For discussion
on 16 April 2012

LEGISLATIVE COUNCIL PANEL ON HEALTH SERVICES

Samaritan Fund

Proposed Government Grant and Relaxation of Financial Assessment Criteria

PURPOSE

This paper seeks Members' support for a Government proposal to provide a $10 billion grant to sustain the operation of the Samaritan Fund (SF) and briefs Members on a proposal by the Hospital Authority (HA) to relax the assessment criteria for drug subsidies under SF.

BACKGROUND

2. SF is a fund established in 1950 to provide financial assistance to needy patients who require designated Privately Purchase Medical Items (including drugs) or new technologies in the course of medical treatment which are not covered in hospital maintenance or out-patient consultation fees in public hospitals and clinics. SF is financed by donations, reimbursement by the Government for persons under Comprehensive Social Security assistance (CSSA), and government grant. It is administered by HA. Further details on the establishment and objective of SF and its administration are set out in **Annex A**.

FINANCIAL SITUATION OF THE SAMARITAN FUND

3. The income and expenditure of SF in the past five years and the relevant projections from 2011-12 to 2014-15 are set out in **Annex B**. Expenditure for SF has surged sharply by 120% from $113 million in 2006-07 to $248.9 million in 2011-12 (projected), with the number of applications supported by SF increased by 36% from 3 978 in 2006-07 to 5 419 in 2011-12.

4. The increase in expenditure and approved applications are mainly due to technology advancement and rising medical demand from the ageing population, cancer and other chronic diseases. Major factors contributed to the substantial increase in expenditure include:

(i) Aging Population

The population of elders in Hong Kong is projected to increase from one in eight in 2007 to one in four by 2033. The aging population has much greater healthcare need. This is evidenced by increasing number of patients suffering from cancer, stroke, heart diseases and other chronic illness. Moreover, a person aged 65 or above uses, on average, six times more in-patient care (in terms of bed-days) than a person aged below 65.

(ii) Advancement in Medical Technology

Public healthcare system needs to up keep with the international development in healthcare technology in order to ensure service standard. The development and application of new medical technology, such as molecular biology and genomic, to the pharmaceutical industry had made significant breakthrough in drug treatment. Furthermore, we can foresee more interventional, diagnostic modalities and medical devices will be developed, bringing major impact to treatment outcomes. These medical technologies could be very expensive in the initial years of introduction and thereby presenting a new challenge to healthcare cost.

(iii) Changing coverage of SF safety net

Alongside with the rapid advancement in medical technologies and the continuous development of international medical research on new drugs and medical items, the list of proven drugs and other medical items falling under the SF safety net may expand progressively. Coupled with new patients eligible for the SF subsidies coming in each year in addition to the

existing cases, and the on-going drug treatment and the repeated use of medical interventions or devices for the chronically-ill patients, the expenditure of SF is expected to increase.

PROPOSED GRANT OF $10 BILLION TO THE SAMARITAN FUND

5. While it is difficult to forecast the future expenditure pattern of SF, given the development of the factors explained in paragraph 4 above, it is expected that the annual expenditure will continue to grow rapidly in the coming years. Based on current projection, SF will start to incur a significant deficit in the order of $390 million in 2014-15 if no timely provision is made.

6. To maintain the operation of SF and to enable it to meet increased expenditure due to the addition of more new drugs, increased subsidy provided to patients and the increase in the number of patients eligible for SF subsidy in the coming years, the Financial Secretary announced in the 2012-13 Budget a proposal by Government to provide a $10 billion grant to SF. The proposed grant is expected to be able to sustain the operation of SF for about 10 years.

7. The proposed grant will not only provide a degree of certainty for the operation of SF, it will also enable HA to consider introducing measures to relax the eligibility criteria of SF to benefit more needy patients.

Current Financial Test for Self-financed Drugs covered by SF

8. At present, the SF safety net covers 17 self-financed drugs as listed at **Annex C**. Patients who meet the specified clinical criteria for the relevant drugs and can pass the financial test will be given a full or partial subsidy for meeting drug expenses, depending on their affordability. Under the principle of targeted subsidy, HA takes into account the patients' annual disposable household financial resources (ADFR) and estimates their drug expenses in the coming year in assessing their affordability and determining their level of contribution to drug expenses. At present, patients' contribution to drug expenses is

capped at 30%[1] of their ADFR. Apart from monthly household gross income and monthly allowable deductions, disposable capital items such as cash, investments in stocks and shares, valuable possessions, properties (except for the flat owned and resided in by the patient's household), lump sum compensation and other realizable assets would be included in calculating the ADFR of a patient. A patient's contribution to the drug cost is determined by the ADFR calculated and the estimated annual drug cost based on a sliding scale at **Annex D**.

