For discussion
on 10 November 2008

Legislative Council Panel on Health Services
Grant for the Samaritan Fund

PURPOSE

This paper seeks Members' support for a proposed grant of $1 billion to the Samaritan Fund (the Fund).

BACKGROUND

2. The Fund was established as a trust in 1950 by resolution of the Legislative Council (LegCo). The objective of the Fund is to provide financial assistance to needy patients to meet expenses on privately purchased medical items or new technologies in the course of medical treatment which are not covered by hospital maintenance fees or outpatient consultation fees in public hospitals/clinics. These items include expensive drugs, prostheses and consumables items purchased by patients for home use, such as wheelchairs and home use ventilators, as well as costly medical treatment not provided for in public hospitals, such as gamma knife treatment and harvesting of bone marrow outside Hong Kong. The Fund is managed by the Hospital Authority (HA). Additional details on the establishment of the Fund, its funding scope and administration are set out in the **Annex**.

3. The Fund was established without an endowment. It has always been operating on a rolling account basis and relied largely on fresh income received each year to meet its expenditure. As demand for assistance from the Fund has been rising steadily while income of the Fund fluctuated widely, it is necessary from time to time for the Government to inject one-off grants to the Fund to meet the expenditure requirement of the Fund.

FINANCIAL SITUATION OF THE FUND

Income

4. The two major sources of annual income of the Fund are private

donations and Government's reimbursement for assistance provided to recipients of the Comprehensive Social Security Assistance (CSSA). The amount of private donations that the HA received has fluctuated in the past few years and was largely related to economic performance. The total income of the Fund in the last five years and projected income in 2008-09 on cash basis are as follows -

Year / Source of Funding	2003-04 ($ M)	2004-05 ($ M)	2005-06 ($ M)	2006-07 ($ M)	2007-08 ($ M)	Projected 2008-09 ($ M)
Donation from charitable organizations	14.0	16.0	12.9	14.7	21.6	15.6
Reimbursement from Government for privately purchased medical items for CSSA recipients	26.3	31.8	34.5	43.6	37.7	42.4
One-off funding from Government (Note)	-	-	160.0	350.0	-	-
Designated donation from Government	2.0	2.0	2.0	2.0	-	-
Other income	0.1	0.02	11.6	11.8	17.9	5.9
Total	**42.4**	**49.8**	**221.0**	**422.1**	**77.2**	**63.9**

Note: Exclude the proposed grant of $1 billion

Expenditure

5. Expenditure for the Fund has surged sharply by 185% from $47.3 million in 2003-04 to $134.8 million in 2007-08. The number of applications

supported by the Fund has increased by 51% from 2 857 in 2003-04 to 4 317 in 2007-08. The increase in expenditure and approved applications is mainly due to technology advancement and rising demand for assistance from the ageing population, cancer and other chronic disease patients. The number of approved applications and the expenditure for the past five years and the projected expenditure for 2008-09 are given in the table below -

	2003-04	**2004-05**	**2005-06**	**2006-07**	**2007-08**	**Projected 2008-09**
Number of approved applications	2 857	3 551	3 838	3 978	4 317	5 170
Total expenditure ($ M)	**47.3**	**86.6**	**113.9**	**122.8**	**134.8**	**179.1**

6. From the above two tables, we can see that the annual income of the Fund could not cover the expenditure. Injection from the Government to the Fund from time to time is necessary.

