For discussion
14 April 2025

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Legislative Council Panel on Health Services
Public Healthcare Fees and Charges Reform

Purpose

This paper aims to brief members on the progress made by the Government in taking forward the fees and charges reform for public healthcare.

The Need for Reform

2. Hong Kong's healthcare system is renowned for its efficient and quality services. The public healthcare system is not only the cornerstone of the healthcare system, but also a safety net for all, which must be robust and sustainable. At present, public healthcare services are heavily subsidised by public funds, with a subsidy rate as high as 97.6%. However, with an ageing population, increasing demand for services and rising healthcare costs, Hong Kong's healthcare system is facing unprecedented challenges.

3. Although Hong Kong's public healthcare system excels in terms of efficiency and quality when compared with other parts of the world, the Hong Kong healthcare system faces a number of structural challenges, including:

(i) Imbalanced System: There has been a serious imbalance between the public and private healthcare systems for a long time, with about half of the doctors working in the public healthcare system but taking care of 90% of the in-patients. This imbalance has resulted in the public healthcare system being overburdened while the private healthcare system has not been able to share the pressure effectively;

(ii) Mismatch of resources: Under the existing subsidisation structure, more subsidies are provided for minor illnesses and relatively less subsidies for major illnesses. As a result, some patients with serious illnesses have to purchase expensive drugs at their own expense. On the other hand, accident and emergency ("A&E") departments are positioned to handle emergency cases, but in fact about 60% of the patients seeking treatment are in fact not emergency cases;

(iii) Service wastage: The existing fees and charges levels are not be able to direct the optical use of resources. For example, there are no itemised charges for non-emergency diagnostic tests, such as computerised tomography and magnetic resonance imaging services, and about 10% of the patients do not receive the services as scheduled after making an appointment, resulting in wastage. Moreover, as the cost of drug at HA out-patient clinics is too low, some members of the public tend to stock up unnecessary drugs; and

(iv) Demand exceeds supply: Hong Kong's ageing population and rising rate of chronic diseases have resulted in long waiting times and pressure on service quality.

4. To ensure the sustainability of the healthcare system, the Government must deepen the healthcare reforms in a holistic manner, including the linkage among reforms in three aspects, i.e. healthcare services (enhancing the governance and effectiveness of HA; promoting primary care services), healthcare protection (reforming fees and charges for public healthcare; enhancing the transparency of private healthcare fees and charges; promoting the Voluntary Health Insurance Scheme) and drugs (enhancing the approval and registration system of drugs and medical devices; enhancing the arrangements for the introduction and procurement of drugs and medical devices), of which reforming fees and charges for public healthcare is an integral part.

Principles and Considerations for Fees and Charges Reform

5. The fees and charges reform for public healthcare is based on the following five principles:

(i) Commitment will not be lessened: the Government's commitment to public health will remain unchanged. All the gains from the reform will be wholly utilised for public healthcare services;

(ii) Co-payment for those who can afford and co-payment by those with mild conditions: the Government will reasonably expand and enhance the co-payment mechanism;

(iii) Enhancement and reduction: protection for "poor, acute, serious, critical" patients will be enhanced and wastage will be reduced;

(iv) High subsidisation: the high level of subsidy will be maintained after the reform, with the target of maintaining the 90% overall public subsidisation rate; and

(v) Gradual and orderly progress: the objective will be achieved on a progressive and orderly manner in five years.

6. The HA has an established mechanism for reviewing its fees and charges every two years. As early as 2002, the Government commissioned a study on "restructuring of fees and charges for public health care services". With reference to the consultancy report, the six major factors in setting and reviewing public hospital fees and charges are as follows:

(i) Cost sharing: while maintaining access, patients should share the cost of service, especially those who can afford to pay more;

(ii) Affordability: to ensure that the fee structure is affordable to both the general public and to lower income groups, and help those who cannot afford with a fee waiver system;

(iii) Appropriateness: fees and charges as a means to encourage appropriate use of services, such as fees for A&E service;

(iv) Resource prioritisation: by providing higher subsidies for services of greater needs and financial risks;

(v) Facilitating access by vulnerable groups: through targeting subsidies to low-income groups and chronic patients; and

(vi) Public acceptance – by ensuring that the fee structure can be clearly understood by patients and service providers, and that it is politically acceptable and administratively simple.

