立法會
Legislative Council

LC Paper No. CB(2)356/19-20(02)

Ref : CB2/PS/1/17

Panel on Health Services

Subcommittee on Issues Relating to the Support for Cancer Patients

Background brief prepared by the Legislative Council Secretariat for the meeting on 16 December 2019

Mechanism for appraisal of cancer drugs for inclusion in the Hospital Authority Drug Formulary and the safety net and arrangement for the provision of sustainable and affordable drug treatment for cancer patients

Purpose

This paper provides background information on the Drug Formulary ("the Formulary") of the Hospital Authority ("HA"), the Samaritan Fund ("the Fund") and the Medical Assistance Programmes of the Community Care Fund ("CCF") ("the Medical Assistance Programmes"), and summarizes the concerns of members of the Panel on Health Services ("the Panel") on issues relating to the appraisal of cancer drugs for inclusion in the Formulary and the safety net as well as arrangement for the provision of sustainable and affordable drug treatment for cancer patients.

Background

The Formulary

2. HA has implemented the Formulary since 2005 with a view to ensuring equitable access by patients to cost-effective drugs of proven safety and efficacy by standardizing the drug policy and drug utilization in all public hospitals and clinics. 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 Medical Assistance Programmes and self-financed items without safety net.[3] Self-financed items 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 November 2019, the Formulary covers 119 cancer drugs for treating various types of cancers.

The safety net

3. Established in 1950, the Fund is a charitable fund administrated by HA to provide subsidy to eligible patients to meet their expenses on those self-financed drugs that are proven to be significant benefits but very expensive for HA to provide as part of its subsidized services; or those designated privately purchased medical items not covered by the standard fees and charges in public hospitals and clinics. As at November 2019, the Fund covers 37 self-financed drugs and nine categories of non-drug items. The total number of approved applications for drugs and non-drug items for the financial year of 2018-2019 was 2 866 and 4 600 respectively, with expenditure on drugs and non-drug items being $363.8 million and $158.0 million respectively.

4. Apart from the Fund, CCF[4] launched in 2011 the First Phase Medical Assistance Programme ("the First Phase Programme") to provide financial assistance to eligible HA patients to purchase specific self-financed cancer drugs which have not been brought into the safety net of the Fund but have been

---

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 have to purchase them at their own expense.

4 Established in 2011 under the Secretary for Home Affairs Incorporation Ordinance (Cap. 1044), CCF is a trust fund aims at providing assistance to people facing financial difficulties, in particular those who fall outside the social safety net or those within the social safety net but are not covered by it because of special circumstances. CCF has since 2013 been integrated into the work of the Commission on Poverty.

rapidly accumulating medical scientific evidence and with relatively high efficacy.[5] As at September 2019, the First Phase Programme covers 22 specific self-financed cancer drugs for treating 14 types of cancers. The number of applications approved and the amount of subsidy for drug costs approved for beneficiaries was 12 707 person-times and around $974.24 million respectively as at 30 September 2019. To allow CCF to exercise its function to fill the gaps in the existing system and create a pioneering effect, CCF launched in August 2017 two new programmes, namely "Subsidy for Eligible Patients to Purchase Ultra-expensive Drugs (Including Those for Treating Uncommon Disorders)" ("the Ultra-expensive Drugs Programme") and "Subsidy for Eligible Patients of Hospital Authority to Purchase Specified Implantable Medical Devices for Interventional Procedures" ("the Specified Implantable Medical Devices Programme") to provide subsidy for eligible patients. To shorten the lead time for the introduction of new drugs or medical devices so as to provide more timely support for the needy patients, the Commission on Poverty endorsed in October 2019 to streamline the existing approval process of new drugs or medical devices under the Medical Assistance Programmes by delegating the authority to the chairperson of the CCF Task Force to grant final approval for new drugs or medical devices.

Deliberations of the Panel

5. The Panel discussed issues relating to the drug management of HA and the means test mechanism for the Fund and the Medical Assistance Programmes in different contexts at various meetings. Views from deputations on expensive drugs, cancer strategy and the means test mechanism for the Fund and the Medical Assistance Programmes were received respectively at three meetings of the Panel. The deliberations and concerns of members are summarized in the following paragraphs.

Review of the Formulary

6. Members had long been calling for a comprehensively review of the Formulary. Expressing concern that many drugs of proven clinical benefits were currently not listed as general drugs, special drugs or self-financed drugs with safety net, some members considered that the principles underlying the

---

[5] CCF rolled out the Second Phase Medical Assistance Programme ("the Second Phase Programme") in January 2012 to provide 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 household annual disposable financial resources.

development of the Formulary should be revisited. There was also a view that HA should engage patient groups and relevant professionals outside HA in managing the Formulary.

7. The Administration advised that the Formulary had been constantly reviewed. The development of the Formulary was underpinned by the core values of evidence-based medical practice, rational use of public resources, targeted subsidy, opportunity cost consideration and facilitation of patients' choice. To enhance the transparency of the Formulary, HA had published a Hospital Authority Drug Formulary Management Manual in 2015 to give an account of the governance structure as well as the principles and operational procedures for managing the Formulary.[6] The Administration assured members that views of external stakeholders, including patient groups and relevant professionals, had been and would continuously be collected in managing the Formulary.

Inclusion of drugs into the Formulary and the safety net

8. Some members were of the view that drugs which were proven to be of significant benefits, including many target therapy drugs for treating cancers which were commonly used in the private healthcare sector, 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 a view that the Formulary should be patient-oriented and HA should accord a higher priority to drugs with same efficacy but fewer side effects. 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.

9. According to the Administration and HA, 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 ("DAC") for consideration via the Cluster or Hospital Drug and Therapeutics Committee. DAC meetings were held quarterly in January, April, July and October each year to evaluate new drug applications. The evaluation process followed the principles of evidence-based medical practice, rational use of public resources, targeted subsidy, opportunity cost consideration and facilitation of patients' choice, and took into account the safety, efficacy and cost-effectiveness of drugs and other relevant factors, including international recommendations, as well as the views of relevant professionals and patient groups, etc. Drugs proven to be of significant clinical benefits but were

---

[6] The latest edition of the Manual can be accessed at HA Drug Formulary Management website at http://www.ha.org.hk/hadf/Portals/0/Docs/HADF_manual_Eng_2018.pdf.

extremely expensive for HA to provide as part of its standard services would be positioned as self-financed drugs with safety net. The Drug Management Committee, which was responsible for calling for proposal submissions from HA clinicians for inclusion of self-financed drugs in the safety net or relaxation of the prescribing indications for safety net drugs, had increased the frequency of the prioritization exercise from once to twice a year since 2018 to shorten the lead time for introducing suitable new drugs into the scope of subsidies. The calls for proposal submissions usually took place in the second and fourth quarters of each year.