7. Four major factors contributed to the substantial funding gap –

(a) due to rapid advancement in medical technologies, more advanced medical items are available for treating patients and such items are often costly and increasing in unit cost with the advances. Taking the three privately purchased medical items for heart disease as examples, the cost of Percutaneous Transluminal Coronary Angioplasty (PTCA) ranges from $10,000 to $48,000 or more per patient; the unit cost of pacemaker ranges from $10,000 to $36,000; and the unit cost of Automatic Implantable Cardioverter Defibrillator (AICD) is from $138,000 to $158,000. The high cost of advanced medical items exerts immense financial pressure on the Fund. Apart from new patients, patients who have received the treatment will need replacement pacemakers or require another angioplastic intervention. The expenditure on these three types of items (i.e. PTCA, pacemaker and AICD) has increased from $38.8 million in 2003-04 to $70.7 million in 2007-08, representing an increase of 82% in five years;

(b) the ageing population has resulted in an increasing number of patients suffering from stroke, heart diseases, disabilities and other

chronic conditions. For example, in 1996-97, 708 patients received subsidies on expenditure on PTCA and pacemakers implantations. In 2007-08, the number of patients receiving assistance on PTCA, pacemakers and AICD implantations surged to 1 941. It is anticipated that more and more elderly and chronic patients will seek assistance from the Fund in the future;

(c) the inclusion of more drugs into the safety net provided by the Fund. To ensure equitable and rational use of public resources, drugs which have proven to be of significant benefits but extremely expensive are categorized as self financed items (SFI). Patients who require these drugs and can afford to pay should pay for these drugs. For poor and needy patients who require such drugs, the Fund acts as a safety net to provide assistance to these patients. The Fund currently covers eight SFIs with safety net. The expenditure on drugs has increased substantially from $17.3 million in 2004-05 to $55.5 million in 2007-08. Cancer drug Imatinib (Glivec) alone accounted for $35.9 million of the Fund's expenditure in 2007-08. Two new oncology drugs and two new rheumatology drugs were introduced into the Fund in 2007-08. In 2008-09, one more oncology drug was introduced into the Fund and coverage of Imatinib and Infliximab was extended further to cover acute lymphoblastic leukaemia and a chronic inflammatory disease of the gastrointestinal tract respectively. Having regard to the need to provide safety net for more new drugs especially cancer drugs, additional funding is required to enable the Fund to introduce additional new drugs in the coming years; and

(d) the financial assessment criteria has been relaxed since January 2008 with re-definition on the calculation of disposable income and allowable deductions to take into account factors such as patient's loss of income in case of unemployment, school fees of children at secondary level or below, etc. The relaxed financial assessment criteria results in more patients being covered by the safety net.

8. The Financial Secretary has proposed in the 2008-09 Budget an injection of $1 billion into the Samaritan Fund to enable more new medicines to be included on the subsidy list of the Fund according to the established mechanism so as to relieve the burden on patients with financial difficulties.

9. The HA has accordingly made a projection on the income and expenditure of the Fund for the five years from 2008-09 to 2012-13 in the table below. The assumptions taken in the projection are as follows -

On the income side

(a) the proposed injection of $1 billion, subject to the approval from the Finance Committee of Legislative Council, will be received in 2008-09;
(b) the amount of private donations in the next five years will remain similar or lower than the level of 2007-08; and
(c) Government's reimbursement for expenditure made by the Fund for CSSA recipients will increase by an average 11% a year in the next five years.

On the expenditure side

(d) expenditure of non-drug items is estimated on the basis of past trends;
(e) pricing adjustments were made to account for the likelihood of currency fluctuation, inflationary factors and escalation in cost as a result of advances in medical technologies; and
(f) additional new drugs will be introduced in the coming years, with additional drug costs progressing from $30 million in 2008-09 to $55 million annually for the three years from 2009-10 to 2011-12, using 2007-08's price. For new drugs introduced in a particular year, it will be adjusted for inflation based on the previous year's actual drug expenditure.

	2008-09 ($ M)	**2009-10 ($ M)**	**2010-11 ($ M)**	**2011-12 ($ M)**	**2012-13 ($ M)**
Estimated Income	**63.9**	**95.0**	**108.0**	**105.3**	**95.9**
Estimated Expenditure	**179.1**	**277.9**	**373.8**	**476.0**	**512.4**
Estimated Deficit for the Year	**(115.2)**	**(182.9)**	**(265.8)**	**(370.7)**	**(416.5)**
Deferred Income					
At start of	**337.6**	**1,222.4**	**1,039.5**	**773.7**	**403.0**

year					
Government Injection (Note)	**1,000.0**	**-**	**-**	**-**	**-**
At end of year	**1,222.4**	**1,039.5**	**773.7**	**403.0**	**(13.5)**

Note: Proposed injection of $1 billion into the Fund subject to approval from the Finance Committee of the Legislative Council.