The Government and HA have taken into account the above established factors in handling the fees and charges reform, and at the same time taken into account the need for institutional reform to enhance the sustainability of Hong Kong's public healthcare system in the long term, in line with the direction of development of other healthcare reform projects.

Main Content of Fees and Charges Reform

7. The current fees and charges reform for public healthcare covers the following three major areas, with a view to ensuring that limited healthcare resources can be deployed in a targeted manner to help those patients most in need.

(i) Reforming the subsidisation structure:

- Reforming the subsidisation structure from a systemic perspective by setting the levels of government subsidisation and the proportion of co-payments by members of the public for various public healthcare services to rationalise the relative demands for in-patient, A&E and different tiers of out-patient services, guide the optimal use of the healthcare resources as well as enhance the system's sustainability in terms of professional healthcare resources and finances. The overall subsidisation rate for public healthcare services after the implementation of the first phase of fees and charges reform will be about 94%.

(ii) Reducing wastage and misuse:

- Introducing a co-payment model for non-urgent diagnostic radiology and pathology services, adjusting the charges for and quantities of standard drugs, making use of the fees and charges to drive changes to the public's behaviour in seeking medical treatment, reduce wastage and misuse as well as enhance service efficiency.

(iii) Enhancing healthcare protection:

- enhancing the medical fee waiving mechanism, relaxing the income and asset limit to significantly strengthen support for low-income families and underprivileged groups;
- introducing a cap on annual spending of $10,000 for public healthcare services to better care for critically ill patients; and
- accelerating the introduction of more effective innovative drugs and devices and relaxing the eligibility criteria of means test for the safety net applications, so that more critically ill patients can receive subsidy for self-financed drugs and devices.

8. Details of the new fee and charges under the reformed subsidisation structure are provided in **Annex 1**. Specific measures to strengthen healthcare protection are outlined below:

(i) Enhancing the Medical Fee Waiver Mechanism

- For patients in need who are not among the three categories of social welfare recipients[1] currently already benefitting from full medical fee waiver, the income and asset limits for applying for fee waivers will be relaxed. The income limit will be increased from the current 75% of median monthly household income (MMDHI[2]) to 100 % of the MMDHI (for 2-person household or larger), or 150% of the MMDHI (for 1-person household, with a view to strengthening assistance to 1-person households lacking in other forms of social support). The asset limit will be relaxed to match the one for public rental housing applicants[3];
- The scope of coverage of all period waivers will be expanded to cover episodic appointments in general out-patient clinics (GOPC)[4], and the maximum validity period of medical fee waivers will be extended from 12 months to 18 months; and
- The definition of "household" will be relaxed to match the one for applying assistance under the Safety Net for self-financed items, so that family members who are not financially connected with the patient may be excluded from financial assessment.

(ii) Introducing an annual cap of HK$10,000 on fees and charges for in-patient and out-patient services

- A new annual cap on fees and charges at HK$10,000 per patient will be introduced, applicable to all public healthcare fee items[5] (excluding self-financed items); and
- The cap will be calculated on a calendar year basis, and all Hong Kong residents will be eligible to apply and benefit.

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[1] The recipients of Comprehensive Social Security Assistance (CSSA), Old Age Living Allowance (OALA) recipients aged 75 or above and Level 0 Voucher Holders of the Residential Care Service Voucher (RCSV) Scheme for the Elderly.

[2] The MMDHI is based on the Census and Statistics Department's General Household Survey. Upon enhancement, the MMDHI excluding foreign domestic helpers will be adopted.

[3] In addition, the HA will maintain the current arrangement of raising the asset limit by $168,000 for each elderly member (i.e. aged 65 or above) in the household.

[4] Currently, if patients below the age of 65 with period waiver needs to attend GOPC services for episodic appointments, s/he is required to approach (medical) social worker to apply for one-off medical fee waiver. For those patients aged 65 or above, there is no additional requirement to apply for waiver.

[5] Applicable to the public charges for all eligible persons, except for special accommodation wards.

(iii) Expansion of the Safety Net for Self-financed Items and Relaxation of Application Eligibility

- With the Samaritan Fund mechanism, the types of self-financed items covered by the safety net will be expanded;
- For subsidy application for drugs and non-one-off non-drug items under the Samaritan Fund, the calculation of income for Annual Disposable Financial Resources (ADFR) will be relaxed. For new applicants, only 80% (currently 100%) of their income will be included for assessment, while for recurrent applicants only 60% (currently 80%) of their income will be included for assessment;
- For subsidy applications for one-off non-drug items, the income limit[6] for 1-person households will be relaxed to 1.5 times of the current limit, in line with the enhancement measures on medical fee waiver mechanism; and
- The sliding scale for calculating the amount of patient contribution will be widened, thereby reducing the amount of patient contribution for patients covered under the safety net.