10. There was a view that the appraisals of new drugs by DAC on quarterly basis might not be able to catch up with the rapid development of new drugs. According to HA, it was appropriate for DAC to meet every three months for evaluation of new drugs.

11. Noting that cost-effectiveness was one of the principles for evaluating drugs, members were concerned about whether HA would compromise patients' interests to save money. Question was raised about the weighting of the factors of efficacy, safety and cost-effectiveness in evaluating the new or existing drugs. There was also a concern over the relatively low number of new drugs introduced in the Formulary when compared with other developed countries. HA advised that public resources should be utilized with maximal effect of healthcare to ensure equitable access by patients to cost-effective drugs. This notwithstanding, the evaluation of drugs would foremost be based on the latest scientific evidence on the safety and efficacy of drugs. The factor of cost-effectiveness would only come into play when a drug was proved to be of benefits to patients. In general, HA made reference to the incremental cost-effectiveness ratio suggested by the National Institute for Health and Care Excellence of the United Kingdom[7] for consideration of the cost-effectiveness of some self-financed drugs under review. As the public healthcare system and the drug procurement policies varied across countries, it was not appropriate to make a direct comparison of the use of drugs by HA with the practice of other places.

12. On the question about whether DAC's decisions on new drug applications could be reviewed, HA advised that there was no limit on the number of applications. Unsuccessful applicants could re-submit their applications providing further information of the reviewed drugs for re-consideration of DAC. To enhance operational transparency, the outcome of each individual drug applications for inclusion in the Formulary, together with a list of references that

---

[7] Incremental cost-effectiveness ratio was calculated by dividing the difference in costs by the difference in quality-adjusted life years. A lower ratio indicated a more favourable cost-effectiveness of a drug.

had been taken into account in the process of considering each drug application, were uploaded to HA's internet and intranet websites after each DAC meeting.

13. There was a view that that HA should gauge patients' views in the inclusion of self-financed drugs into the safety net through a regularized consultative mechanism. HA advised that HA had maintained close communication with patient groups on drug-related matters through established liaison channels. Two consultation meetings with patient groups were convened every year to provide updates on the latest development and gauge their views on the introduction of new drugs as well as review of prevailing drugs under the Formulary and the safety net. Meetings with individual patient groups would also be arranged to discuss specific issues of concern.

Financial support for patients purchasing self-financed drugs

14. Members were concerned about the financial burden imposed by the extremely expensive self-financed drugs (including 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. Some members expressed concern over the substantial increase in the price of targeted therapy drugs for treating cancers in the past two decades. They considered it necessary for the Administration to exercise certain control over the prices of drugs. The Administration advised that where necessary, HA would liaise with pharmaceutical companies concerned on the feasibility of offering compassionate long-term drug arrangements for needy patients requiring ultra-expensive drugs for treatment.

15. Members noted that to be eligible for financial assistance under the Fund, the HA patients concerned had to meet, among others, the clinical requirement. Some members considered that the clinical criteria for prescription of safety net drugs lacked transparency. HA advised that treatment options were determined in accordance with evidence-based medical practice, having regard to international recommendations and practices, side effects of drugs and patients' clinical conditions.

16. Some members had strong views against the 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 a view that the patients' maximum contribution ratio to the drug expenses should be lowered to avoid financial hardship on patients, including the middle-class patients, due to substantial out-of-pocket payments of drug cost. In addition, the Administration should highly subsidize those patients requiring long-term or ultra-expensive drug treatment.

17. 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. 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.

18. Members were subsequently briefed on 19 November 2018 that based on the findings of a consultancy study commissioned by HA on the means test of the Fund and the Medical Assistance Programmes, the Administration would adopt a number of enhancements to the means test mechanism. These included (a) modifying the calculation of the annual disposable financial resources ("ADFR") for drug subsidy applications by discounting 50% of patients' household net assets, whereas patients' actual contribution to the drug expenses would continue be determined in accordance with the sliding formula which was capped at 20% of ADFR[8]; and (b) refining the definition of "household" to include (i) the patient, his/her parents/legal guardians, and dependent siblings living under the same roof for the case of a patient who was a dependent (i.e. was unmarried and was either under 18 years old or between 18 and 25 years old receiving full-time education); (ii) the patient, his/her spouse and dependent children (but not parents/legal guardians or siblings) living under the same roof for the case of a married non-dependent patient; and (iii) only the patient himself/herself for the case of an unmarried non-dependent patient, irrespective of whether parents/legal guardians or siblings were living under the same roof.

19. Referring to the enhancement measure of modifying the calculation of patients' household ADFR for drug subsidy applications, some members held

---

[8] According to the Administration, the existing $1 million cap under the Ultra Expensive Drugs Programme would be retained. The Administration and HA would review the cap in future having regard to the effectiveness of the enhancement measures and the actual number of cases that might trigger the cap.

the view that the annual financial assessment so conducted would deplete, rather than protect, patients' household assets as the level of a patient's contribution to drug expenses was determined by his or her household's ADFR. They suggested that the 50% net assets of a patient being protected should be maintained permanently, instead of subjecting the amount to annual calculation in this regard in order to ensure that no patients and their families would run into financial difficulties as a result of meeting high drug expenditure. They also shared some deputations' view that in the calculation of ADFR, the monthly allowable deductions should include expenditures on medical consumables relating to the treatments concerned. There were suggestions that a patient's ADFR should be allowed to maintain, throughout the whole approval period, at the level when the drug subsidy was approved; the maximum patient contribution under the sliding scale should be lowered to 10% of the patient's household ADFR; adult patients who were not receiving full-time education but were unemployed should be classified as a dependent patient; and parents who received financial support from a non-dependent adult patient should not be excluded from the definition of "household".

20. The Administration advised that annual financial assessment was conducted under the safety net to ensure prudent use of public funds. It was estimated that more than 30% of the applications for drug subsidy approved under the Fund and the Medical Assistance Programmes during the period of June 2017 to February 2018 would be better off after the introduction of the above enhancement measures. Patients would pay a smaller amount of contribution by an average of around $30,000 per application under the proposed enhancement measures. The Administration assured members that the medical social workers would have discretion to adjust the household size based on a case-by-case basis in light of special familial factors or circumstances that warranted exceptional consideration to ensure that no patients would become worse off as a result of the enhancement measures. Some members were of the view that the above arrangement for medical social workers to exercise discretion on a case-by-case basis when assessing applications for drug subsidies lacked transparency. They called on the Administration to set up an appeal mechanism with participation of lay persons and representatives of patients and their families. According to the Administration, a mechanism had been put in place at hospital level to handle appeals concerning drug subsidy applications. Any further enhancements to the safety net, such as setting up an appeal mechanism at the level of HA Headquarters, could be considered in future review exercise on the safety net.