THE PROPOSAL

10. The funding requirement of the Fund will outstrip its income by a significant amount in the foreseeable future especially in the light of increasing demand to introduce more items into the safety net and the current economic environment which may result in increase in utilization of the Fund. To meet the Fund's projected funding requirements up to 2012 with the addition of more new drugs to be covered by the Fund, we propose to make a one-off grant of $1 billion to the Fund. It should be noted that any unforeseeable circumstances in the coming years, such as the economic environment and currency fluctuation, will affect the expenditure of the fund and hence the actual duration the $1 billion can support the Fund's operation. The Administration recognizes that the major reasons for the rapid increase in expenditure of the Fund are technological advancement and the ageing population. The long term funding arrangement for the Fund will be examined in the context of health care financing and funding arrangement for the HA.

ADVICE SOUGHT

11. Members are invited to support the proposed grant of $1 billion to the Fund.

Food and Health Bureau
Hospital Authority
November 2008

Annex

Background Note on the Samaritan Fund

Establishment and Objective of the Fund

The Samaritan Fund (the Fund) was established in 1950 with the objective of providing relief to needy patients and it is currently being managed by the Hospital Authority (HA).

2. At present, hospital maintenance fees or outpatient consultation fees in public hospitals/clinics are highly subsidized by the Government and cover a wider range of medical services, procedures and consultations. Patients are however required to purchase certain medical items which are not stocked by hospitals and are not included in the hospital maintenance fees. These privately purchased medical items are mostly products of new medical technology at the time of their introduction.

3. Unlike expensive capital equipment which can benefit a relatively large number of patients, these items are either implanted to individual patients or used only once on a patient or with significant cost burden for the HA to provide as part of its standard service without opportunity costs to other public patients. The high costs involved therefore make it impossible for hospitals to stock these items as part of the normal inventory within the hospital's baseline budget.

Funding Scope

4. The Fund provides financial assistance to needy patients who require privately purchased medical items, and drugs that are proved to be of significant benefits but extremely expensive for the HA to provide as part of its subsidized service. Medical items supported by the Fund or its mechanism are as follows -

(a) Privately purchased medical items

i. Percutaneous Transluminal Coronary Angioplasty (PTCA) and other consumables for interventional cardiology
ii. Cardiac Pacemakers
iii. Intraocular Lens
iv. Myoelectric Prosthesis

v. Custom-made Prosthesis
vi. Appliances for prosthetic and orthotic services, physiotherapy and occupational therapy services
vii. Home use equipment, appliances and consumables
viii. Positron Emission Tomography (PET) service
ix. Gamma knife surgery
x. Harvesting of marrow in a foreign country for marrow transplant

The Fund will only support the most basic model which can meet the essential medical needs of the patients.

(b) Self-financed drugs supported by the Fund (newly added coverage in October 2008 shown in *Italic*)

i. Etanercept for rheumatoid arthritis / ankylosing spondylitis / juvenile idiopathic arthritis
ii. Infiximab for rheumatoid arthritis, ankylosing spondylitis / juvenile idiopathic arthritis */ Crohn's Disease*
iii. Imatinib for chronic myeloid leukaemia / gastrointestinal stromal tumour / *acute lymphoblastic leukaemia*
iv. Irinotecan for advanced colorectal cancer
v. Trastuzumab for HER 2 overexpressed metastatic breast cancer
vi. Growth Hormone
vii. Interferon
viii. Rituximab for malignant lymphoma

Administration of the Fund

5. The Fund is a Government Fund under the management of the HA. Medical Social Workers (MSWs) assist in vetting funding applications of individual patients.