9. Under the current practice, ADFR of a patient is assessed based on the following formula –

ADFR = (Monthly Household Gross Income – Monthly Allowable Deductions) x 12 + Disposable Capital

10. Since the calculation of ADFR only provides deductions for disposal income but not disposal capital, applicants with a moderate family saving would become ineligible for SF assistance depending on the cost of the drugs and the assessed contribution level.

Revised Financial Test

11. HA proposes to provide a deductible allowance when calculating the total value of disposable capital, ranging from $203,000 to $670,000 depending on the family size of the patients. With the introduction of a disposal capital deduction, instead of taking into account all disposable capital of a patient's household for determining his ADFR, a fixed sum of allowance will be deducted from the disposable capital, as set out in the table below, before calculating a patient's maximum contribution for the self-financed drug expenses. The proposed amount of deductible allowance is set with reference to the prevailing asset limit for applicants for public rental housing (PRH) in assessing their eligibility for the Waiting List of PRH. The level of allowance will be regularly

[1] Through the second phase of the Community Care Fund (CCF) Medical Assistance Programme, the maximum contribution level of a SF subsidized patient has been reduced to 20%.

reviewed with reference to the PRH's asset limit which is subject to annual review under an established mechanism.

Number of Household members	**Allowance to be deducted from Disposal Capital**
1 Person	$203,000
2 Persons	$274,000
3 Persons	$359,000
4 Persons	$418,000
5 Persons	$465,000
6 Persons	$503,000
7 Persons	$537,000
8 Persons	$563,000
9 Persons	$622,000
10 or more Persons	$670,000

12. HA also proposes to simplify the tiers of patients' contribution ratio, from the present 12 bandings to seven bandings. The revised sliding scale is at **Annex E**.

Estimated Benefits

13. With the introduction of a deductible allowance from the disposable capital, more patients who have to rely on expensive self-financed drugs will be able to meet the financial test under SF and become eligible for the SF subsidy. The deductible allowance will help protect the family savings and disposable capital from being depleted for drug expenses and thus help maintain the patients' and their family's living standard.

14. The number of patients receiving SF subsidies on drug was about 1 350 in 2010-11 (with 720 received full subsidy and 630 partial subsidy). With the relaxation of the financial test, using the deductible allowance for a 4-member household (i.e. around $400,000) as the average for the purpose of estimation, it is estimated that about 2 300 patients using the 17 drugs covered by SF will be better off after the introduction of the deductible allowance for disposal capital. The 2 300 patients include patients who are receiving partial subsidy and will

become fully subsidised or contribute a smaller amount of the drug cost, as well as patients who will become newly eligible for the SF subsidy. Moreover, those who are currently enjoying full subsidy from SF will continue to benefit.

15. As regards the estimated amount of additional subsidy a patient may receive, it will vary depending on the drugs the patient is consuming as well as the dosage, both of which hinge on the clinical conditions of the patient concerned on a case-by-case basis. The additional subsidy for a patient is estimated to range between a few hundreds dollars to around $200,000 per year. The proposed relaxed financial test will also benefit future applicants. It is expected that the number of patients benefited from the SF drug subsidy will increase following the relaxation of the financial test.

16. Subject to the approval of the $10 billion grant to SF by the Finance Committee (FC), we plan to implement the proposed relaxation of financial assessment criteria for SF drug subsidies with effect from the third quarter of 2012.

FINANCIAL IMPLICATIONS

17. The proposed grant of $10 billion into SF has no recurrent financial implications.

ADVICE SOUGHT

18. Members are invited to support the proposed grant of $10 billion to SF and note HA's proposal to relax the assessment criteria for drug subsidies under SF. Subject to Members' views, we will seek FC's approval for the proposed injection into SF within this legislative year.

Food and Health Bureau
Hospital Authority
April 2012

Annex A

Background Note on the Samaritan Fund

Establishment and Objective of the Fund

The objective of the Samaritan Fund (SF) is to provide financial assistance to needy patients who meet the specified clinical criteria and passed the means test to meet expenses on self-financed drugs or privately purchased medical items needed in the course of medical treatment but are not covered by the standard fees and charges in public hospitals and clinics. Unlike expensive capital equipment which can benefit a relatively large number of patients, these items are either implants to individual patients or used only once on a patient or with significant cost burden for the Hospital Authority (HA) to provide as part of its standard service without opportunity costs to other patients.

