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Legislative Council

LC Paper No. CB(2)1578/17-18(04)

Ref : CB2/PL/HS

Panel on Health Services

Background brief prepared by the Legislative Council Secretariat for the meeting on 19 June 2018

The Samaritan Fund and the Community Care Fund Medical Assistance Programmes

Purpose

This paper provides background information and summarizes the concerns of members of the Panel on Health Services ("the Panel") on the Samaritan Fund ("the Fund") and the Community Care Fund Medical Assistance Programmes ("the Medical Assistance Programmes").

Background

Drug Formulary of the Hospital Authority

2. The Hospital Authority ("HA") has implemented the Drug Formulary ("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. At present, there are around 1 300 drugs listed on the Formulary. These drugs are classified into four categories, namely general drugs,[1] special drugs,[2] self-financed items with safety net coverage by the Fund or the Community Care Fund ("CCF") and self-financed items without safety net.[3] Self-financed items

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1 General drugs are drugs with well-established indications and cost-effectiveness which are available for general use as indicated by patients with relevant clinical conditions and provided at standard fees and charges in public hospitals and clinics.

2 Special drugs are drugs used under specific clinical conditions with specific specialist authorization. They are provided at standard fees and charges in public hospitals and clinics when prescribed under specific clinical conditions. Patients who do not meet the specified clinical conditions but choose to use the drugs are required to pay for the drugs.

3 Self-financed items include drugs with preliminary medical evidence only, drugs with marginal benefits over available alternatives but at significant higher costs, and lifestyle drugs (e.g. anti-obesity drugs). These drugs are not provided as part of HA's standard services nor covered by the standard fees and charges in public hospitals and clinics. Patients who choose to use these drugs must purchase them at their own expense.

with safety net 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 may apply for assistance from the Fund or the Medical Assistance Programmes to fully or partially cover their expenses on these drugs. As at January 2018, there were 824 general drugs, 363 special drugs and 68 self-financed items (among which 29 drugs were covered by the Fund and 17 drugs were supported by the Medical Assistance Programmes) in the Formulary.

The Samaritan Fund

3. The Fund is a charitable fund established by resolution of Legislative Council ("LegCo") in 1950. Its objective is 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 the standard fees and charges in public hospitals and clinics. The Fund is administered by HA. It is mainly financed by donations and Government grant. HA reviews annually the income and expenditure accounts of the Fund and estimates the overall expenditure of the Fund for the next few years, and will seek additional funding from the Government if necessary.[4]

4. Patients who meet the specified clinical criteria for the relevant items supported by the Fund and can pass the financial assessment conducted by the Medical Social Workers will be given a full or partial subsidy for meeting the expenses on the items. Financial assessment for applications is made on a household basis which includes patient and his/her core family members living under the same roof.[5] Under the Fund, patients have to contribute to the drug costs according to their household annual disposable financial resources ("ADFR") against a percentage stipulated in a pre-determined sliding scale. The maximum contribution is capped at the contribution ratio of 20%. Details of the financial assessment and patient's contribution to drug cost are in **Appendix I**. The number of approved applications and the amount of subsidies granted in respect of self-financed drugs covered by the Fund from 2015-2016 to 2017-2018 are in **Appendix II**.

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[4] The Finance Committee of the Legislative Council approved a commitment of $10 billion in June 2012 to support the continued operation of the Fund for the next 10 years or so.

[5] Core family members living under the same roof include patient's spouse, children, parents and dependent siblings (i.e. siblings aged below 18; siblings aged between 18 and 25 receiving full-time education; and disable adult siblings who are receiving disability allowance under the Social Security Assistance Scheme or standard rates for 100% disabled or requiring constant attendance under the Comprehensive Social Security Assistance Scheme).

