For Information
on 19 June 2018

Legislative Council Panel on Health Services

Update on Samaritan Fund and Community Care Fund Medical Assistance Programmes

PURPOSE

This paper provides an update on Samaritan Fund (SF) and Community Care Fund (CCF) Medical Assistance Programmes.

BACKGROUND

2. In Hong Kong, public healthcare services are heavily subsidised by the Government. It is the Government's public healthcare policy to ensure that no one is denied adequate medical treatment due to lack of means. As the major provider of public healthcare services in Hong Kong, the Hospital Authority (HA) strives to provide optimal care for all patients. Patients are provided with medical items or drugs at highly subsidised rates based on their clinical needs and in accordance with HA's treatment guidelines.

3. As a publicly-funded healthcare organisation, HA has to ensure rational use of public resources so as to protect public health and patients' interest. Guided by the principles of evidence-based medical practice, targeted subsidy and opportunity cost consideration, the standard fees and charges in public hospitals and clinics do not apply to designated Privately Purchased Medical Items (PPMI) and self-financed drugs (both with or without safety net coverage). While patients who need these items/drugs and have the ability to pay for their costs have to purchase at their own expense, financial assistance is provided through the SF and CCF Medical Assistance Programmes to subsidise the medical expenses of patients who have financial difficulties for PPMI and specified self-financed drugs.

SAMARITAN FUND

4. For self-financed drugs that are proven to be of significant benefits but very expensive for HA to provide as part of its subsidised services; or designated PPMI not covered by the standard fees and charges in public hospitals and clinics, HA provides financial assistance for needy patients through the safety net of SF[1]. As at June 2018, the SF covers 29 self-financed drugs for treating different types of diseases and 9 categories of non-drug items (details at **Annex A**). The amount of subsidies granted under the SF has increased from $328.5 million in 2012-13 to $515.7 million in 2017-18.

CCF MEDICAL ASSISTANCE PROGRAMMES

5. In addition to the SF safety net, the CCF provides assistance for people with financial difficulties, in particular those who fall outside the social safety net or those within the safety net but have special circumstances that are not covered. The CCF also considers implementing measures on a pilot basis to help the Government identify those that can be considered for incorporation into its regular assistance and service programmes.

6. In August 2011, the HA introduced the CCF Medical Assistance Programme (First Phase Programme) to provide subsidy for needy patients to purchase specified self-financed cancer drugs which have been rapidly accumulating medical scientific evidence and with relatively higher efficacy but have not yet fulfilled the criteria for inclusion in the safety net coverage of SF. As at June 2018, the CCF covers 16 self-financed drugs for treating different types of cancer (details at **Annex B**) and the amount of drug subsidies granted under the First Phase Programme has increased from $61.6 million in 2012-13 to $168.8 million in 2017-18.

7. To allow the CCF to exercise its function to fill the gaps in the existing system and create a pioneering effect, two new CCF Medical

[1] The SF was established in 1950 by resolution of the Legislative Council. The objective of the SF is to provide financial assistance to needy patients who meet the specified clinical criteria and passed the means test to meet expenses for designated PPMI or new technologies required in the course of medical treatment which are not covered by the standard fees and charges in public hospitals and clinics.

Assistance Programmes are endorsed by the CCF in 2017-18 with effect from 1 August 2017 to provide subsidy for needy and eligible patients to purchase ultra-expensive drugs (including those for treating uncommon disorders) and specified implantable medical devices for interventional procedures. The two new programmes are named "Subsidy for Eligible Patients to Purchase Ultra-expensive Drugs (Including Those for Treating Uncommon Disorders)" (CCF Ultra-expensive Drugs Programme) and "Subsidy for Eligible Patients of Hospital Authority to Purchase Specified Implantable Medical Devices for Interventional Procedures" respectively.