6. All items supported by the Fund are subject to close scrutiny before these are covered by the Fund. To ensure that the Fund is put to appropriate use, the HA adopts a prioritization mechanism to vet and evaluate items of new technologies to make the best use of public resources. New items supported by the Fund will need to be endorsed by the Medical Services Development Committee (MSDC) of the HA Board. The mechanism takes into account the following factors -

(a) efficacy, effectiveness and cost-effectiveness;

(b) fair and just use of public resources targeting subsidies to effective interventions to areas of greatest need; and

(c) societal values and views of professionals and patients.

7. For drug items, the Drug Utilization Review Committee (DURC) of HA which is responsible for the periodic review on the existing drugs included in the HA Drug Formulary (HADF) and drugs categorized as SFI will advise the Fund at the beginning of each year on the potential list of SFI to be supported by the Fund. The DURC recommendations will be considered by the Samaritan Fund Management Committee (SFMC) which in turn will make recommendations to the MSDC. The SFMC is co-chaired by both the Chief Executive of HA and representative from the Food and Health Bureau (FHB). In evaluating the priority for including drug items under the scope of the Fund, consideration will be given to the safety, efficacy, effectiveness, cost effectiveness and health impact of the new drugs, and other factors, such as the equity and patients' choice, societal values and ethical factors, the overall priorities for the planning and development of hospital services and the financial constraints of the HA.

8. Every application which has fulfilled the clinical indications will be assessed carefully by MSWs to ensure that the Fund will be used to benefit the poor and the needy patients. In considering the consumption characteristic (one off versus recurrent) and price of items (range from a few hundred to over a hundred thousand dollars per item), two sets of financial guidelines have been developed for non-drug and drug items. The financial assessment and patient contribution criteria of both sets of guidelines are based on targeted subsidy principle.

9. For non-drug items, MSWs will determine the level of subsidy granted based on the patient's household income, household total savings and assets and reference to the actual cost of the medical item. Apart from the above criteria, consideration will also be given to any special social financial factors/circumstances faced by the patients.

10. For drug items, the level of subsidy would be assessed on the basis of the patient's household disposable financial resources (DFR), which essentially means the amount of their household disposable income (i.e. gross income minus allowable deductions for basic expenditure such as rent, living expenses, provident fund contributions, medical expenses at public hospitals/ clinics, etc.) and disposable capital (i.e. savings, investment, properties, etc.

Residential property resided by the patient and tools/implementation of the patient's trade are excluded).

11. In line with the targeted subsidy principle, patients will be required to contribute to the cost of the drugs from their DFR. The level of their contributions will be determined on the basis of a sliding scale and the drug cost. For example, patients with annual DFR between $20,001 and $40,000 would be required to make a maximum contribution of $1,000. The contribution rate is capped at 30% for patients with DFR of $260,001 and above. The adoption of the concept of DFR is to ensure that the patient's quality of life would be maintained largely even if they have to purchase the more costly drugs.

Funding Source and Expenditure

12. The Fund was started without an endowment and has always operated as a rolling account with contributions from the following -

(a) Donations from various charities, with Sir Robert Ho Tung Charitable Fund, Tung Wah Group of Hospitals, S K Yee Medical Foundation, Hong Kong Jockey Club Charity Trust, Board of Management of Chinese Permanent Cemeteries and HA Charitable Foundation being some of the more notable contributors in recent years;

(b) reimbursements from Government for assistance provided to recipients of Comprehensive Social Security Assistance (CSSA); and

(c) Government contributions from time to time, which included a $20 million endowment for the Designated Donation Fund in 1995-96 from which $2 million can be withdrawn each year, and one-off grants in 1997-98, 2000-01, 2002-03, 2005-06 and 2006-07 totaling $531.7 million.

13. The number of patients benefiting from the Fund and the expenditure incurred has increased from 617 patients with a total expenditure of $10.7 million in 1995-96 to 4 317 patients with a total expenditure of $134.8 million in 2007-08.

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