The Community Care Fund Medical Assistance Programmes

5. CCF, established in 2011, aims at providing assistance to people facing financial difficulties, in particular those who fall outside the safety net or those within the safety net but are not covered by it because of special circumstances. In 2011-2012, CCF launched two Medical Assistance Programmes (First Phase and Second Phase). Patients who have financial difficulties may be given full or partial assistance of the drug costs, depending on their financial situation.

6. The First Phase Medical Assistance Programme ("the First Phase Programme"), rolled out in August 2011, aims to provide financial assistance to HA patients to purchase specified self-financed cancer drugs which have not been brought into the safety net of the Fund but have been rapidly accumulating medical scientific evidence and with relatively high efficacy. The prevailing mechanism of the Fund has been adopted for the First Phase Programme. The number of approved applications and the amount of subsidies granted in respect of self-financed drugs covered by the First Phase Programme from 2015-2016 to 2017-2018 are in the **Appendix III**.

7. The Second Phase Medical Assistance Programme ("the Second Phase Programme"), rolled out in January 2012, provided subsidy to HA patients who marginally fell outside the safety net of the Fund for the use of specified self-financed drugs. It complemented the Fund by providing patients with additional subsidy on designated self-financed drugs. The Second Phase Programme was incorporated into the Fund in September 2012 by reducing the patients' maximum contribution ratio on drug costs from 30% to 20% of their ADFR.

Deliberations of the Panel

8. The Panel discussed issues relating to the operation of the Fund and the Medical Assistance Programmes in different contexts at various meetings. The deliberations and concerns of members are summarized in the following paragraphs.

Role of the Fund

9. Noting that HA was responsible for determining the drugs to be introduced and categorized as self-financed drugs with safety net, as well as managing the Fund, some members doubted whether the Fund could serve its intended purpose of providing relief to needy patients. In their view, the Fund might be used as a justification by HA for excluding drugs proven to be of significant benefits but extremely expensive to provide in the Formulary. They urged the Administration to enhance the transparency of the operation of the

Fund. Consideration should be given to setting up a consultation mechanism with the patient groups to gauge their views and making public the evaluation and decisions of the Samaritan Fund Management Committee.

10. The Administration stressed that the Fund had never deviated from its objective of providing relief to needy patients. The introduction of drugs into the Formulary and the inclusion of self-financed drugs into the scope of the Fund would foremost be based on the latest scientific and clinical evidence on efficacy and safety of drugs and not their cost. HA had put in place mechanism to update the Formulary quarterly, and reviewed the need for expanding the safety net twice yearly to cover additional self-financed drugs, relaxing the prescribing indications for existing safety net drugs and repositioning drugs covered by the Medical Assistance Programmes to be under the coverage of the Fund. In addition, a number of measures had been implemented to enhance the transparency of the overall drug policy. A consultation mechanism with patient groups had also been put in place to gauge their views on the formulation and changes to the scope of the Formulary and the Fund.

Financial assistance to needy patients

11. Members were concerned about the financial burden imposed by the extremely expensive self-financed drugs, such as cancer drugs, on patients. They called on the Administration to provide greater financial support to patients, in particular those requiring long-term medication, in their purchase of self-financed drugs. 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.

12. 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 Fund to meet expenses on self-financed drugs or seek fee waiver from HA. Separately, the First Phase Programme would 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 Fund but had been rapidly accumulating medical scientific evidence and with relatively high efficacy.

13. Some members were 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. There was also a view that the number of self-financed drugs covered by the Fund and the First Phase Programme was far from adequate to meet the needs of the patients in need of expensive drug treatments. Some

members considered it inappropriate for HA to adopt the principle of cost-effectiveness in determining the inclusion of a drug in the safety net coverage. They called on HA to review the Formulary and expand the scope of the Fund to cover more self-financed drugs such as cancer drugs.