8. The CCF Ultra Expensive Drugs Programme currently covers the drug "Eculizumab" for treating Paroxysmal Nocturnal Haemoglobinuria and Atypical Haemolytic Uraemic Syndrome; while "Subsidy for Eligible Patients of Hospital Authority to Purchase Specified Implantable Medical Devices for Interventional Procedures" covers two medical devices namely Transcatheter Aortic Valve Implantation for severe aortic stenosis and MitraClip System for severe mitral regurgitation.

RECENT MODIFICATIONS TO THE SF AND CCF MEDICAL ASSISTANCE PROGRAMMES

9. The current financial assessment criteria for drug subsidies under the SF and the CCF Medical Assistance Programmes are based on the principle of targeted subsidy, i.e. the level of patient contribution to drug expenses depends on the patient's household affordability. HA takes into account patients' annual disposable household financial resources (ADFR) and estimates their drug expenses in the coming year in assessing their affordability and determining their level of contribution to drug expenses.

10. With the aim to provide assistance to more needy patients, modifications on the means test mechanism for drug subsidies have been introduced in recent years in light of the rapid advancement in medical technology and changing social values.

11. The patient contribution for drug applications was capped at 30% of the patient's household ADFR in July 2005 when the HA Drug Formulary was introduced. In response to public calls for relaxing the means test for granting subsidies under the safety net, HA had relaxed the

financial assessment criteria and re-defined the calculation of disposable income, allowable deductions and disposable capital in 2008 by taking more financial factors into account. In 2012, the financial assessment criteria were further relaxed with a deductible allowance[2] for calculating patients' disposable capital and simplified tiers of patient contribution ratio. Patients' maximum contribution ratio for drug expenses was also reduced from 30% to 20% of their ADFR. The introduction of deductible allowance helps to protect the family savings and disposable capital from being depleted for drug expenses and thus help maintain the patients' and their family's living standard.

12. With effect from mid-June 2017, the "household" definition in the financial assessment of the SF and CCF Medical Assistance Programmes has also been refined to include only the patient and his/her core family members living under the same roof, which include patient's spouse, children, parents and dependent siblings.

13. In addition, the government and HA acknowledged that the cap of patient contribution at 20% of ADFR may not be applicable for drugs with prices significantly higher than those currently covered by the SF as some patients from middle-income families may have to contribute to or pay for the drug expenses which may cost up to several million dollars a year. In particular, if the use of ultra-expensive drug is recurrent, the long-term prescription of these ultra-expensive drugs will deplete patients'/household members' assets quickly and exert a heavy financial burden on them.

14. To address this limitation and enable early use of ultra-expensive drugs by needy patients, HA has introduced the annual patient contribution capped at 20% of patient's ADFR or $1 million (whichever is lower) in the new CCF Ultra-expensive Drugs Programme in August 2017 to test the feasibility and recognition of this adjusted criteria for the means test.

[2] The amount of deductible allowance is set with reference to the prevailing asset limit for applicants for public rental housing (PRH) in assessing their eligibility for the Waiting List of PRH. The level of allowance is subject to annual review under an established mechanism with reference to the PRH's asset limit.

ENHANCEMENT ON PROVISION OF DRUG TREATMENTS AND SAFETY NET COVERAGE

15. Apart from the above modifications, HA has also implemented the following measures to enhance its support to more needy patients through the SF and CCF Medical Assistance Programmes.

Expansion of coverage of the HA Drug Formulary

16. Rapid technological advances have brought many new drugs to the market, which differ in evidential support on safety, efficacy and cost-effectiveness. Over the years, HA has been appraising new drugs once every three months through established mechanisms. The evaluation process follows the principles of evidence-based medical practice, rational use of public resources, targeted subsidy, opportunity cost consideration and facilitation of patients' choice, and takes into account the safety, efficacy and cost-effectiveness of drugs and other relevant factors, including international recommendations and practices, advance in technology, actual experience in the use of drugs as well as the views of relevant professionals and patient groups, etc.