21. Members considered that the Administration should further review the means test mechanism of the safety net, say, one year after the implementation of the proposed enhancement measures to further enhance the mechanism, and gauge the views of patients and their families in this regard. Three motions

were passed at the Panel meetings of 19 November 2018 and 11 December 2018 and the wordings of which are in **Appendices I and II** respectively. Some members called on the Administration to formulate a timetable for a further review of the means test mechanism. The Administration undertook to revert to the Panel on the progress of and feedback received on the implementation of the enhancement measures after 12 months of implementation.

Recent developments

22. The enhancement measures for the means test mechanism referred to in paragraph 18 above have been applicable for new applications under the Ultra-expensive Drugs Programme starting from January 2019. As regards the Fund, the First Phase Programme and the Specified Implantable Medical Devices Programme, the enhancement measures on means test took effect on 16 February 2019.

23. Four written questions concerning the support for cancer drug treatment were raised at the Council meetings on 31 January, 6 June and 24 October 2018, and 30 January 2019 respectively. The questions and the Administration's replies are in **Appendices III to VI** respectively.

24. It was announced in the Chief Executive's 2019 Policy Address that the Administration would continue to expand the coverage of cancer drugs in the Formulary and strengthen support to patients of cancers through the Samaritan Fund.

Relevant papers

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

Council Business Division 2
Legislative Council Secretariat
13 December 2019

立法會 CB(2)317/18-19(01)號文件
LC Paper No. CB(2)317/18-19(01)

衞生事務委員會
Panel on Health Services

在 2018 年 11 月 19 日的會議上就議程項目 V "撒瑪利亞基金和關愛基金醫療援助項目經濟審查機制的檢討結果"通過的議案
Motions passed at the meeting on 19 November 2018 under agenda item V "Review findings of means test mechanism for Samaritan Fund and Community Care Fund Medical Assistance Programmes"

議案一：

本委員會要求當局將領取撒瑪利亞基金和關愛基金醫療援助項目的病人分擔藥費上限由政府建議的病人家庭每年可動用財務資源的兩成進一步降低至一成或以下，並放寬可領取撒瑪利亞基金和關愛基金醫療援助項目的各種長期病患的特定臨床準則，以及完善文件建議的每年可動用財務資源的計算方法，以確保現時領取撒瑪利亞基金和關愛基金醫療援助項目的病人不會因新的計算方法而支付更多藥費。

動議人： 陳志全議員

(Translation)

Motion 1:

This Panel requests that the Government-proposed maximum ratio of patient contribution to drug expenses under the Samaritan Fund ("SF") and Community Care Fund ("CCF") Medical Assistance Programmes should be further reduced from 20% of the patients' household annual disposable financial resources ("ADFR") to 10% or below, the specified clinical criteria for determining the eligibility of patients of various types of chronic diseases under SF and CCF Medical Assistance Programmes should be relaxed, and the method for calculating ADFR as proposed in the paper should be enhanced to ensure that the new calculation method will not result in higher drug costs to be paid by patients currently eligible for financial assistance under SF and CCF Medical Assistance Programmes.

Moved by: Hon CHAN Chi-chuen

議案二：

本委員會歡迎政府放寬撒瑪利亞基金和關愛基金醫療援助項目的經濟審查機制。本委員會要求保障病人資產淨值的五成應該是一個永久保障，而非每年計算，以致病人資產最終大幅下降。此外，病人分擔上限亦應由每年可動用財務資源的兩成下降至一成或以下，並擴闊資產階梯。

動議人： 張超雄議員
邵家臻議員

(Translation)

Motion 2:

This Panel welcomes the Government's relaxation of the means test mechanism for the Samaritan Fund and Community Care Fund Medical Assistance Programmes. This Panel requests that the 50% net assets of a patient being protected should be maintained permanently, instead of subjecting the amount to annual calculation in this regard which will, in the end, result in a substantial decrease in the patient's assets. Besides, the maximum ratio of patient contribution should be reduced from 20% of annual disposable financial resources to 10% or below, and the asset bands on the sliding scale should also be widened.

Moved by: Dr Hon Fernando CHEUNG Chiu-hung
Hon SHIU Ka-chun

附錄 II
Appendix II

立法會 CB(2)459/18-19(01)號文件
LC Paper No. CB(2)459/18-19(01)

衞生事務委員會
Panel on Health Services

在 2018 年 12 月 11 日的會議上就議程項目 I
"撒瑪利亞基金和關愛基金醫療援助項目經濟審查機制的
檢討結果"通過的議案
Motion passed at the meeting on 11 December 2018 under agenda item I
"Review findings of means test mechanism for Samaritan Fund and Community Care Fund Medical Assistance Programmes"

議案：

就撒瑪利亞基金和關愛基金醫療援助項目經濟審查機制的檢討結果，本委員會促請政府：

(一) 進一步下調撒瑪利亞基金和關愛基金醫療援助項目的病人分擔藥費上限，下調至病人家庭每年可動用財務資源的一成以下或五十萬元以下，以有效紓緩病人及其家庭的經濟負擔；
(二) 進一步放寬「家庭」的定義，讓病人以「個人名義」提出資助申請，不需計算其家人入息及資產，讓資助更加貼心和到位；
(三) 在申請人能證明其家庭成員受其供養的情況下，可在計算全年總入息時，按申請人供養的家庭成員人數計算豁免額；
(四) 放寬申請者的每月家庭總收入的入息限額，讓更多病人獲得資助；及
(五) 設立上訴機制，處理對於審批決定及分擔費的覆核。

動議人： 蔣麗芸議員
陳恒鑌議員

(Translation)

Motion:

Regarding the findings of the review of the means test mechanism for the Samaritan Fund ("SF") and Community Care Fund ("CCF") Medical Assistance Programmes, this Panel urges the Government to:

(1) further reduce the maximum ratio of patient contribution to drug expenses under SF and CCF Medical Assistance Programmes to below 10% of the patients' household annual disposable financial resources or less than $500,000, in order to effectively alleviate the financial burden on patients and their families;
(2) further relax the definition of "household", so that patients are allowed to submit applications for subsidies on an individual basis without taking into account the income and assets of their family members, thereby providing a subsidy arrangement that is more appropriate and tailor-made for the patients;
(3) on the premise that an applicant is able to prove that a family member is a dependent of the applicant, calculate the amount of deductible allowance on the basis of the number of dependent family members of the applicant when determining the total annual income;
(4) relax the limit imposed on an applicant's total monthly household income, so that more patients would be subsidized; and
(5) put in place an appeal mechanism to review the decisions made on vetting and approving applications and on patient contributions.