14. Members were gravely concerned about the drug treatment for, and the financial burden so incurred by, patients suffering from rare diseases. Members were advised that a new Medical Assistance Programme, namely Subsidy for Eligible Patients to Purchase Ultra-expensive Drugs (Including Those for Treating Uncommon Disorders ("Subsidy to Purchase Ultra-expensive Drugs") had been implemented since 1 August 2017 to subsidize eligible patients in need. Paroxysmal Nocturnal Haemoglobinuria and Atypical Haemolytic Uraemic Syndrome had been covered under the Subsidy since August and November 2017 respectively. As at 31 December 2017, eight applications involving a total amount of subsidy of $31.4 million had been approved. In addition, the scope of the Medical Assistance Programmes would be expanded to provide patients with subsidies for specific drug treatments according to individual patients' special clinical needs. Eligible patients would be subsidized to participate in compassionate programmes of individual pharmaceutical companies.

Financial assessment for drug subsidies

15. Some members had strong views against the current household-based financial assessment of the Fund and the Medical Assistance Programmes as it might force many patients concerned to separate from their core family members living under the same roof in order to meet the financial assessment criteria. They considered that the scope of household income should be limited to the income from spouse of the patient. Some members further suggested that patients living with their family members should be allowed to apply for assistance from the Fund on an individual basis. 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. There was also a view that the Administration should further remove the means test mechanism for the Fund.

16. The Administration advised that the practice of using patients' household income in assessing the level of subsidy granted under the Fund was in line with the means test mechanism for other financial assistance schemes, such as 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. In response to stakeholders' views, HA had conducted a review of the household definition adopted in the financial assessments of the medical fee waiver mechanism, the Fund and the Medical Assistance Programmes. Under the refined definition

adopted in the second half of 2017, "household" included only the core family members living with the patient, which included the patient's spouse, children, parents and dependent siblings. It should be noted that due regard would also be given to non-financial factors, such as medical and social grounds meriting special discretion, when vetting an application for the Fund.

17. While expressing support for the provision of a $10 billion grant to the Fund and the regularization of the Second Phase Programme in 2012, some members considered that the financial assessment of the Fund was too stringent. Many families of cancer patients, chronic disease patients and rare disease patients had to deplete all their financial resources to purchase the self-financed drugs concerned at their own expenses before becoming eligible for assistance. The Administration should further relax the financial assessment criteria to benefit more needy patients, in particular those from the middle class families. The Administration advised that the relaxation of the Fund financial assessment criteria for drug subsidies was implemented in September 2012 to introduce a deductible allowance for calculating the total value of applicant's disposable capital, simplify the tiers of patients' contribution ratio for drug expenses and reduce the patient's maximum contribution ratio from 30% to 20% of their ADFR.

18. While welcoming the introduction of the Subsidy to Purchase Ultra-expensive Drugs, some members were gravely concerned that the patient's maximum contribution to drug expenses would be either 20% of the ADFR of his family or $1 million, whichever was the lower. They considered the threshold too high. The Administration should highly subsidize all patients with rare diseases to support their ultra-expensive drug treatment. The Administration advised that the Subsidy to Purchase Ultra-expensive Drugs was aimed at filling in the gaps in the existing drug subsidy mechanism which was kept under review and creating a pioneering effect. HA would expedite the review of patient's co-payment mechanism under the Medical Assistance Programmes with a view to alleviating the financial burden on patients requiring long-term ultra-expensive drug treatment.

Long-term sustainability of the Fund

19. Noting that there would be a multifold increase in the annual expenditure for the Fund in the coming years, members urged the Administration to invest the funds which were not immediately required to generate return to sustain the operation of the Fund. The Administration advised that it was expected that the expenditure of the Fund would continue to increase in the coming years due to advancement in medical technology, and rising demand from an aging population which had resulted in an increasing number of patients suffering from cancer and other chronic diseases. To make better use of public resources

and to enhance the sustainability of the Fund, a prudent investment approach was being considered with the aim of optimizing investment returns and meeting operating cash flow requirements.