17. While HA continues to include new drugs in the HA Drug Formulary or in the scope of subsidies under the safety net, public hospitals will, based on their respective clinical service needs, select appropriate drugs from the HA Drug Formulary to provide appropriate care and treatment for patients. To keep clinicians abreast of newly registered drugs in Hong Kong, HA has shared the link to the Department of Health's webpage on newly registered medicines in Hong Kong in the internet and intranet websites of the HA Drug Formulary. In addition, to expedite the process of including newly approved new drugs in the hospital drug formulary, HA has requested Clusters / Hospital Drug and Therapeutics Committees to set a standing agenda item on new drug listing in their regular meetings.

18. The HA Drug Formulary now covers around 1 300 drugs. Total drug consumption expenditure on General and Special drugs in the HA Drug Formulary has increased from $3.75 billion in 2012-13 to $5.37 billion in 2017-18.

Expedite the process for inclusion of drugs in safety net

19. The Government and HA also understand that there have been views and requests from the public to expedite process of including new drugs into the HA Drug Formulary and safety net coverage. To provide more timely support to needy patients, HA has increased the frequency of the prioritisation exercise for including self-financed drugs in the safety net from once to twice a year since 2018 so as to shorten the lead time for introducing suitable new drugs to the safety net.

Support for Patients with Uncommon Disorders

20. HA makes use of the recurrent funding from the Government, an additional annual recurrent funding for treatments of uncommon disorders, the SF and CCF Medical Assistance Programmes to provide sustainable, affordable and optimal care for all patients, including those with uncommon disorders.

21. In June 2018, HA recommends the Commission on Poverty to include a new drug, namely, "Nusinersen" for treatment of Infantile-onset and Childhood-onset Spinal Muscular Atrophy under the coverage of the CCF Ultra-expensive Drugs Programme. HA has set up an expert panel to assess patients' suitability, according to individual patient's clinical condition, for the drug treatment. Upon approval by the Commission on Poverty and registration of this drug in Hong Kong, needy patients with clinical needs could apply for drug subsidy through the CCF Medical Assistance Programme.

REVIEW ON MEANS TEST OF SF AND CCF MEDICAL ASSISTANCE PROGRAMMES – INTERIM FINDINGS

22. In December 2017, HA commissioned Jockey Club School of Public Health & Primary Care of the Chinese University of Hong Kong and the Department of Social Work of the Hong Kong Baptist University to carry out a consultancy study to review the existing means test of the SF and CCF Medical Assistance Programmes. With a view to identifying the challenges and concerns of the current means test mechanism of the SF and

CCF Medical Assistance Programmes, establishing a set of related guiding principles and formulating enhancement measures, the consultant team conducted literature review; analysed existing services statistics and data; reviewed local government financial assistance programmes that adopt means test mechanism; and interviewed key stakeholders including patients groups representatives and patients, medical and social work practitioners, government officials and legislators and executives from HA.

23. In May 2018, the consultant team has completed the first six months of the study and has proposed to further explore improvements to the means test mechanism of the SF and CCF Medical Assistance Programmes along the following directions –

(i) Modifying the calculation of ADFR to lower patients out-of-pocket spending for avoiding financial hardship by lowering the contribution of asset to the calculation of ADFR;

(ii) Redefining "household" to further remove non-monetary barriers to access to the services and relieve families' financial and emotional burden; and

(iii) Establishing an appropriate upper limit for patient contribution, especially for patients with recurrent use or in needs of multiple items.

(i) Modifying the calculation of ADFR

24. As mentioned in paragraph 9, HA takes into account patients' ADFR and estimates their drug expenses in the coming year in assessing their affordability and determining their level of contribution to drug expenses. Patients will be given a full or partial subsidy for meeting drug expenses, depending on their households' affordability. To avoid financial hardship on patients due to substantial out-of-pocket payments of drug cost, the consultant team is studying how the calculation of ADFR should be modified. Among other things, the team will study ways to enhance the mechanism for assessment of patients' affordability and avoid asset depletion particularly those with relatively lower earning power and

less disposable assets.

