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Panel on Welfare Services and Panel on Health Services

Joint Subcommittee on Long-term Care Policy

Updated background brief prepared by the Legislative Council Secretariat for the meeting on 18 July 2017

Policy on subsidizing chronic patients for purchasing expensive drugs

Purpose

This paper gives an account of past discussions of the Council and its committees regarding policy on subsidizing chronic patients for purchasing expensive drugs.

Background

2. According to the Administration, patients may apply for financial assistance from relevant charitable funds (such as the Samaritan Fund ("SF")) to purchase designated self-financed drugs which are not Standard Drugs[1] in the Drug Formulary ("the Formulary") implemented by the Hospital Authority ("HA").

3. Established in 1950, SF aims to provide financial assistance to needy patients, who meet the specified clinical criteria and pass the means test, for meeting expenses for designated Privately Purchased Medical Items (including home use equipment and appliances, expensive medical procedures and self-financed 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. Financial assessment is conducted by Medical Social Workers.

[1] Standard Drugs can be classified into General Drugs which have well-established indications and 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.

4. For drug items, partial or full subsidy can be provided through the SF safety net to needy patients to cover their expenses on drugs proven to be of significant benefits but extremely expensive for HA to provide as part of its subsidized service under the Formulary[2]. Under the SF mechanism, financial assistance will be granted if the estimated cost of the drug is above the patients' maximum annual contribution payable, the calculation of which is based on the applicant's annual disposable financial resources, i.e. the sum of the patient's annual household disposable income and disposable capital. With the relaxation of the financial assessment criteria since 1 September 2012, a deductible allowance is also provided when calculating the value of disposable capital of the patient's household. The tiers of patients' contribution ratio for drug expenses are also simplified from the past 12 bandings to the present seven bandings.

5. The operation of SF mainly relies on donations and Government subsidies. HA is charged with the responsibility of managing SF and will seek additional funding from the Administration if necessary. In view of the ageing population, advancement in medical technology and changing coverage of the SF safety net, the Administration provided a $10 billion grant to SF in 2012 which is expected to be able to sustain the operation of SF for about 10 years.

6. To support HA patients to purchase self-financed cancer drugs which have not yet been brought into the SF safety net and benefit needy patients who marginally fall outside the SF safety net for the use of specified self-financed drugs, the Administration introduced First Phase and Second Phase of the Community Care Fund ("CCF") Medical Assistance Programmes in August 2011 and January 2012 respectively. The Second Phase has been incorporated into the regular mechanism of SF with effect from 1 September 2012.

7. According to the Administration, a new CCF assistance programme is proposed to provide subsidy for needy patients of HA who are in financial difficulty and meet specific clinical criteria to purchase ultra-expensive drugs (including those for treating uncommon disorders) for early treatment. The programme will be launched in August 2017. The first budget will cover 20 months with a total funding provision of $117.348 million. It is expected that about 10 to 16 patients will benefit in the first 12 months.

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[2] The safety net of SF does not cover the other three self-financed drug categories, namely (a) drugs which have preliminary medical evidence only; (b) drugs with marginal benefits over available alternatives but at significantly higher costs; and (c) life-style related drugs (e.g. weight loss drugs).

Deliberations by Members

Safety net for self-financed drugs

8. 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 a 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.

9. 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 SF to meet expenses on self-financed drugs or seek fee waiver from HA. The CCF Medical Assistance Programme also provided financial assistance to needy HA patients for the use of specified self-financed drugs which had not been brought into the SF safety net but had been rapidly accumulating medical scientific evidence and with relatively high efficacy.

10. Some Members considered 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 items with safety net. Given that HA was responsible for determining the drugs to be introduced and categorized as self-financed drugs with safety net as well as managing SF, they considered that SF might be used as a justification by HA for excluding drugs which had been proven to be of significant benefits but were extremely expensive to provide in the Formulary. To ensure an efficient use of the $10 billion grant to SF, there was a suggestion that HA should review the Formulary and expand the scope of SF to cover more self-financed drugs such as cancer drugs.

11. Some Members considered that the number of self-financed drugs currently covered under SF and the CCF Medical Assistance Programme was far from adequate to meet the needs of patients in need of expensive drug treatments. These Members asked whether HA had conducted any analysis on the types of diseases which required expensive drug treatments not being covered by SF.

12. HA advised that the coverage of the Formulary was driven by service needs. Hence, all applications for new drug listing would be initiated by HA clinicians and submitted to the Drug Advisory Committee for consideration via the Cluster or Hospital Drug and Therapeutics Committee. Drugs which had

been proven to be of significant clinical benefits but were extremely expensive for HA to provide as part of its standard services would be positioned as self-financed drugs with safety net. For those ultra-expensive drugs for uncommon disorders, HA would liaise with the drug suppliers with a view to mapping out the way forward for providing sustainable drug treatments for patients with these diseases.

13. Members noted that during the period from 2010-2011 to 2015-2016, HA had conducted sample checks on 1 369 approved financial assistance cases for purchasing self-financed drugs under SF and the CCF Medical Assistance Programme. They were concerned that under-reporting of income and/or assets had been found in 591 cases (i.e. 43%), involving overpayment of $5.4 million subsidy. According to HA, it would take actions to recover the overpaid amounts for cases involving overpayment of subsidy and report suspected fraud cases to the police for investigation. HA had enhanced patient education in this regard in order to safeguard proper use of public funds. Among the cases of post-approval checks, there was a decreasing trend of under-reporting cases with overpayment of subsidy from 27% in 2010-2011 to 1% in 2015-2016.