Details and beneficiary examples are at **Annex 2**.

Expected increase in effectiveness of health protection under the fees and charges reform

9. Through a more targeted subsidisation, the fees and charges reform can enhance the protection of "poor, acute, serious, critical" patients, strengthening the safety net for all.

"Support the Poor"

(i) We expect that more low-income earners will benefit from this reform, thereby expanding the safety net and achieving the objective of "supporting the poor". Regarding the underprivileged groups in the community with the least affordability economically, there are currently about 600 000 people eligible to enjoy full medical fee waiver mechanism, including about 270 000 CSSA recipients, about 330 000

[6] At present, the income limit for application of one-off non-drug item under the Samaritan Fund is set at the MMDHI. Upon enhancement, this limit will be relaxed to 150% of the MMDHI and the MMDHI (excluding foreign domestic helpers) will be adopted

OALA recipients aged 75 or above, about 4 000 beneficiaries of the RCSV Scheme for the Elderly (Level 0 Voucher holders) and about 14 000 people who currently receive full or partial waiver of medical fees. They will continue to benefit from the fees and charges reform and will not be affected at all. Currently, about 95% of patients in public hospitals pay less than $2,500 on hospitalisation and clinic medical expenses throughout the year. Based on the current usage of services by HA patients, it is projected that after the implementation of the first phase of the fees and charges reform, 80% of patients (excluding those whose fees are waived currently) will still pay less than $2,500 on medical expenses throughout the year, while less than 10% of patients will pay more than $4,500 per year. The above projections have not taken into account that，under the enhanced fee waiver mechanism, patients with financial difficulties may apply for medical fee waiver and receive partial/full waiver according to the relevant conditions. It is estimated that the number of eligible beneficiaries will increase from 300 000 to 1.4 million under the enhanced fee waiver mechanism.

"Save the acute patients"

(ii) The reform would also improve the utilisation of A&E resources. At the same time, we will regularise the special refund arrangement for A&E service to facilitate patients with less urgent conditions to flexibly choose other consultation arrangements so as to enable A&E departments to better perform its emergency and life-saving functions, develop advanced critical care (such as chest pain centres and stroke centres), improve treatment outcomes and survival rates, thereby making the safety net more stable to save the acute patients.

"Protect those with serious conditions"

(iii) In respect of serious illnesses, patients with serious illnesses who unfortunately need frequent hospitalisation and out-patient treatment and thus incur a relatively high cost burden will be better protected with an cap on annual spending of $10,000 with a view to making the safety net thicker for "protecting those with serious conditions". It is estimated that about 70 000 patients with serious conditions will benefit from this measure each year. The measure would help ensure that public medical expenditure for individual patients remains at an affordable level, and increase subsidies on drugs and medical devices for the critically ill prevent "patients with serious conditions falling into poverty".

"Help the critically ill"

(iv) For patients with critical illnesses, the enhanced subsidy on the use of the use of drugs and medical devices will help more patients, including those from middle-income families, to receive subsidy as appropriate, thereby achieving the goal of "helping the critically ill" and making the safety net denser. The specific directions of the fees and charges reform include making good use of the additional resources released after the reform to expedite the introduction of more effective and innovative drugs into the HA Drug Formulary for patients' choice; at the same time, increasing the types of drugs and medical devices subsidised under the safety net of the Samaritan Fund to provide subsidies for the needy patients; and adding suitable drugs subsidised by the Samaritan Fund to the Special Drugs category in an orderly manner having regard to the clinical data of the drugs and healthcare needs. Patients will then only need to pay the standard drug fees to receive appropriate drug with high subsidy for treatment. Meanwhile, HA will also relax the means test criteria for subsidies under the Samaritan Fund, so that patients can receive a higher proportion of subsidies for self-financed drugs and equipment, reducing the risk of the public being impoverished due to critical illnesses.

Progress of Reform

10. Since the Government announced the public healthcare reform to the public on 25 March, the Health Bureau (HHB) and HA have proactively explained the fees and charges reform and listened to the views of stakeholders on driving the reform through the public media, as well as through reaching out to and meeting with stakeholders in different sectors, including Legislative Council Members and political groups, professional bodies, healthcare professionals, patients' organisations and representatives, and advisory bodies related to public hospital services. The relevant work is still in full swing. Meanwhile, the Government has been closely monitoring the views and requests from various sectors of the community and different fields on the fees and charges reform.

