also cited access problems in the community, recounting experience where they had to visit multiple community pharmacies to procure all the different drugs required. In order to minimise interference with the private market, prices for the expanded SFI drugs supplied by HA (i.e. SFI drugs not within the existing three categories mentioned in paragraph 5 above) would be set at rates which were comparable to the levels in the market so as not to restrict patients' choice from obtaining SFI drugs from other sources.

20. Dr Hon Joseph LEE asked HA the reason for ignoring the call from the pharmaceutical industry to allow community pharmacies to be set up in HA hospitals to sell SFI drugs to HA patients.

21. HA responded that it was neutral on how SFI drugs should be supplied to HA patients, so long as the mode of supply was in the best interests of patients. Hitherto, no decision had yet been on the mode of supply of SFI drugs to HA patients. In taking forward the proposal of allowing community pharmacies to set up pharmacies in HA hospitals to sell SFI drugs, several issues needed to be considered. First, the annual sale volume of SFI drugs might be too small to spread among private pharmacies for them to be viable. Second, leaving the supply of SFI drugs to HA patients to the private sector might lead to monopoly by large companies. Third, the quality and safety of SFI drugs sold at HA hospitals had to be assured. A meeting with the trade would be arranged in the coming week to discuss the viability of involving the trade in the supply of SFI drugs to HA patients.

22. At the meeting on 25 September 2006, HA briefed members on the latest progress in its discussion with the private sector on the supply of SFI drugs to HA patients. Members noted that subsequent to the Panel meeting in July 2006, HA held two high-level meetings with representatives of the Practicing Pharmacists Association of Hong Kong, the Hong Kong General

Chamber of Pharmacy Limited and two major retail pharmacy groups in Hong Kong to exchange views on possible private-public collaboration in the supply of SFI drugs in public hospitals. The private sector representatives welcomed the opportunity to work with HA on the supply of SFI drugs to public patients. They also agreed that further discussion at the working level was necessary to work out the framework of a collaboration model between HA and the private sector. To that end, a Task Group, comprising representatives of HA and four private sector parties, was formed to take the discussion forward. Members also noted that following three meetings held between August and early September 2006, the Task Group had reached preliminary consensus on inviting private sector participation by tender for the setting up of community pharmacies in public hospitals to supply SFI drugs to public patients.

23. The Panel also listened to the views of seven deputations, including representatives from the Consumer Council, patient groups, the medical sector, the pharmaceutical trade and pharmacists' organisations, on the mode of supply of SFI drugs to HA patients. Generally speaking, the Consumer Council and patient groups welcomed the supply of SFI drugs by HA, as this would provide an assurance of continuous supply, quality, safety, reasonable prices and convenience. On the other hand, the Hong Kong Medical Association and the pharmacists' organisations considered that public-private collaboration in the supply of SFI drugs was the solution that would truly benefit patients. They were further of the views that to allow HA to supply all SFI drugs was not conducive to raising the professional standards of community pharmacists and would further exacerbate the imbalance between the public and the private sectors. The Hong Kong Association of the Pharmaceutical Industry had no preference on the mode of supply of SFI drugs to HA patients, so long as such mode of supply could provide patients with a safe, high quality, convenient and continuous source of drug supply at reasonable prices.

24. The main views expressed by members together with HA and the Administration's responses are outlined in the following paragraphs.

25. Some members, including Hon LI Fung-ying, expressed the view that although the proposal of HA supplying SFI drugs to public patients had merits, the proposal raised a concern over conflict of interest, having regard to the fact that the list of SFI drugs was determined by HA and that any revenue to be generated from the supply of SFI drugs would be fully ploughed back to HA as it saw fit. There was also the question of the appropriateness for HA, being a public organisation, going into business as a retailer of medicines and competing with the private pharmacies for the business.

26. The Administration responded that there was no cause for concern of conflict of interest if HA were to supply SFI drugs to its patients, as the operation of the supply of SFI drugs by HA pharmacies, if implemented, would be made open and transparent for scrutiny by the public. Moreover, HA was

accountable to the Legislative Council (LegCo) and stood ready to answer any queries on its operation.

27. A member cautioned that the proposal of HA inviting private sector participation by tender for the setting up of community pharmacies in public hospitals to supply SFI drugs to public patients would likely be monopolised by large retail pharmacy groups whose profit-driven nature would likely lead to an increase in drug prices.

28. The Administration pointed out that the rationale for supplying SFI drugs in the pharmacies in public hospitals was to facilitate patients' choice and provide them convenience. Revenue generation had never been HA's concern in the supply of SFI drugs to its patients.

29. In response to members' enquiry as to why patient groups had not been involved in the discussion of private-public collaboration in the supply of SFI drugs in public hospitals, HA advised that it had consulted representatives of patient groups on the matter prior to the meeting. Although these representatives preferred the supply of SFI drugs by HA pharmacies, they had no objection to private sector participation by tender in the supply of SFI drugs in public hospitals.

30. Dr Hon Joseph LEE was of the view that HA should involve patient groups in the formulation of tender specifications and in the monitoring of the operation of the community pharmacies set up in public hospitals to supply SFI drugs to HA patients.

31. HA responded that it would consider involving patient groups in the formulation of tender specifications, as the overall HA objective of supplying SFI drugs to its patients was that it must be in the best interests of patients. HA also explained that the reason for HA to supply SFI drugs to its patients if no suitable private sector participant could be identified was to cater for the eventuality that the project was found to be not viable or of no market interest. HA would need to seek the approval of the HA Board if there came the need for HA to supply SFI drugs to its patients.

32. Hon Audrey EU asked how HA could ensure that prices of SFI drugs set by private sector participants would be at reasonable levels, having regard to the fact that the supply of drugs in the private market was dominated by two major pharmacy retail groups.

33. HA responded that the findings of a recent survey conducted by HA on the pricing of drugs by the community pharmacies revealed no sign of any price monopoly by the major retail pharmacy groups, which could be attributed to the wide range of prices set by different pharmacies for the same types of

drugs generally. To ensure that SFI drugs to be supplied by community pharmacies in public hospitals would be set at reasonable levels, the private sector participants had to provide an assurance that the pricing of these drugs would be benchmarked against market prices. In addition, consideration was being given to incorporating a price-capping strategy on SFI drugs which the private sector participants could charge. To prevent the tender from being monopolised by the major retail pharmacy groups in Hong Kong, HA advised that terms would be incorporated in the tender specification to facilitate fair competition by small community pharmacies.

34. At the meeting on 12 February 2007, members agreed that it might be better for the Panel to decide whether to pursue the issue after the HA Board had come to a view on the mode of supply of SFI drugs as the issue had been thoroughly discussed by members on 25 September 2006 and 23 January 2007. The Administration was requested to report to the Panel when the HA Board had come to a view on the supply of SFI drugs before implementation.

Relevant papers

35. Members are invited to access LegCo's website (http://www.legco.gov.hk) for details of the relevant papers and minutes of the meetings of the Panel held on 31 January 2005, 8 March 2005, 13 June 2005, 10 July 2006, 25 September 2006, 8 January 2007 and 23 January 2007.

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