Recent developments

20. According to the Administration, HA has commenced a consultancy study to review patient's co-payment mechanism under the Medical Assistance Programmes. HA will propose improvement measures after having taken into account the review findings. The Financial Secretary announced in his 2018-2019 Budget Speech that $500 million has been set aside for this purpose.

21. An oral question on, among others, the financial assistance for cancer patients was raised at the Council meeting of 6 June 2018. The question and the Administration's reply are in **Appendix IV**.

Relevant papers

22. A list of the relevant papers on the LegCo website is in **Appendix V**.

Council Business Division 2
Legislative Council Secretariat
15 June 2018

Appendix I

The Samaritan Fund - Financial Assessment

(a) Application for Non-drug Items

All applications are to be assessed on a household basis, taking into account the income and assets of the patient and his/her core family members living under the same roof[1], which include patient's spouse, children[2], parents[2] and dependent siblings (i.e. siblings aged below 18, aged between 18-25 receiving full-time education or disabled adult siblings[3]).

The patient's household income includes but not limited to salary, pension, regular financial contributions from relatives and/or friends not living together, income generated from the assets and/or properties of the patient and his/her core family members living together, other income/compensation received on a regular basis. Financial assistance provided by the HKSAR Government (e.g. Work Incentive Transport Subsidy Scheme, Low-income Working Family Allowance, Allowances under the Social Security Assistance (SSA) scheme such as Normal Disability Allowance, Higher Disability Allowance, Old Age Living Allowance, and Old Age Allowance) and subsidy from the assistance programmes of the Community Care Fund should not be taken into account as household income.

The patient's household assets include savings, investments in stocks and shares, insurance, valuable possessions, properties, lump-sum compensation and other liquidable assets owned by patient and his/her core family members living together. The first flat (self-owned or rented) resided in together by the patient's household and the tools of trade owned by the patient's household at the time of application are excluded from the calculation.

In assessing the financial condition of the patient, his/her monthly household income must first fulfil the income limit. Medical Social Worker ("MSW") would make reference to the Median Monthly Domestic Household Income ("MMDHI") (Table 1) by Household Size based on the General Household Survey ("GHS") conducted regularly by the Census and Statistics Department. The patient's monthly household income must not exceed the MMDHI corresponding to his/her household size.

Table 1: Median Monthly Domestic Household Income
(update on a regular basis)

Household Size	Median Monthly Domestic Household Income (HK$) (4th Quarter 2017)
1	$9,000
2	$19,300
3	$30,000
4	$40,000
5	$53,600
6 or above	$57,200

After having passed the income limit, if the patient's household assets are equal to or less than two times of the cost of the item concerned, he/she would generally receive full assistance from the Samaritan Fund. If the patient's household assets are above two times but not more than three times of the cost of the item concerned, he/she is required to contribute to the item cost based on the sliding scale (Table 2). For patient whose monthly household income is above the MMDHI corresponding to his/her household size, OR the patient's household assets are above three times of the cost of the item concerned, no Samaritan Fund assistance would be provided normally. However, apart from the above criteria, the Samaritan Fund might consider any special social and financial factors/circumstances faced by the patient on a discretionary basis.

Table 2: Sliding Scale

Household assets with reference to the cost of the item concerned	Percentage of partial contribution to the cost of the item concerned
Above 2 times to below 2.25 times	55%
From 2.25 to below 2.5 times	65%
From 2.5 to below 2.75 times	75%
From 2.75 to below 3 times	85%
Equal to 3 times	90%

Full assistance will be granted to the patient if his/her CSSA* status is valid during application submission and at the time when the medical procedure is performed or when the patient acquires the privately purchased medical items.