11. The majority of the community agrees that the current highly subsidised public healthcare services in Hong Kong, which are entirely dependent on government tax revenue, will not be able to cope with the increase in demand for healthcare services brought about by demographic changes and healthcare development in Hong Kong in the long run. Therefore, reforms are imperative. The majority of the community agrees with the reform directions of improving the allocation of healthcare resources

in a targeted manner and minimising wastage through increasing the co-payment ratio by the public, thereby inducing the public to change their habit of using healthcare services.

12. On the enhancement of healthcare protection, many patients and non-governmental organisations (NGOs) welcome the increased support provided by the fees and charges reform to the poor, the seriously ill and the critically ill. At the same time, there are also concerns about the application procedures of various measures to enhance healthcare protection for patients, which may be cumbersome and inconvenient, thus discouraging needy patients from applying; there are also concerns about whether the application processing procedures will involve a large amount of additional manpower, especially medical social workers, which will make it difficult for the responsible staff to cope with and result in substantial administrative costs.

13. As A&E services are positioned to serve critically ill and emergency patients, the majority of the public recognises the direction that fees should be charged to guide people with minor illnesses and other people who do not need the A&E services to choose other services. However, there are also concerns about the availability of other medical options and channels to obtain relevant information during non-office hours and holidays.

14. The fees and charges reform for public healthcare involves a number of innovations and enhancements to the HA system. In implementing the new fee waiver arrangement and setting up application procedures related to the cap on spending, the HA will adhere to the principle of streamlining procedures as much as possible to reduce the need for repeated verification of patients' income and asset information. For example, the HA will make good use of the means-tested eligibility of members of the public under social welfare and other government subsidy schemes which have been vetted as a reference in processing fee waiver applications. During the processing period, applicants will be required to provide necessary or missing information based on the actual situation without the need to re-evaluate each application anew, so that all arrangements and processing procedures can be clear and simple for patients. The assessment process will also be digitalised as far as possible to reduce the administrative burden and cost as well as the burden on medical social workers, so that they can focus on assisting cases with specific individual or family welfare needs. After the fees and charges reform plan is published in the Gazette and announced, the HA will continue to communicate with stakeholders, including patient groups, healthcare professionals, the HA staff, etc., to design details in the implementation phase and streamline the application procedures for medical fee waiver and safety net. Meanwhile, the HA will also consider setting up an information platform to provide detailed application guides so as to facilitate the public's better understanding and use of these services.

15. The first point of contact for citizens' health should be their primary healthcare family doctor. The Government will strengthen the gatekeeping role of primary healthcare in the public secondary healthcare system, and leverage the advantages of the dual-track model of the public and private sectors in the provision of primary healthcare services, with a view to enhancing the sustainability of the healthcare system. In respect of public primary healthcare, the HA's general out-patient clinics will be repositioned to prioritise the provision of comprehensive primary healthcare services for the underprivileged. The HA will also continue to increase the capacity of its family medicine out-patient service, and increase the night-time and holiday out-patient services at specific districts in need through cross-district collaboration and flexible deployment of resources. To optimise the use of private healthcare resources and provide more diversified healthcare choices for the public, the Government is strengthening the concept of "Family doctor for all" through the Chronic Disease Co-care Pilot Scheme and developing a community pharmacy programme to enhance the primary healthcare at the community level, and reduce the over-reliance of patients with mild illnesses on the public healthcare system. The HA and the Primary Healthcare Commission will also collaborate with the private medical sector to compile information on private hospitals and primary care Chinese and Western medical practices in the region that provide services in the evenings and during holidays, such that patients, in particular those with mild illnesses, can easily access such information through coordination platforms (such as eHealth) and choose appropriate healthcare services.

16. The new fees and charges will be published in the Gazette at the end of this month and will come into effect on 1 January 2026. Following the principle of progressive and orderly implementation, we expect that the reform will take five years. Subsequent adjustments will be made in accordance with the established mechanism, i.e. the subsequent adjustment arrangements will be reviewed every two years in accordance with the relevant principles.