Moved by: Dr Hon CHIANG Lai-wan
Hon CHAN Han-pan

Appendix III

Press Releases

LCQ20: Diagnoses and treatments for patients with cancers, uncommon diseases and terminal illnesses

****

Following is a question by the Dr Hon Elizabeth Quat and a written reply by the Secretary for Food and Health, Professor Sophia Chan, in the Legislative Council today (January 31):

Question:

At present, there are four categories of drugs in the Hospital Authority Drug Formulary (HADF), i.e. General Drugs, Special Drugs, Self-Financed Items (SFIs) with Safety Net (Safety Net drugs) and SFIs without Safety Net. Some patient groups have relayed that it takes up to 10 years for a new drug to go through the process from application for its registration in Hong Kong, approval given for its registration, its being listed on HADF as a Safety Net drug by the Hospital Authority (HA), to its being reclassified as a General or Special Drug. During such period, there may be quite a number of patients (especially those with cancers) who have missed the golden opportunity for receiving treatments with the new drugs. On the other hand, the Government advised at a meeting with a concern group in November last year that a mechanism would be established to support patients with uncommon diseases. Regarding the provision of diagnoses and treatments for patients with cancers, uncommon diseases and terminal illnesses, will the Government inform this Council:

(1) given that at present, an application for registration of a pharmaceutical product containing a new chemical or biological entity must be accompanied by official evidence of registration approval of the product in two or more specified countries, whether the Government has made a comparison to see if (i) the relevant requirements in neighbouring countries/regions (e.g. Taiwan, Singapore, Malaysia, Korea and Thailand) are less stringent than those in Hong Kong and (ii) the time taken for registration of pharmaceutical products in those countries/regions is shorter than that in Hong Kong; if it has compared and the outcome is in the affirmative, of the details, and whether it will expeditiously study the relaxation of the relevant registration requirements in order to expedite the registration process for pharmaceutical products; if so, of the details; if not, the reasons for that;

(2) given that the Drug Advisory Committee (DAC) under HA currently meets once every three months to vet and approve applications for listing of new drugs on HADF, but the health conditions of some cancer patients may deteriorate rapidly within a short period of time, whether the Government knows if HA will (i) request DAC to meet more frequently and provide it with the necessary manpower and resources, so as to expedite the vetting and approval of applications for listing of new drugs on HADF, and (ii) introduce a fast-track mechanism for vetting and approval of applications for listing of drugs for treating cancers on HADF; if HA will, of the details; if not, the reasons for that;

(3) as the main reason for the applications for listing of drugs for treating cancers on HADF being rejected in the past two years was that the justification of the treatments' cost of the drugs

in relation to their benefits was insufficient, but the listing of such drugs as SFIs without Safety Net (i) will not increase HA's expenditure, (ii) will provide more treatment options for patients to choose, and (iii) will help HA accumulate clinical data, whether the Government knows if HA will consider afresh the applications for the listing of such category of drugs on HADF as SFIs without Safety Net;

(4) of the details of the mechanism to be established by the Government for supporting patients with uncommon diseases, including the government department responsible for and the progress of its co-ordination work; whether it knows if HA will establish specialties to provide treatments to such patients; if HA will, of the specific arrangements;

(5) given that most uncommon diseases are hereditary diseases, whether the Government will step up publicity on premarital health check-up, so as to enable newly-wed couples to know the chances of their next generation having such diseases before reproduction; if so, of the details; if not, the reasons for that;

(6) whether it knows (i) the current number of public hospitals with palliative care specialty; if so, of the types of terminally-ill patients receiving palliative care and the service quotas, with a breakdown of such information by name of hospital, and (ii) if HA has adopted the Quality of Death Index in reviewing the services provided by such specialty; and

(7) given that according to the Quality of Death Index published by a think tank in 2015, Hong Kong was ranked 22nd among 80 countries and regions, whether the Government will review and improve palliative and healthcare in terms of the environment, human resources, affordability of the services, quality of the services and community engagement, so as to raise the ranking of Hong Kong in that index?

Reply:

President,

My reply to different parts of the question raised by the Dr Hon Elizabeth Quat is as follows:

(1) Under the Pharmacy and Poisons Ordinance (Chapter 138), pharmaceutical products should meet the criteria of safety, efficacy and quality, and be registered with the Pharmacy and Poisons Board of Hong Kong (PPB) before they can be sold in Hong Kong. For pharmaceutical products containing new chemicals or biological entities (i.e. active ingredients which have not been registered in Hong Kong), applications should be submitted to the PPB for approval. In such cases, legislative amendments are required in order to incorporate the new chemicals or biological entities into the relevant schedules to the Ordinance.

For registration of a pharmaceutical product containing new chemicals or biological entities, a "secondary review" approach is adopted in Hong Kong, i.e. the approval of the product should make reference to the reviews conducted by drug regulatory authorities of two or more designated reference countries. When applying for registration of a pharmaceutical product containing a new chemical or biological entity in Hong Kong, the applicant should provide supporting documents as set out in the "Guidance Notes on Registration of Pharmaceutical Products/Substances",

including expert evaluation reports on the safety, efficacy and quality of the new product, and documentary proof of registration of the product (such as free sale certificates) issued by the drug regulatory authorities of two or more designated reference countries.

The Drug Office of the Department of Health (DH) has published and uploaded to its website a detailed guide on the registration of pharmaceutical products to help the pharmaceutical industry better understand the registration requirements of pharmaceutical products. In addition, the DH regularly organises talks on the registration of pharmaceutical products to explain the registration requirements to the industry and answer enquiries. Stakeholders are also encouraged to direct their enquiries to and seek assistance from the DH.

The DH has always emphasised service efficiency and has pledged that at least 90 per cent of applications for pharmaceutical product registration would be processed within five months upon the submission of all required documents by the applicants. In 2016-17, the Drug Office of the DH fulfilled the above performance pledge with about 99 per cent of applications processed within five months. The DH will continue to maintain close communication and liaison with the pharmaceutical industry, and review and improve the registration mechanism for pharmaceutical products in due course.

(2) and (3) Being the major provider in the publicly-funded public healthcare services, the Hospital Authority (HA) places high importance on providing appropriate treatment for all patients while ensuring rational use of public resources so as to protect public health and patients' interests.