* *With effect from March 2017, the application procedures, eligibility and important points to note of CSSA recipients for the Samaritan Fund are also applicable for Level 0 Voucher Holders of the Pilot Scheme on Residential Care Service Voucher for the Elderly.*

[1] *With effect from 18 June 2017, all new applications include only patient and his/her core family members (i.e. patient's spouse, children, parents and dependent siblings) living under the same roof in the financial assessment.*

[2] *Legally recognised adoptive parents/children or illegitimate children with proof of parentage are also included.*

[3] *Disable adult siblings refer to siblings who are receiving disability allowance under the SSA scheme or standard rates for 100% disabled or requiring constant attendance under the CSSA scheme.*

(b) Application for Drug Items

All applications are to be assessed on a household basis, taking into account the income, expenditures and capital assets of the patient and his/her core family members living under the same roof[1], which include patient's spouse, children[2], parents[2] and dependent siblings (i.e. siblings aged below 18, aged between 18-25 receiving full-time education or disabled adult siblings[3]).

Annual disposable financial resources are taken as the annual household disposable income plus the disposable capital.

Annual household disposable income is the annual household gross income less allowable deductions during the period.

Household gross income includes but not limited to salary, pension, financial contributions from children, relatives and friends not living together, income generated from the assets and properties of the patient and his/her core family members living together and compensation received. Financial assistance provided by the HKSAR Government (e.g. Work Incentive Transport Subsidy Scheme, Low-income Working Family Allowance, Allowances under the Social Security Assistance ("SSA") scheme such as Normal Disability Allowance, Higher Disability Allowance, Old Age Living Allowance, Old Age Allowance) and subsidy from the assistance programmes of the Community Care Fund are excluded from the calculation.

Allowable deductions[4] include rental or mortgage payment, rates, Government rents, property management fee of the property occupied by the patient's household (total deduction of not more than one-half of the household gross income), salary taxes, personal allowances (Table 3) for the patient and his/her core family members living together, child care expenses, provident fund contribution, school fees of children (up to age of 21) who are at secondary level or below (other expenses, such as school activity fees, board & lodging fees, will not be counted as the allowable deductible item) and medical expenses at public hospitals/clinics (other than the drug(s) subsidized by the SF and /or Community

Care Fund Medical Assistance Programme and drug payment under this application) for the last 12 months.

Table 3: Personal Allowances (as at 27 February 2018)

Number of Household Member(s) (including the Patient)	Total Personal Allowances (HK Dollar)
1 Person	$6,220
2 Persons	$10,880
3 Persons	$15,490
4 Persons	$20,060
5 Persons	$26,700
6 Persons	$25,060
7 or more Persons	$27,950

The figures are adjusted every year in line with the Consumer Price Index A, and every five years in line with the latest Household Expenditure Survey conducted by the Census and Statistics Department.

Disposable capital includes cash owned by the patient and his/her core family members living together at the time of the application and such which have been accrued through past savings from any sources or which have just been acquired, investments in stocks and shares, insurance (refer to investment-linked insurance policies and dividend provided by life insurance policies, but cash value under a life insurance policy should not be counted), valuable possessions, property (for example, land, car park and flat owned in Hong Kong and outside Hong Kong), lump-sum compensation and other realizable assets. The first flat (self-owned or rented) resided in together by the patient's household and the tools of trade owned by the patient's household at the time of application are excluded from the calculation.

Deductible Allowance (Table 4) is provided when calculating the total value of disposable capital of patient and his/her core family members living together. The amount of deductible allowance depends on the patient's household size. If the disposable capital of the patient's household is below the deductible allowance, the amount of deductible will be capped at the disposable capital of the patient's household. It is set with reference to the prevailing asset limit in assessing eligibilities for applications for the Waiting List of Public Rental Housing ("PRH"). The level of allowance will be regularly reviewed with reference to the PRH's asset limit which is subject to annual review under an established mechanism.

Table 4: Deductible Allowance (as at 1 April 2018)

Number of Household Member(s) (including the Patient)	Allowance to be deducted from Disposable Capital (HK Dollar)
1 Person	$249,000
2 Persons	$338,000
3 Persons	$440,000
4 Persons	$514,000
5 Persons	$571,000
6 Persons	$618,000
7 Persons	$660,000
8 Persons	$692,000
9 Persons	$764,000
10 or more Persons	$823,000

The figures are subject to annual review.