(ii) Redefining household

25. Like other publicly-funded safety nets, the financial assessment for drug subsidies under HA has been household-based. Applications should be submitted on a household basis as families constitute the core units of a community and members of the same family should render assistance and support to each other. Nevertheless, with a view to relieving financial and emotional burdens of patients' families due to expenditure on drug treatments, the consultant team is considering how the definition of household in the calculation of ADFR could be further refined, taking into account the changing social and family values as well as making reference to other government means-tested subsidy programmes. For instance, consideration can be given to whether and how the income, assets and allowable deductions in relation to the patients' parents, adult children and dependent siblings should be calculated in assessing the patients' household ADFR.

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(iii) Establishing an appropriate upper limit for patient contribution

26. In addressing the concern of recurrent use of ultra-expensive drugs which may deplete patients'/household members' assets quickly, the consultant team is reviewing the current upper limit, which is set at $1 million or 20% of patient's ADFR (whichever is lower) under the CCF Ultra-expensive Drugs Programme. Having regard to the findings of paragraph 24 above, the team will examine the implications of adjusting the capping mechanism for patient contribution as one of the alleviation measures.

Way Forward

27. HA will further work with the consultant team to formulate the details of recommendations along the above directions and the projection of the respective financial implications. In addition, the consultant team will continue to engage relevant stakeholders, including patient groups and representatives, to collect feedback on the preliminary recommendations. The final report of the consultancy study will be completed by late 2018.

The Government aims to make a final decision by late 2018/early 2019 having regard to the findings of the consultancy study.

ADVICE SOUGHT

28. Members are invited to note the above updates on the SF and CCF Medical Assistance Programmes.

Food and Health Bureau
Hospital Authority
June 2018

Annex A

Items supported by the Samaritan Fund

(A) Drug items

Drug	Clinical Indications
Haematology	
Dasatinib	Acute lymphoblastic leukaemia
	Chronic myeloid leukaemia
Eltrombopag	Chronic immune thrombocytopenia
Nilotinib	Chronic myeloid leukaemia
Bortezomib	Multiple myeloma
Rituximab	Relapsed follicular lymphoma
	Chronic lymphocytic leukaemia
Lenalidomide	Multiple myeloma
Azacitidine	Myelodysplastic syndromes / chronic myelomonocytic leukaemia / acute myeloid leukaemia
Plerixafor	Multiple myeloma / Non-Hodgkin's lymphoma (Re-mobilisation in a patient who failed mobilisation attempt; or pre-emptive treatment)
Rheumatology	
Etanercept	Rheumatoid arthritis
	Ankylosing spondylitis
	Psoriatic arthritis
	Juvenile idiopathic arthritis
Infliximab	Rheumatoid arthritis
	Ankylosing spondylitis
	Psoriatic arthritis
Rituximab	Refractory rheumatoid arthritis
Adalimumab	Rheumatoid arthritis
	Ankylosing spondylitis
	Psoriatic arthritis
	Polyarticular juvenile idiopathic arthritis
Abatacept	Rheumatoid arthritis
Golimumab	Rheumatoid arthritis
	Ankylosing spondylitis
	Psoriatic arthritis
Tocilizumab	Rheumatoid arthritis

Drug	Clinical Indications
	Active systemic juvenile idiopathic arthritis
	Polyarticular juvenile idiopathic arthritis
Certolizumab Pegol	Rheumatoid arthritis
	Ankylosing spondylitis
	Psoriatic arthritis
Neurology	
Fingolimod	Refractory relapsing-remitting multiple sclerosis
Natalizumab	Rapidly evolving severe relapsing remitting multiple sclerosis
Oncology	
Imatinib	Gastrointestinal stromal tumour
Rituximab	Malignant lymphoma
Trastuzumab	Breast cancer
Erlotinib	Lung cancer (Second line treatment)
Gefitinib	Lung cancer (Second line treatment)
Temozolomide	Glioblastoma multiforme
Cetuximab	Colorectal cancer
Crizotinib	Lung cancer
Dermatology	
Etanercept	Severe psoriasis
Infliximab	Severe psoriasis
Adalimumab	Severe psoriasis
Ustekinumab	Severe psoriasis
Endocrinology	
Growth hormone	Dwarfism
Others	
Interferon	Chronic granulomatous disease
Canakinumab	Cryopyrin-associated periodic syndromes
Everolimus	Renal angiomyolipoma (AML) associated tuberous sclerosis complex (TSC) / TSC with subependymal giant cell astrocytoma