As for introduction of new drugs, the HA has an established mechanism under which experts conduct meeting once every three months to evaluate new drugs (including drugs for treating cancers and uncommon disorders). The evaluation process follows principles such as evidence-based medical practice, rational use of public resources, targeted subsidy, opportunity cost consideration and facilitation of patients' choice, and takes into account safety, efficacy and cost-effectiveness of the 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. The HA will include approved new drugs in the HA Drug Formulary (HADF) or in the scope of subsidies under the safety net as appropriate.

Drug evaluation is an on-going process driven by evolving medical evidence, latest clinical developments and market dynamics. Currently, some newly developed drugs for treating uncommon disorders and anti-cancer drugs are very expensive or even ultra-expensive. The HA notes that there is normally a lack of large-scale scientific research data and evidence of long-term efficacy, and that these drugs vary greatly in terms of evidence in safety and efficacy as well as the clinical response of patient. Hence, when evaluating applications of these new drugs, apart from adhering to the principles and considering the factors stated above, the relevant committee takes into account internationally published scientific research data. In respect of treatment, the HA will monitor the clinical conditions of individual patients and consider the drug efficacy and the risks involved in individual patients through an independent expert panel, so as to evaluate their suitability of using the drugs

concerned.

The Government and the HA understand the financial pressure and burden on patients as well as their strong aspirations for the listing of certain Self-Financed Items on the HADF. The HA will continue to pay close attention to international medical research studies and the healthcare policies on uncommon disorders in other regions, listen to views and suggestions of patient groups, and continue to keep the HADF under review having regard to the principles of effective use of limited public resources and maximising health benefits for more patients.

(4) In August 2017, the Government and the HA introduced a new Community Care Fund (CCF) Medical Assistance Programme to provide subsidy for eligible patients in need to purchase ultra-expensive drugs (including those for treating uncommon disorders), and implemented on a pilot basis the adjusted financial assessment criteria and patients' co-payment mechanism. A consultancy study has been commissioned by the HA to review the mechanism, and it is expected that recommendations for improvement measures will be put forward in the first half of 2018 with a view to refining the financial assessment criteria for the CCF programme and lowering the patient's maximum contribution to drug expenses.

The Government and the HA are also examining the extension of the scope of the CCF Medical Assistance Programme 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. The HA is in active discussion with the pharmaceutical company concerned, and specific arrangements and details of relevant programmes are being considered. The Government and the HA will announce the details in due course.

(5) Genetic diseases are diseases caused by abnormalities in genetic materials. Most of the uncommon disorders are either hereditary or due to genetic mutation. The Newborn Screening Programme for Inborn Errors of Metabolism is now underway. Certain relatively common inborn errors of metabolism can be detected and thus early follow-up care can be provided. Among various genetic diseases, thalassaemia is an autosomal recessive genetic disease relatively common in Hong Kong and can readily be diagnosed with blood tests.

The Family Health Service (FHS) of the DH provides woman health service for women aged at or below 64 years at its three Women Health Centres and 10 Maternal and Child Health Centres, which covers such services as health education, assessments and counselling. The health assessments include taking personal and family medical history, performing physical examinations and conducting investigations (such as blood tests and cervical screening). If a woman indicates that she is planning for pregnancy and gives a history of possible familial genetic conditions, the healthcare personnel will refer her to the Clinical Genetic Service of the DH for genetic counselling and testing as necessary. In addition, the FHS has put in place, in collaboration with the HA's obstetric departments, an antenatal shared-care programme for pregnant women, under which thalassaemia screening is provided. Pregnant women identified to have risk factors including familial genetic conditions will be referred to the HA's obstetric departments for follow-up.

(6) and (7) Currently, palliative care service in Hong Kong is

mainly provided by the HA. Palliative care service of the HA provides holistic care and support for patients suffering from life-threatening or life-limiting illnesses and their families to meet their physical, psychological, social and spiritual needs, so as to facilitate a more peaceful dying process. Currently, palliative care service is provided by the HA in all its seven clusters, which includes inpatient service, outpatient service, day care service, home care service and bereavement counselling. With the aim to provide holistic care for patients, the HA has been providing appropriate palliative care with a comprehensive service model for terminally-ill patients and their families through a multi-disciplinary team, which comprises doctors, nurses, medical social workers, clinical psychologists, physiotherapists, occupational therapists, etc.

The palliative care service provided by the HA is led by palliative care specialists under the specialties of Medicine and Oncology. In the past, the service focused mainly on the care of advanced cancer patients. In the last decade, it has been gradually extended to cover patients with other diseases, such as patients suffering from end-stage organ failure (e.g. renal failure and chronic obstructive pulmonary disease).

In-patient palliative care service provides care for those with more complex conditions or dying patients. The HA also provides a range of ambulatory palliative care services including outpatient services for patients with less acute or complex symptoms, day care services for rehabilitation and psychosocial support, and home care services to optimise symptom control in the community and to empower informal care-givers. In addition, families are supported by bereavement care before and after patients' death. Statistics on the utilisation of various palliative care services provided by the HA in 2014-15, 2015-16 and 2016-17 (up to December 31, 2016) are set out at the Annex.

In 2017, the HA developed the "Strategic Service Framework for Palliative Care" to guide the development of palliative care service in the coming five to ten years. The framework is to set out specific guidelines on its service model and system infrastructure. Measures will be introduced to provide palliative care and end-of-life care services for an increased number of terminally-ill patients within hospital settings and in the community. Such measures include offering home palliative care service, increasing the frequency of home visits by nurses each year and providing training for the staff of residential care homes for the elderly. Moreover, enhancing medical-social collaboration with community partners, such as non-governmental organisations, patient groups and volunteers, for supporting patients and their families or carers is also highlighted among the strategies.

With the aim of formulating the long-term development direction of healthcare services in response to the challenges of an ageing population, including palliative care service, the Food and Health Bureau commissioned in 2015 the Chinese University of Hong Kong to conduct a three-year research study on the quality of healthcare for the ageing. By making reference to the findings and recommendations of the study, the Government will continue to enhance the palliative care service in Hong Kong, including considering amendment to the relevant legislation.

Ends/Wednesday, January 31, 2018
Issued at HKT 19:23

Annex

Statistics on Utilisation of Hospital Authority's Palliative Care Services in 2014-15, 2015-16 and 2016-17 (up to December 31, 2016)

Palliative Care Service	Number of Attendances		
	2014-15	**2015-16**	**2016-17 (up to December 31, 2016) [Provisional Figures]**
Palliative care inpatient service[1] (total number of inpatient / day inpatient discharges and deaths)	8 254	7 970	6 006
Palliative care specialist outpatient service[1]	9 449	9 058	7 130
Palliative home visit[2]	33 199	34 311	30 273
Palliative day care attendance	12 275	12 231	9 560
Bereavement service	3 034	3 436	2 942

Note:

1. The above statistics refer to the throughput in Palliative Care Specialty only.
2. Data definition was refined in April 2016. Therefore, the statistics are not comparable before and after April 2016.