Full assistance will be granted to the patient if his/her CSSA* status is valid during application submission and during the treatment period in which the self-financed drug is subsidized by the Samaritan Fund.

* *With effect from March 2017, the application procedures, eligibility and important points to note of CSSA recipients for Samaritan Fund are also applicable for Level 0 Voucher Holders of the Pilot Scheme on Residential Care Service Voucher for the Elderly.*

[1] *With effect from 18 June 2017, all new applications include only patient and his/her core family members (i.e. patient's spouse, children, parents and dependent siblings) living under the same roof in the financial assessment.*

[2] *Legally recognised adoptive parents/children or illegitimate children with proof of parentage are also included.*

[3] *Disable adult siblings refer to siblings who are receiving disability allowance under the SSA scheme or standard rates for 100% disabled or requiring constant attendance under the CSSA scheme.*

[4] *The expenditures on patient and his/her core family members living together which are paid by themselves.*

Patient's Contribution to Drug Cost

Patient's contribution is determined by the disposable financial resources and the estimated drug cost that is required to pay, with the latter being determined by

multiplying the unit drug cost by the total units of drug consumption. The maximum contribution is capped according to Table 5.

Where the estimated cost of the applied drug is below the maximum contribution payable, patient is required to pay the drug cost and no assistance will be granted. Where the estimated drug cost is above the maximum contribution payable, the Samaritan Fund will pay the outstanding balance.

Under normal circumstances, the patient should settle the patient's contribution before the utilization of the approved subsidies as far as possible. However, if the patient has special difficulties, he/she could approach MSW to apply for payment by instalment. The Samaritan Fund might consider the request on a case-by-case basis.

Table 5: Sliding Scale

(A) Annual Disposable Financial Resources (ADFR) (HK$)	(B) Contribution Ratio (%)	(C) Maximum Contribution from Patient (HK$) (C) = (A) x (B)	(D) ADFR after deducting Annual Contribution (HK$) (D) = (A) - (C)
$0 - 20,000	-	$0	$0 - $20,000
$20,001 - 40,000	-	$1,000	$19,001 - 39,000
$40,001 - 60,000 #	-	$2,000	$38,001 - 58,000
$60,001 - 100,000	5	$3,000 - 5,000	$57,001 - 95,000
$100,001 - 140,000	10	$10,000 - 14,000	$90,001 - 126,000
$140,001 - 180,000	15	$21,000 - 27,000	$119,001 - 153,000
$180,001 - 280,000	20	$36,000 - 56,000	$144,001 - 224,000
280,001 - 380,000	20	$56,000 - 76,000	$224,001 - 304,000
$380,001 - 480,000	20	$76,000 - 96,000	$304,001 - 384,000
$480,001 - 580,000	20	$96,000 - 116,000	$384,001 - 464,000
$580,001 - 680,000	20	$116,000 - 136,000	$464,001 - 544,000
$680,001 - 780,000	20	$136,000 - 156,000	$544,001 - 624,000
$780,001 - 880,000	20	$156,000 - 176,000	$624,001 - 704,000
$880,001 - 980,000	20	$176,000 - 196,000	$704,001 - 784,000
$980,001 - 1,080,000	20	$196,000 - 216,000	$784,001 - 864,000
≥ $1,080,001	20~	as calculated	

 # Fixed contribution amount is required from patients whose household's annual disposable financial resources are $60,000 or below, the formula calculating the applicant's annual contribution in the above table is not applicable.

~ Capped at a flat contribution ratio of 20%.