(B) Non-drug items

1. Percutaneous Transluminal Coronary Angioplasty (PTCA) and other consumables for interventional cardiology
2. Cardiac Pacemakers
3. Intraocular Lens
4. Myoelectric Prosthesis
5. Custom-made Prosthesis
6. Appliances for prosthetic and orthotic services, physiotherapy and occupational therapy services (e.g. prosthesis)
7. Home use equipment and appliances (e.g. wheelchair, replacement of external speech processor for patients done with cochlear implant)
8. Gamma knife surgery
9. Harvesting of marrow in a foreign country for marrow transplant

Annex B

Drugs Supported by the Community Care Fund Medical Assistance Programme (First Phase Programme)

Item	Drug	Designated type of cancer	Designated clinical indication
1a	Bevacizumab	Colorectal cancer	First line treatment of KRAS mutated type colorectal cancer in combination with fluoropyrimidine based chemotherapy in metastatic disease confined to the liver
1b		Epithelial ovarian / fallopian tube / primary peritoneal cancer	With carboplatin and paclitaxel for front-line advanced epithelial ovarian / fallopian tube / primary peritoneal cancer
2a	Sunitinib	Renal cell carcinoma	First line treatment for advanced renal cell carcinoma
2b		Gastrointestinal tumour	Unresectable or metastatic gastrointestinal stromal tumour after failure or intolerance to Imatinib
3	Pegylated liposomal Doxorubicin	Ovarian cancer	Second line of platinum refractory or subsequent treatment of platinum resistant advanced ovarian cancer
4	Lapatinib	Breast cancer	HER2+ve advanced breast cancer with prior therapy including an anthracycline, a taxane, and Trastuzumab
5	Pemetrexed	Lung cancer	First line treatment of patients with metastatic non-small-cell-lung cancer (stage IV) of adenocarcinoma or large cell carcinoma histology
6	Gefitinib	Lung cancer	First line treatment for patients with activating EGFR mutation positive non-small cell lung cancer
7	Erlotinib		
8	Afatinib		

Item	Drug	Designated type of cancer	Designated clinical indication
9	Sorafenib	Liver cancer	Hepatocellular carcinoma (HCC): ineligible for resection, transplant or loco-regional therapy
10	Pazopanib	Renal cell carcinoma	First line treatment for advanced renal cell carcinoma
11	Bendamustine	Leukaemia	Treatment of Chronic Lymphocytic Leukaemia (CLL) in patients who are unable to tolerate Fludarabine-based chemotherapy OR are refractory to Fludarabine
12	Vemurafenib	Skin cancer	As monotherapy for the treatment of adult patients with BRAF V600 mutation-positive unresectable or metastatic melanoma
13	Trastuzumab	Gastric carcinoma	Combined with Cisplatin & Capecitabine or 5FU for HER2 overexpressed metastatic gastric disease (IHC2+ and confirmatory FISH+ result, or IHC3+) in treatment-naive patients for their metastatic disease
14	Pertuzumab	Breast cancer	In combination with trastuzumab and docetaxel (taxane) in human epidermal growth factor receptor 2 protein (HER2) +ve metastatic or locally recurrent unresectable breast cancer patients with no prior anti-HER2 or chemotherapy for their metastatic disease
15	Abiraterone	Prostate cancer	For metastatic castration resistant prostate cancer progressed on or after docetaxel-based chemotherapy regimen
16	Enzalutamide		