Appendix IV

Press Releases

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

****

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

NNNN

Appendix V

Press Releases

LCQ2: Application of immunotherapy in Hong Kong
****

Following is a question by the Hon Chan Han-pan and a reply by the Secretary for Food and Health, Professor Sophia Chan, in the Legislative Council today (October 24):

Question:

The Nobel Committee has earlier decided to award this year's Nobel Prize in Physiology or Medicine to two immunologists to commend their breakthroughs in treating cancers with immunotherapy. Although immunotherapy has been proven to be effective in treating cancers, and has brought a ray of hope to quite a number of cancer patients, the Hospital Authority (HA) has not adopted immunotherapy as a regular treatment for cancers. As a result, patients cannot receive immunotherapy treatment even though they are willing to pay for such treatment. Besides, the medications needed for immunotherapy are costly. In this connection, will the Government inform this Council whether it knows if HA:

(1) has drawn up a timetable for adopting immunotherapy as a regular treatment for cancers; if HA has, the details; if not, the reasons for that;

(2) arranged immunotherapy-related training for its healthcare staff in the past three years; if HA did, the details; if not, the reasons for that and when HA will make such arrangements; and

(3) will add the medications needed for immunotherapy to the Hospital Authority's Drug Formulary either as a drug on the list of special drugs subsidised by public funds, or on the list of self-financed drugs with safety net; if HA will, 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 the highly subsidised public healthcare system. My reply to the various parts of the question raised by the Hon Chan Han-pan is as follows.

(1) Drugs for cancer treatment can be classified into different types according to the types of treatment such as traditional chemotherapy, targeted therapy, immunotherapy and hormonal therapy, among which immunotherapy is a new type of cancer treatment. Medications for immunotherapy are mainly intravenously injected into a patient's body to boost or supplement his/her own immune system, so that it will kill or suppress his/her cancer cells. Doctors will consider the condition and wish of a patient in deciding what type of cancer treatment is suitable for the patient including immunotherapy, and immunotherapy is one of the cancer treatment options.

(2) On the technical side, the current injection method of immunotherapy drugs is similar to that of other anti-cancer drugs, and does not require any additional techniques. That said, continuous on-the-job training is provided for healthcare professionals for professional development and for them to learn about the clinical application and the side effects of drugs in treating different diseases so as to keep abreast of the ever-changing scientific development and meet the clinical needs of patients.

(3) The HA has an established mechanism for regular appraisal of new drugs and review of its Drug Formulary and coverage of the safety net, and would make changes as appropriate. The process is based on scientific and clinical evidence, taking into account the safety, efficacy and cost-effectiveness of drugs and other relevant considerations, including international recommendations and practices as well as professional views, so as to ensure equitable and rational use of public resources as well as the provision of optimal care for patients.

At present, there are three immunotherapy drugs listed as self-financed items (SFIs) on the HA Drug Formulary (HADF) for treating four types of cancers, namely skin cancer, renal cell cancer, lung cancer as well as head and neck cancer. Nivolumab, a type of immunotherapy drug for treating skin cancer, has been covered by the Community Care Fund Medical Assistance Programme since August 2018. Patients with clinical needs and meeting specified criteria may apply for drug subsidy to use this drug.

We understand the financial pressure and economic burden on patients, as well as their strong aspiration for listing certain drugs on the HADF and including them in the scope of subsidy under the safety net. To shorten the lead time for introducing suitable new drugs to the safety net, the HA has, since 2018, increased the frequency of prioritisation for including SFIs in the safety net from once to twice a year. The HA will also liaise with pharmaceutical companies from time to time on setting up risk sharing programmes for certain suitable SFIs. Under the programmes, the HA, patients and pharmaceutical companies would contribute to the drug costs in specific proportions within a defined period, or the drug treatment costs to be borne by patients would be capped, with a view to facilitating patients' early access to specific drug treatments.

The HA will continue to keep abreast of the latest development of clinical and scientific evidence, listen to the views and suggestions of patient groups and follow the principle of rational use of limited public resources to review the HADF under the established mechanism and to include suitable self-financed drugs as special drugs or under the coverage of the safety net so as to benefit more patients in need.

Ends/Wednesday, October 24, 2018
Issued at HKT 14:55

NNNN

Appendix VI

Press Releases

LCQ17: Samaritan Fund and Community Care Fund Medical Assistance Programmes

****

Following is a question by the Dr Hon Chiang Lai-wan and a written reply by the Secretary for Food and Health, Professor Sophia Chan, in the Legislative Council today (January 30):

Question:

Having considered the findings of a consultancy study carried out by two universities, the Government has agreed to enhance the means test mechanism for the Samaritan Fund and Community Care Fund Medical Assistance Programmes (the two Programmes). The enhancement measures include: (1) taking into account only 50% (previously 100%) of the net disposable capital when calculating the annual disposable financial resources (ADFR) of the household to which a drug subsidy applicant belongs, and (2) amending the definition of "household" adopted for financial assessment. According to the new definition of "household", (i) for a married non-dependent patient, the assets of his/her parents living under the same roof will not be counted, and (ii) for an unmarried non-dependent patient, the patient will be treated as a single-person household. Regarding the two Programmes, will the Government inform this Council:

(1) whether it knows the average, longest and shortest time taken by the authorities in the past three years on vetting and approval of the applications under the two Programmes;

(2) whether it knows, in respect of each category of drugs (categorised by type of illness), (i) the total number of patients receiving subsidies under the two Programmes and, among them, the respective numbers of those receiving full and partial subsidies, (ii) the average amount of subsidy received by each subsidised patient, (iii) the average amount of drug cost contributions made by each subsidised patient, and (iv) the total subsidy amount for each category of drugs, in each of the past three years;

(3) whether it knows the respective numbers of applications for subsidies for (i) drug items and (ii) non-drug items which were rejected in each of the past three years;

(4) given that the school fees of children at secondary level or below are allowable deductions in determining the ADFR of the households to which the applicants under the two Programmes belong, whether the authorities will treat school fees of children at post-secondary level as allowable deductions; if so, of the details; if not, the reasons for that;

(5) whether it will set a retrospective period for the two Programmes so as to provide subsidies for covering the expenses incurred by the medical procedures carried out, medical supplies/devices procured or medical treatments commenced within a certain period of time prior to the approval of applications, in order to avoid delays in the treatment of patients with financial needs as their applications for subsidy are pending; if so, of the details; if not, whether it will streamline the application procedure and shorten the processing time; and

(6) whether it will regularly review the two Programmes in terms of their scope of subsidies, eligibility criteria and issues relating to vetting and approval of applications, so that the subsidies may better meet the needs of patients; if so, of the timetable; if not, the reasons for that?