Financial assessment for drug subsidies

14. Some Members took the view that income of the extended family members living with the patients should not be counted as the patients' household income when assessing the financial condition of the applicants for drug subsidies. They suggested that patients living with their family members should be allowed to apply for assistance from the drug subsidy schemes on an individual basis, and the maximum contribution to drug expenses payable by patients should be lowered. A high-level committee should also be set up for the exercise of discretion to grant approval for subsidy to patients who fell marginally outside the safety net.

15. The Administration advised that the practice of using patients' household income in assessing the level of subsidy granted under SF was in line with other safety nets funded by public money, such as public housing, student loans, legal aid and the Comprehensive Social Security Assistance. The rationale was to encourage family members to support each other and to prevent the avoidance of responsibility by resorting to public assistance in the first instance. After taking into account public opinions and the definitions of "family" adopted by other existing financial assistance schemes in Hong Kong, SF would amend its definition of "family" and count only the patient and the core family members living together with him/her (including parents, spouse, children, and brothers and sisters who were under 18 years old or who were 18 to 25 years old and receiving full-time education or adults with disabilities) in the financial

assessments. The above amendments would also be applicable to applications under the CCF Medical Assistance Programme.

16. The Administration further advised that it had proposed to implement a pilot CCF programme subsidizing eligible patients to purchase ultra-expensive drugs, and to adjust the financial assessment criteria of the proposed programme accordingly by setting a ceiling on the contribution rate of the patients and introducing a maximum annual contribution. Through the proposed new CCF assistance programme, the feasibility of the above adjusted financial assessment criteria would be tested. The Administration and HA would monitor progress of the proposed programme, actively solicit public opinions, continuously review the existing drug subsidy schemes (including those under SF and the CCF Medical Assistance Programmes) and make enhancements where necessary to benefit more needy patients.

Drugs for patients with rare diseases

17. Some Members raised concern over the drug treatments for rare diseases. They considered that the Administration should provide a clear definition and policy on rare diseases to support patients suffering from these diseases. They also suggested developing a territory-wide database for rare diseases to provide a profile of the common types of such diseases in Hong Kong, so as to foster scientific research and facilitate support for patients with rare diseases.

18. According to the Administration, there was no common definition of rare diseases worldwide. The definition of rare diseases in different countries varied depending on their healthcare systems and situations. HA managed uncommon disorders by putting in place an independent expert panel to formulate treatment protocols for specific uncommon disorders and evaluate the efficacy of treatments on individual patients. The Administration had allocated an additional annual recurrent funding amounting to $75 million to HA in phases to meet the increasing demand for ultra-expensive drug treatments for uncommon disorders. Currently, ultra-expensive drug treatments for six types of lysosomol storage disorders (namely Pompe, Gaucher, Fabry and Mucopolysaccharidosis Types I, II and VI) were provided for individual patients at standard fees and charges when the treatments were proven to be of significant clinical benefits to the patients concerned.

19. Some Members called on HA to include in the Formulary more target therapy drugs for treating cancers and drugs for treating rare diseases, which were usually very expensive. According to HA, drug treatments for uncommon disorders could be extremely expensive and amounted to as high as $4 million a year. HA had been actively liaising with the drug suppliers with a view to formulating a sustainable financial arrangement to support the patients

concerned. A mechanism was in place for HA to provide the ultra-expensive drug treatments for individual patients at standard fees and charges in emergency situations.

Relevant papers

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

Council Business Division 2
Legislative Council Secretariat
13 July 2017

Appendix

Relevant papers on
policy on subsidizing chronic patients for purchasing expensive drugs

Committee	Date of meeting	Paper
Panel on Health Services	10 November 2008 (Item IV)	Agenda Minutes
	8 June 2009 (Item VI)	Agenda Minutes
	19 June 2009 (Item I)	Agenda Minutes
	14 February 2011 (Item VI)	Agenda Minutes CB(2)1602/10-11(01)
	14 June 2011 (Item I)	Agenda Minutes
	14 November 2011 (Item VI)	Agenda Minutes
	16 April 2012 (Item IV)	Agenda Minutes
	10 July 2012 (Item II)	Agenda Minutes
Subcommittee on Poverty	24 May 2013 (Item II)	Agenda Minutes
	17 December 2013 (Item I)	Agenda Minutes
Panel on Health Services	17 March 2014 (Item III)	Agenda Minutes CB(2)2053/13-14(01)
Joint Subcommittee on Long-term Care Policy	24 March 2014 (Item I)	Agenda Minutes

Committee	Date of meeting	Paper
Panel on Health Services	15 June 2015 (Item V)	Agenda Minutes
	19 December 2016 (Item III)	Agenda Minutes
	20 March 2017 (Item VI)	Agenda
Legislative Council	24 May 2017	Official Record of Proceedings Pages 8149-8160
Panel on Home Affairs	26 June 2017 (Item III)	Agenda

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