Advice Sought

17. Members are invited to note the content of the paper.

Background

18. Under section 4(d) of the HA Ordinance (Cap. 113), the HA is required to "recommend to the Secretary for Health, for the purposes of section 18, appropriate policies on fees for the use of hospital services by the public, having regard to the principle that no person should be prevented, through lack of means, from obtaining adequate medical treatment".

19. Section 18 of the HA Ordinance provides that a Hospital Governing Committee established for a public hospital may determine fees payable for hospital services provided by the public hospital for which it is established, subject to any directions that may be given by the HA, which in turn shall comply with the directions that may be given by the Secretary for Health. The level of fees and charges determined under this section should be gazetted for public notice.

Health Bureau
Hospital Authority
April 2025

Annex 1

Fees and Charges Effective from 1 January 2026

Services		Fees Effective from 1 January 2026	Subsidisation Rate
Inpatient (Acute bed)	**Admission fee**	To Cancel	~95%
	Maintenance fee (per day)	$300	
Inpatient (convalescent / rehabilitation, infirmary & psychiatric beds) Maintenance fee (per day)		$200	~95%
Day procedure and treatment	**Admission fee**	To Cancel	~95%
	Maintenance fee (per day)	$250	
Day hospital (Geriatric、Rehabilitation)		$100	~95%
Community Nursing Service, Community Allied Health Service		$100	~85%-95%
Community Psychiatric Nursing Service		Free	100%
Psychiatric Day Hospital		Free	100%
A&E		$400 (note) (Fee exempted for Category I and II)	~80%
Specialist Outpatient Clinic (SOPC) (Include Allied Health Clinic)	**1st attendance**	$250	~75%
	Subsequent		
	Drug	$20 per unit, up to 4 weeks	
Pathology Testing Service (applicable for SOPC)	**Basic**	Free	~90%
	Intermediate	$50	
	Advanced	$200	
Non-emergency Radiology Imaging Service	**Basic**	Free	~90%
	Intermediate	$250	
	Advanced	$500	
Family Medicine Outpatient Service (Include General Outpatient Clinic and Family Medicine Specialist Clinic)	**Consultation**	$150	~70%
	Drug	$5 per unit, up to 4 weeks	

Note: Patients can apply for a refund of $350 while waiting for medical consultation at the A&E.

Annex 2

Strengthening Healthcare Protection

(A) Enhancing the Medical Fee Waiver Mechanism

1. Existing Medical Fee Waiver Mechanism

The recipients of Comprehensive Social Security Assistance (CSSA), Level 0 Voucher Holders of the Residential Care Service Voucher (RCSV) Scheme for the Elderly and Old Age Living Allowance (OALA) recipients aged 75 or above (including those under the Guangdong and Fujian schemes) under Social Welfare Department (SWD) will be waived from payment of public medical fees upon presentation of identity proof and claim their waiver eligibility status each time they register for consultation and their waiver status could be confirmed through online eligibility checking. For others who need to apply for medical fee waiver, Medical Social Workers or Social Workers (MSWs / SWs) would assess the application on a household basis, mainly taking into account the income and assets. If the patient's monthly household income and asset do not exceed the respective limits (75% of the Median Monthly Domestic Household Income (MMDHI) applicable to his / her household size for income limit; and the specified limit applicable to their household size for asset limit (Table 1)), he/she will be considered for medical fee waiver. MSWs / SWs will also consider various non-financial factors[7], apart from the financial factors of household income and asset.

Table 1: Asset Limit for Waiving of Medical Charges

Household Size	Asset Limit (without elderly member)	Asset Limit (with 1 elderly member*)	Asset Limit (with 2 elderly members*)
1	$41,500	$209,500	-
2	$85,000	$253,000	$421,000
3	$127,500	$295,500	$463,500
4	$170,000	$338,000	$506,000
5	$212,500	$380,500	$548,500

*Note: The asset limit is increased by $168,000 for each elderly member (i.e. aged 65 or above) in the household.

2. Measures for Enhancing the Medical Fee Waiver Mechanism include:

(i) Relaxation of the income and asset limit

[7] Examples of non-financial factors:
(a) The patient's clinical condition (as defined by the patient's frequency of use of different public medical services and the severity of illness);
(b) Whether the patient is a disabled person, single parent with dependent children, or from other vulnerable groups;
(c) Whether a medical fee waiver could provide incentive and support to solve the patient's family problems;
(d) Whether a patient has any special expenses that make it difficult for him/her to pay for medical fees at public clinics / hospitals; or
(e) Other justifiable social factors.