Reply:

President,

My reply to the various parts of the question raised by Dr Hon Chiang Lai-wan is as follows:

(1) The Hospital Authority (HA) does not keep statistical records on how long it takes to complete the vetting and approval of an application for subsidies under the Samaritan Fund (SF) or Community Care Fund (CCF) Medical Assistance Programmes upon receipt of the application from the applicants. Yet, all such applications will be processed by medical social workers as soon as possible once doctors' referrals and the necessary information or documents required from the patients concerned are received so that timely support can be provided for patients in need. As for urgent cases, medical social workers will expedite the processing so as to give support to eligible patients as early as possible.

(2) The information on drug subsidies provided under the SF and CCF Medical Assistance Programmes in the past three years is set out at the Annex.

(3) The numbers of applications for subsidies not being approved in the past three years are set out in the table below:

Year	2015-16	2016-17	2017-18
Subsidies for drug items	0	1	0
Subsidies for non-drug items	2	1	0

(4) Currently, allowable deductions to be counted in the calculation of patients' household annual disposable income include school fees of children (up to age of 21) who are at secondary level or below, but do not cover school fees of children at post-secondary level. In reviewing the means test mechanism for the SF and CCF Medical Assistance Programmes, the consultant team collected views from various stakeholders, and recommended the Government and the HA to consider increasing the number of allowable deductible items and relaxing the restrictions on the existing allowable deductions. Yet adding school fees of children at post-secondary level as allowable deductions is not among those suggested by the consultant team. The Government and the HA will continue to study these issues taking into account the consultant team's recommendations, stakeholders' views and the HA's capacity on an incremental basis.

(5) As mentioned in the reply to Part 1 above, applications for subsidies will be processed by medical social workers as soon as possible once doctors' referrals and the necessary information or documents required from the patients concerned are received so that timely support can be provided for patients in need. Under the existing arrangements for applications under the SF and CCF Medical Assistance Programmes, patients are granted subsidies only after the approval of their applications. For cardiac medical items covered by the SF, the HA will make special

arrangements where necessary under special clinical circumstances (such as emergency cases) if the means test for a patient has not yet been completed before the surgery.

Furthermore, based on the review findings, the Government and the HA have introduced a number of enhancement measures, including confining the definition of "household" adopted for financial assessment to cover only core family members living under the same roof and having direct financial connection with the patient concerned. If a patient is classified as a dependent patient (i.e. a person who is unmarried and either (i) under 18 years old; or (ii) 18 to 25 years old receiving full-time education), the corresponding "household" definition will only include the patient's parents/legal guardians, and dependent siblings living under the same roof. As regards non-dependent patients, the corresponding "household" definition will only include the patient's spouse and dependent children living under the same roof. A non-dependent patient who is unmarried will be treated as a single person household, irrespective of whether the patient's parents or siblings are living under the same roof. The refined definition of "household" will reduce the number of household members, and hence the incomes and assets of non-core family members will not be included in the calculation of the annual disposable financial resources (ADFR). This will help further reduce patient contribution to drug expenses and simplify the application procedures.

(6) The HA has an established mechanism for reviewing the scope of subsidies under the SF and CCF Medical Assistance Programmes. To provide more timely support for needy patients, the HA has, since 2018, increased the frequency of prioritisation exercise for including self-financed drugs in the safety net of the SF or the scope of subsidies under the CCF Medical Assistance Programmes from once a year to twice a year, so as to shorten the lead time for introducing suitable drugs into the scope of subsidies.

Regarding the means test mechanism, apart from confining the definition of "household" adopted for financial assessment, the enhancement measures also include modifying the calculation of ADFR by counting only 50% of the net assets of a household. The consultant team expected that these enhancement measures would significantly alleviate the financial burden on patients' families arising from drug expenditure. The consultant team also studied other related issues such as the financial assessment for patients who are in need of multiple and/or recurrent items. The Government and the HA will continue to study these issues taking into account the consultant team's recommendations, stakeholders' views and the HA's capacity on an incremental basis.

Ends/Wednesday, January 30, 2019
Issued at HKT 17:35

NNNN

Annex

Drug Items	2015-16					2016-17					2017-18				
	No. of cases with full subsidy	No. of cases with partial subsidy	Average subsidy amount ($)	Average patient contribution[1] ($)	Total subsidy ($ million)	No. of cases with full subsidy	No. of cases with partial subsidy	Average subsidy amount ($)	Average patient contribution[1] ($)	Total subsidy ($ million)	No. of cases with full subsidy	No. of cases with partial subsidy	Average subsidy amount ($)	Average patient contribution[1] ($)	Total subsidy ($ million)
Samaritan Fund															
Abatacept	28	7	84,855	21,758	2.97	33	10	81,672	13,751	3.51	26	9	89,060	17,146	3.12
Adalimumab	81	39	102,353	16,306	12.28	98	46	100,266	19,448	14.44	110	38	102,589	15,843	15.18
Azacitidine	-	-	-	-	-	25	14	285,696	31,398	11.14	36	15	252,663	46,380	12.89
Bortezomib	61	42	200,945	21,132	20.70	57	29	168,915	35,543	14.53	61	38	178,684	33,012	17.69
Canakinumab	-	-	-	-	-	-	-	-	-	-	0	2	345,851	28,549	0.69
Certolizumab Pegol	-	-	-	-	-	14	6	74,167	19,194	1.48	18	11	74,612	11,341	2.17
Cetuximab	-	-	-	-	-	38	13	77,313	22,479	3.94	22	14	100,550	11,480	3.62
Crizotinib	-	-	-	-	-	-	-	-	-	-	28	19	209,270	27,796	9.84
Dasatinib	62	49	188,583	23,883	20.93	70	60	184,358	26,059	23.96	68	52	187,646	21,539	22.52
Eltrombopag	25	8	95,624	12,531	3.16	26	5	78,018	22,460	2.42	38	10	78,311	7,075	3.76
Erlotinib	9	4	103,553	22,444	1.35	4	2	156,157	2,616	0.94	6	1	101,504	49,519	0.71
Etanercept	141	76	90,409	14,169	19.62	149	71	86,602	16,398	19.05	136	64	89,213	15,886	17.84
Everolimus	-	-	-	-	-	-	-	-	-	-	5	1	156,916	4,124	0.94
Fingolimod	11	6	233,530	30,914	3.97	16	10	238,177	16,182	6.19	19	12	238,101	16,275	7.38

[1] This refers to the average patient contribution in cases with partial subsidy.