Source: Website of the Hospital Authority

Appendix II

The number of approved applications and the amount of subsidies granted in respect of self-financed drugs covered by the Samaritan Fund in 2015-2016, 2016-2017 and 2017-2018

Samaritan Fund

Financial Year	No. of applications received[#]	No. of applications approved[#]	Amount of subsidies granted ($ million)
2015-2016	2 237	2 237	317.5
2016-2017	2 555	2 555	332.4
2017-2018 (up to 31.12.2017)	1 767	1 767	252.6

[#] The number does not include those withdrawn/cancelled applications.

Source: *The Administration's written replies to Members' written questions in examining the Estimates of Expenditure 2018-2019*

Appendix III

The number of approved applications and the amount of subsidies granted in respect of self-financed drugs covered by the Community Care Fund Medical Assistance Programme in 2015-2016, 2016-2017 and 2017-2018

The Community Care Fund Medical Assistance Programme (First Phase Programme – Cancer Drugs)

Financial Year	No. of applications received[#]	No. of applications approved[#]	Amount of subsidies granted ($ million)
2015-2016	1 678	1 678	156.8
2016-2017	1 832	1 831	160.4
2017-2018 (up to 31.12.2017)	1 485	1 485	130.5

[#] The number does not include those withdrawn/cancelled applications.

Source: The Administration's written replies to Members' written questions in examining the Estimates of Expenditure 2018-2019

Press Releases

LCQ3: Provision of new targeted therapy drugs and financial assistance for cancer patients

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Following is a question by the Dr Hon Chiang Lai-wan and a reply by the Secretary for Food and Health, Professor Sophia Chan, in the Legislative Council today (June 6):

Question:

Some patient groups have relayed that quite a number of new targeted therapy drugs with significant benefits in curing cancers have come onto the market in recent years, but most of them have not been incorporated into the list of Self-Financed Items (SFIs) under the Drug Formulary of the Hospital Authority (HA). This, coupled with the stringent eligibility criteria for applications under the Samaritan Fund and the Community Care Fund, has resulted in cancer patients who cannot afford the medication costs not being able to grasp the opportunities for treatments, thereby undermining patients' rights and interests. In this connection, will the Government inform this Council:

(1) whether it will request the HA to expedite its appraisal procedure so as to incorporate those new targeted therapy drugs with significant benefits in curing cancers into the list of SFIs; if so, of the details; if not, the reasons for that;

(2) whether it will relax the eligibility criteria for applications under the two aforesaid relief funds and raise their subsidy ceilings, so that more cancer patients in need can obtain assistance; if so, of the details; if not, the reasons for that; and

(3) whether it will consider setting up a new dedicated fund to subsidise cancer patients with financial difficulties in receiving expensive treatments (including treatments with targeted therapy drugs); if so, of the details; if not, the reasons for that?

Reply:

President,

The Government and the Hospital Authority (HA) place high importance on providing optimal care for all patients, including cancer patients, and assuring patients of equitable access to safe, efficacious and cost-effective drugs under our highly subsidised public healthcare system. My consolidated reply to the various parts of the question raised by Dr the Hon Chiang Lai-wan is as follows.

The HA has an established mechanism for regular appraisal of new drugs and review of its Drug Formulary and the coverage of the safety net. As pledged in last year's Policy Address, the Drug Management Committee under the HA and other committees concerned will more closely monitor the research developments and the accumulation of medical scientific evidence for new drugs so that needy patients could receive early treatment. The Drug Advisory Committee of the HA currently conducts meetings once every three months to appraise new drugs. The whole appraisal 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, disease state, patient compliance, quality of life, actual experience in the use of drugs as well as the views of professionals and patient groups. In appraising new drugs, especially expensive ones, the HA will also

carefully examine the long-term financial sustainability of the drug therapies with a view to providing all patients with appropriate treatments. The HA will include approved drugs in the Drug Formulary or under the coverage of the safety net as appropriate.

Currently, the HA Drug Formulary includes effective drugs for the treatment of various diseases. These drugs, including targeted therapy drugs for treating cancer, are provided for patients at standard fees and charges. The HA has been extending the coverage of its Drug Formulary through regular review. Self-financed cancer drugs are incorporated into the Drug Formulary's special drug category in phases and provided for patients with specific clinical indications at standard fees and charges.