Income Limit	Relaxing the income limit from the current 75% of MMDHI to: 2-person household or larger: MMDHI[8] 1-person household: 150% of MMDHI
Asset Limit	Relaxing the asset limit to match the one for Public Rental Housing application, and maintain the arrangement of raising the asset limit by $168,000 for each elderly member (i.e. aged 65 or above) in the household.

(ii) Expansion of the scope of coverage and validity period of waiver

- Expand the scope of coverage for period waiver for those below the age of 65, to include general out-patient clinic (GOPC) services for episodic appointments[9]
- The maximum validity period of medical fee waiver will be extended from 12 months to 18 months
- For re-application within a maximum of 18 months, there is no need to submit financial documents for means test[10]

(iii) Refining the definition of "household"

- Under the existing mechanism, household includes patient and his/her core family members living under the same roof, i.e. patient's parents, children, spouse and dependent siblings. Upon enhancement, the definition of "household" will be relaxed to match the one for applying assistance for self-financed items under the safety net. Details are as follows:

Patient type	"Household" and Core Family Member Definition
Dependent patient[11]	The patient, his/her parents/legal guardians, and dependent siblings living together
Non-dependent patient	If married, the definition of "Household" includes: the patient, his/her spouse, and dependent children (but not parents/legal guardians or siblings) living together If unmarried, the patient would be treated as a single person household (irrespective of whether parents/legal guardians or siblings are living together)

[8] Upon enhancement, MMDHI (excluding foreign domestic helpers) will be adopted.

[9] Currently, if patient below the age of 65 with period waiver needs to attend GOPC services for episodic appointments, s/he is required to approach (medical) social worker to apply for one-off medical fee waiver. For those patients aged 65 or above, there is no additional need for them to apply for waiver.

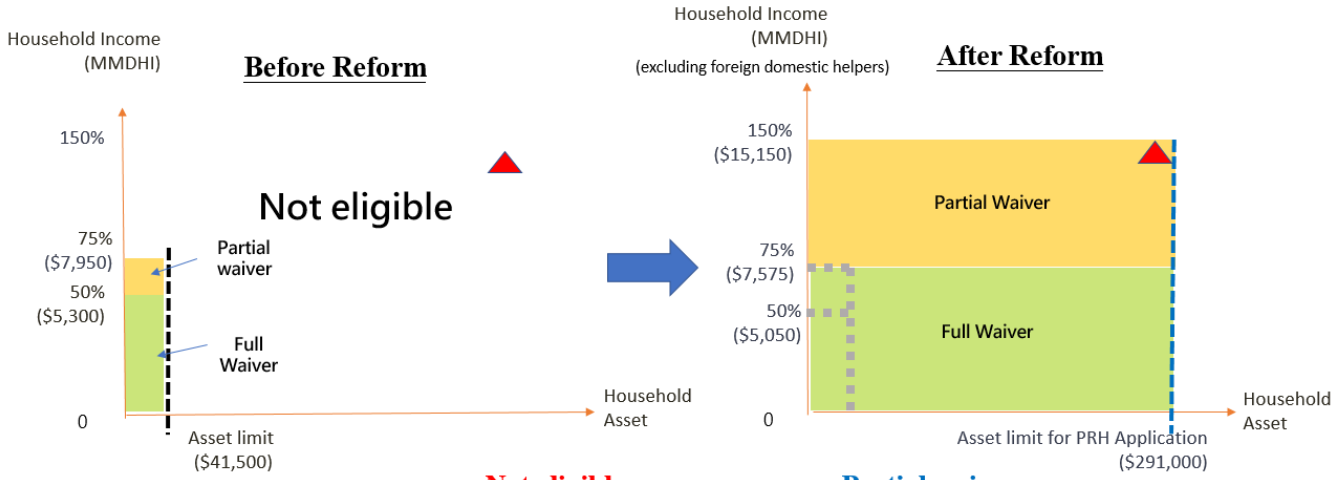
[10] Patients are required to sign a declaration to confirm no change in their household's financial condition. If changes in household financial condition is revealed through post-approval check, the above streamline arrangement may be terminated immediately. The HA may withdraw and/or vary the terms and conditions of any financial assistance. Any paid financial assistance prior to withdrawal shall be recoverable by the HA as a debt or otherwise repayable on demand and the patient / applicant should undertake to repay to the HA the paid financial assistance.