	2015-16					2016-17					2017-18				
Drug Items	No. of cases with full subsidy	No. of cases with partial subsidy	Average subsidy amount ($)	Average patient contribution[1] ($)	Total subsidy ($ million)	No. of cases with full subsidy	No. of cases with partial subsidy	Average subsidy amount ($)	Average patient contribution[1] ($)	Total subsidy ($ million)	No. of cases with full subsidy	No. of cases with partial subsidy	Average subsidy amount ($)	Average patient contribution[1] ($)	Total subsidy ($ million)
Gefitinib	4	3	135,285	48,788	0.95	4	3	115,169	38,096	0.81	4	3	68,692	40,458	0.48
Golimumab	81	40	87,805	10,686	10.62	90	50	87,133	11,628	12.20	101	43	88,952	12,607	12.81
Growth hormone	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Imatinib	208	150	202,731	23,320	72.57	218	154	124,285	27,263	46.23	145	70	158,118	26,867	34.00
Infliximab	30	13	106,409	9,000	4.58	39	7	110,415	23,985	5.08	30	8	113,137	23,189	4.30
Interferon	2	1	184,971	4,097	0.55	0	0	0	0	0	0	2	198,350	13,276	0.40
Lenalidomide	17	5	131,764	20,685	2.90	30	9	124,292	23,563	4.85	33	16	152,066	24,947	7.45
Natalizumab	0	1	234,755	12,824	0.23	0	1	244,358	3,221	0.24	0	0	0	0	0
Nilotinib	50	54	230,194	26,716	23.94	57	58	223,309	23,213	25.68	63	51	237,425	28,602	27.06
Plerixafor	-	-	-	-	-	5	1	93,218	4,991	0.56	16	2	82,167	4,345	1.48
Rituximab	152	104	81,291	28,909	20.81	179	93	86,351	34,204	23.49	167	104	80,962	32,867	21.94
Temozolomide	34	12	55,056	9,109	2.53	34	19	58,208	18,375	3.08	33	15	65,234	18,068	3.13
Tocilizumab	70	32	72,863	11,116	7.44	87	33	66,793	19,271	8.02	85	39	65,913	17,841	8.17
Trastuzumab	264	260	162,766	42,500	85.29	301	283	171,588	45,831	100.21	241	248	187,433	52,133	91.65
Ustekinumab	0	1	110,320	2,000	0.11	2	2	81,861	64,890	0.33	4	2	80,068	57,932	0.48
Community Care Fund Medical Assistance Programme (First Phase Programme)															
Abiraterone	-	-	-	-	-	-	-	-	-	-	19	11	138,140	44,955	4.15
Afatinib	-	-	-	-	-	12	8	134,625	23,901	2.69	32	16	130,655	36,363	6.27
Bendamustine	-	-	-	-	-	2	0	228,972	0	0.46	6	2	250,488	12,337	2.00

	2015-16					2016-17					2017-18				
Drug Items	No. of cases with full subsidy	No. of cases with partial subsidy	Average subsidy amount ($)	Average patient contribution[1] ($)	Total subsidy ($ million)	No. of cases with full subsidy	No. of cases with partial subsidy	Average subsidy amount ($)	Average patient contribution[1] ($)	Total subsidy ($ million)	No. of cases with full subsidy	No. of cases with partial subsidy	Average subsidy amount ($)	Average patient contribution[1] ($)	Total subsidy ($ million)
Bevacizumab	10	4	94,879	17,061	1.33	7	6	79,625	33,558	1.04	22	21	145,170	20,242	6.24
Cetuximab	18	12	75,189	21,066	2.26	10	8	18,769	8,283	0.34	-	-	-	-	-
Enzalutamide	-	-	-	-	-	-	-	-	-	-	21	9	139,721	39,210	4.19
Erlotinib	174	124	115,198	35,648	34.33	219	128	116,228	32,102	40.33	247	136	94,726	26,052	36.28
Gefitinib	309	189	132,223	26,915	65.85	341	165	109,289	28,627	55.30	341	145	86,909	20,703	42.24
Lapatinib	36	30	61,038	5,058	4.03	67	29	63,116	6,612	6.06	70	40	63,808	12,037	7.02
Pazopanib	18	9	121,913	36,445	3.29	33	12	130,736	37,684	5.88	31	19	103,162	31,254	5.16
Pegylated liposomal Doxorubicin	36	8	59,385	29,780	2.61	23	18	63,834	23,166	2.62	41	12	65,423	24,040	3.47
Pemetrexed	242	108	61,731	19,842	21.61	273	118	62,478	20,300	24.43	294	56	20,028	6,134	7.01
Pertuzumab	-	-	-	-	-	-	-	-	-	-	17	31	445,060	69,790	21.36
Sorafenib	200	82	53,656	11,667	15.13	196	94	48,898	12,195	14.18	212	88	46,906	10,115	14.07
Sunitinib	46	23	92,108	38,558	6.35	35	25	106,868	18,887	6.41	46	15	114,658	26,454	7.00
Trastuzumab	-	-	-	-	-	-	-	-	-	-	6	3	177,704	5,256	1.60
Vemurafenib	-	-	-	-	-	0	2	330,696	95,304	0.66	1	2	241,203	64,195	0.72
Community Care Fund "Subsidy for Eligible Patients to Purchase Ultra-expensive Drugs (Including Those for Treating Uncommon Disorders)" [2]															
Eculizumab	-	-	-	-	-	-	-	-	-	-	3	6	3,953,510	207,462	35.58

[2] This Community Care Fund medical assistance programme was introduced in August 2017.

Appendix VII

Relevant papers on mechanism for appraisal of cancer drugs for inclusion in the Hospital Authority Drug Formulary and the safety net and arrangement for the provision of sustainable and affordable drug treatment for cancer patients

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 III)	Agenda Minutes CB(2)2053/13-14(01)
	15.6.2015 (Item V)	Agenda Minutes

Committee	Date of meeting	Paper
	19.12.2016 (Item III)	Agenda Minutes CB(2)480/17-18(01)
	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 Minutes
	19.6.2018 (Item IV)	Agenda Minutes
	19.11.2018 (Item V)	Agenda Minutes CB(2)321/18-19(01)
	11.12.2018 (Item I)	Agenda Minutes CB(2)600/18-19(01) CB(2)963/18-19(01)

Council Business Division 2
Legislative Council Secretariat
13 December 2019