The HA provides a safety net for patients with financial difficulties in respect of specific self-financed items through the Samaritan Fund and the Community Care Fund (CCF) Medical Assistance Programmes, under which eligible patients are subsidised to purchase self-financed drugs covered by the safety net. As at April 2018, a total of 29 self-financed drugs proven to be of significant benefits were covered by the Samaritan Fund. Among them, 13 are for cancer treatment, of which 10 are targeted therapy drugs.

To provide cancer patients with more support, the Government and the HA launched the First Phase Programme of the CCF Medical Assistance Programmes in August 2011 to offer patients financial assistance to purchase specified self-financed cancer drugs which have not yet been brought into the Samaritan Fund safety net but have been rapidly accumulating medical scientific evidence and have relatively higher efficacy. As at April 2018, a total of 16 self-financed cancer drugs have been covered by this Programme and 13 of which are targeted therapy drugs.

The appraisal of drugs is an on-going process driven by evolving medical evidence, latest clinical developments and market dynamics. At this stage, more scientific evidence is required to confirm the clinical efficacy and cost-effectiveness of most newly-developed drugs for cancer treatment and the actual benefits to patients. The HA will keep abreast of the latest development of clinical treatment and scientific evidence, heed the views and suggestions of patients' groups, and continue to review the Drug Formulary and the coverage of the safety net under the principle of rational use of limited public resources while maximising the health benefits for patients in need. The HA is also examining the extension of the coverage of the CCF Medical Assistance Programmes to provide patients with subsidies for specific drug treatments according to individual patients' special clinical needs, including subsidising eligible patients to participate in compassionate programmes of individual pharmaceutical companies.

To alleviate the financial burden on cancer patients, the HA has been in close liaison with pharmaceutical companies on the setting up of risk sharing programmes for specific cancer drugs. Under the programmes, the HA, patients and pharmaceutical companies will contribute to the drug costs in specific proportions within a defined period, or the drug treatment costs to be borne by patients will be capped. The aim is to facilitate patients' early access to drug treatments and provide the patients with sustainable, affordable and optimal drug treatments in the long term.

The HA has commissioned a consultancy study to review the current financial assessment and patient's co-payment mechanism under the Samaritan Fund and the CCF Medical Assistance Programmes. Improvement measures will be put forward in the light of the review findings with the aim of providing more appropriate assistance for patients in need. The Government has earmarked funding in the 2018-19 Budget for this purpose. Actual use of the funding will be subject to the review findings and recommendations.

Ends/Wednesday, June 6, 2018
Issued at HKT 14:28

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Appendix V

Relevant papers on the Samaritan Fund and the Community Care Fund Medical Assistance Programmes

Committee	Date of meeting	Paper
Panel on Health Services	10.11.2008 (Item IV)	Agenda Minutes
	8.6.2009 (Item VI)	Agenda Minutes
	14.2.2011 (Item VI)	Agenda Minutes CB(2)1602/10-11(01)
	14.11.2011 (Item VI)	Agenda Minutes CB(2)1680/11-12(01)
	16.4.2012 (Item IV)	Agenda Minutes CB(2)2087/11-12(01)
	10.7.2012 (Item II)	Agenda Minutes
	17.3.2014 (Item II)	Agenda Minutes CB(2)2053/13-14(01)
	15.6.2015 (Item V)	Agenda Minutes
	19.12.2016 (Item III)	Agenda Minutes CB(2)480/17-18(01)

Committee	Date of meeting	Paper
	11.4.2017 (Item I)	Agenda Minutes CB(2)618/17-18(01)
	16.10.2017 (Item IV)	Agenda Minutes
	2.3.2018 (Item I)	Agenda

Council Business Division 2
Legislative Council Secretariat
15 June 2018