[11] A dependent is defined as a person who is unmarried AND either (i) under 18 years old; or (ii) 18-25 years old receiving full-time education. A patient who does not fulfill the above requirements is classified as a non-dependent patient.

3. Case examples for beneficiary of enhanced Medical Fee Waiving Mechanism are as follows:

Case: 1-person Family

Background: A 40-year-old cleaning worker with no self-owned property

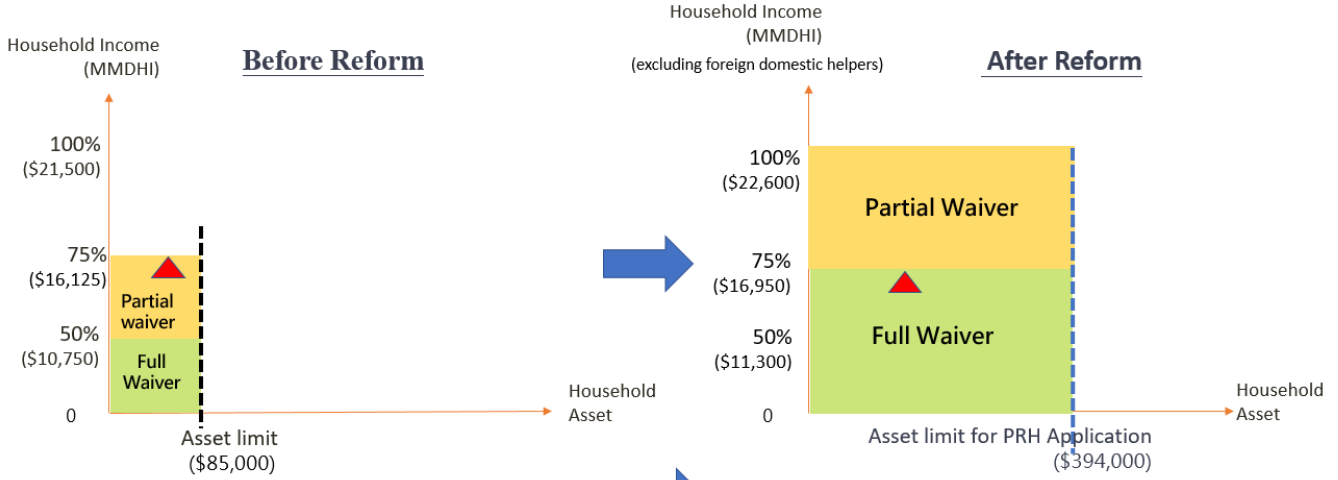


Household Income : $15,000
Household Asset: $280,000

Not eligible (> 75% of MMDHI and asset limit) → **Partial waiver (<150% of MMDHI)**

Case: 2-person Family

Background: A 35-year-old patient and his wife with chronic illnesses, required to attend medical follow-up every 1-2 months



Household Income: $16,100
Household Asset: $80,000

Partial Waiver (< 75% of MMDHI & Asset Limit) → **Full Waiver (< 75%MMDHI & Asset Limit)**

(B) Introducing a cap on fees and charges for in-patient and out-patient services

1) An annual cap on fees and charges for each patient is set at HK$10,000, which is applicable to all public healthcare fee items (excluding self-financed items).

2) All Hong Kong residents are eligible to apply.

(C) Enhanced Safety Net[12] for Self-financed Items

4. Guided by the principles of evidence-based medical practice, targeted subsidy and opportunity cost consideration, the standard fees and charges in public hospitals and clinics do not apply to designated Privately Purchased Medical Items (PPMI) and self-financed drugs. That said, financial assistance is provided through the Safety Net to subsidise the medical expenses of patients who have financial difficulties in purchasing PPMI and specified self-financed drugs on the Hospital Authority Drug Formulary (HADF) at their own costs.

5. Patients applying for financial assistance from the SF have to undergo means test to assess their ability to pay and determine their share of contribution. For subsidy application for drugs and non-one-off non-drug items, the level of patient contribution to the expenses is determined by his/her household's annual disposable financial resources (ADFR) capped by a sliding scale. The maximum patient contribution under the existing sliding scale is 20% of the patient's household ADFR[13] . The formulae for calculating ADRF under the existing mechanism are as follows:

New applicant
ADFR = [(Monthly Household Gross Income – Monthly Allowable Deductions) x ***100%****] x 12 +*
(Disposable Capital – Deductible Allowance) x 50%

Recurrent applicant
ADFR = [(Monthly Household Gross Income – Monthly Allowable Deductions) x ***80%****] x 12 +*
(Disposable Capital – Deductible Allowance) x 50%

6. The calculation of income for ADFR for applications of the Samaritan Fund will be relaxed. Only 80% and 60% of the income will be included for assessment of new applicants and recurrent applicants respectively:

New applicant
ADFR = [(Monthly Household Gross Income – Monthly Allowable Deductions) x ***80%****] x 12 +*
(Disposable Capital – Deductible Allowance) x 50%

[12] Including Samaritan Fund.
[13] The patient contribution under the Ultra-expensive Drug (UED) Programme has been capped at $1 million or 20% of the patient's household ADFR (whichever is lower) to offer extra protection for patients' assets.

<u>Recurrent applicant</u>
*ADFR = [(Monthly Household Gross Income – Monthly Allowable Deductions) x **<u>60%</u>**] x 12 +*
(Disposable Capital – Deductible Allowance) x 50%

7. On the other hand, the sliding scale for calculating the amount of patient contribution will be widened to reduce the amount of patient contribution and provide a higher amount of subsidy for existing patients. More patients who are currently NOT eligible for subsidy due to relatively higher annual disposable financial resources will also be supported. Please refer to the following **<u>Table 2</u>** for details:

<u>Table 2: Current and Enhanced Sliding Scale</u>

A) ADFR ($)		B) Contribution Ratio (%)	Max. Contribution from Patient =AxB (Capped at drug cost)		
0 - 20,000	→ 0 - 56,202.50	-	0		
20,001 - 40,000	→ 56,202.51 - 112,405.00	-	1,000		
40,001 - 60,000	→ 112,405.01 - 168,607.50	-	2,000		
60,001 - 100,000	→ 168,607.51 - 224,810.00	5	3,000 - 5,000	→ 8,430 -	11,241
100,001 - 140,000	→ 224,810.01 - 281,012.50	10	10,000 - 14,000	→ 22,481 -	28,101
140,001 - 180,000	→ 281,012.51 - 337,215.00	15	21,000 - 27,000	→ 42,152 -	50,582
≥ 180,001	→ ≥ 337,215.01	20	36,000 - As calculated	→ 67,443 -	As calculated

8. The income limit[14] for 1-person household will be relaxed to 1.5 times of the current income limit to tie in with the enhancement measures on medical fee waiver mechanism. HA will also further review the arrangement of applications for one-off non-drug items, e.g. adopting the concept of Disposable Financial Resources (DFR), similar to the one in applications for drug items, so as to maintain a consistent approach in the assessment criteria across different types of safety net applications for self-financed items.

9. Case examples of widening the sliding scale and relaxing the income limit are as follows:

[14] Currently, the patient's monthly household income must not exceed the MMDHI corresponding to his/her household size. Upon enhancement, the income limit will be relaxed and MMDHI (excluding foreign domestic helpers) will be adopted.

Case 1

- **Background Information**
  - 50 year-old patient who is a headmaster living with retired husband in a self-owned property
  - Suffering from lung cancer receiving treatment with self-financed drug named Afatinib
  - Annual drug cost: around $153,400

Annual household gross income
$912,000

Disposable capital
$879,000
(Self-occupied property Exempted)

Patient contribution * < Drug Cost ,
Becomes eligible

Patient contribution (~$153,500)* > Drug Cost

NOT eligible

	Patient contribution*	Subsidy*
1st application	~$132,700	~$20,700
Recurrent	~$111,800	~$41,500

* Under the existing mechanism, when the drug cost exceeds the maximum contribution payable by the patient, the remaining balance will be subsidised by the Samaritan Fund.

Case 2

Background Information

- 37 year-old patients working as a clerk and living alone in a public housing estate
- Suffering from Psoriatic arthritis and taking self-financed drug Guselkumab
- Annual drug cost: around $107,100

Annual household gross income
~ $329,000

Disposable capital
~ $365,000

Patient contribution (<$55,400)*, < Drug cost, Eligible

	Patient Contribution*	Subsidy
1st application	~$55,400	~$51,600
Recurrent application	~$45,900	~$61,100

Patient contribution reduced to $22,900, existing beneficiary can receive more subsidies

	Patient Contribution*	Subsidy
1st application	~$22,900 (↓59%)	~ $84,100
Recurrent application	~$9,100 (↓80%)	~$97,900