Administration of the Fund

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

3. All items supported by SF are subject to close scrutiny before they are covered by SF. To ensure that SF is put to appropriate use, 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 SF 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.

4. 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 Self-financed items (SFI), will advise SF at the beginning of each year on the potential list of

SFI to be supported by SF. The DURC's 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 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 SF, 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.

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

6. For non-drug items, the level of subsidy granted will be determined 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, MSWs will also consider any special social and financial factors/circumstances faced by the patients.

7. For drug items, the level of subsidy would be determined on the basis of the patient's household annual disposable financial resources (ADFR), 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. Self-use residential property of the patient and tools/implementation of the patient's trade are excluded).

8. In line with the targeted subsidy principle, patients will be required to contribute to the cost of the drugs from their ADFR. The level of their contributions will be determined based on a sliding scale and the drug cost. For

example, patients with annual ADFR 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 ADFR of $260,001 and above. The adoption of the concept of ADFR is to ensure that the patient’s quality of life would be broadly maintained even if they have to purchase the more costly drugs.

Annex B

Income and Expenditure of the Samaritan Fund (in $ million)

	Actual 2006/07	Actual 2007/08	Actual 2008/09	Actual 2009/10	Actual 2010/11	Projected 2011/12	Projected 2012/13	Projected 2013/14	Projected 2014/15	
	(Note 1)	(Note 1)	(Note 1)	(Note 1)	(Note 1)					
Income										
Donations from charitable organisations	14.7	21.6	17.5	20.1	17.1	10.1	9.4	9.4	9.4	
Reimbursement from Social Welfare Department for privately purchased medical items for CSSA recipients	43.6	37.7	39.7	41.2	43.9	46.1	51.5	56.9	62.9	
Transfer from designated donation from Government	2.0	-	-	-	-	-	-	-	-	
Other income	11.8	17.9	7.5	15.0	11.4	14.5	14.3	9.5	2.7	
Total	**72.1**	**77.2**	**64.7**	**76.3**	**72.4**	**70.7**	**75.2**	**75.8**	**75.0**	
Expenditures										
Drugs	30.4	42.9	48.3	56.3	143.6	160.7	256.4	366.4	522.3	
Non drugs	82.6	76.7	80.7	85.3	83.8	88.2	103.8	114.6	126.9	
Total	**113.0**	**119.6**	**129.0**	**141.6**	**227.4**	**248.9**	**360.2**	**481.0**	**649.2**	
Deficit for the year	**(40.9)**	**(42.4)**	**(64.3)**	**(65.3)**	**(155.0)**	**(178.2)**	**(285.0)**	**(405.2)**	**(574.2)**	
Deferred income at beginning of year	120.9	380.0	337.6	1,273.3	1,208.0	1,053.0	874.8	589.8	184.6	
Government Grant received (Note 2)	300.0	-	1,000.0	-	-	-	-	-	-	
Balance at end of year	**380.0**	**337.6**	**1,273.3**	**1,208.0**	**1,053.0**	**874.8**	**589.8**	**184.6**	**(389.6)**	
% change from prior year										**Overall % change**
Total income	*18%*	*7%*	*-16%*	*18%*	*-5%*	*-2%*	*6%*	*1%*	*-1%*	*-2%*
Expenditures										
Drugs	*-3%*	*41%*	*13%*	*17%*	*155%*	*12%*	*60%*	*43%*	*43%*	*429%*
Non drugs	*4%*	*-7%*	*5%*	*6%*	*-2%*	*5%*	*18%*	*10%*	*11%*	*7%*
Total	*2%*	*6%*	*8%*	*10%*	*61%*	*9%*	*45%*	*34%*	*35%*	*120%*

Notes: 1. Per SF 2006/07 to 2010/11 audited financial statements.

2. Exclude the proposed grant of $10 billion. For the government grant received in 2006/07 and 2008/09, the amount is recognized as income in the SF audited financial statements to match with the related expenditure incurred in the financial year.

Annex C

Self-financed drugs covered by the Samaritan Fund

At present, the following 17 Self-financed drugs are covered by SF -

1. Adalimumab for rheumatoid arthritis / ankylosing spondylitis / psoriatic arthritis (introduced in June 2010)/ Crohn's Disease (introduced in July 2011)
2. Bortezomib for multiple myeloma (introduced in June 2010)
3. Cetuximab for initial treatment of locally advanced squamous cell carcinoma of head and neck (introduced in December 2009)
4. Dasatinib for Imatinib-resistent chronic myeloid leukaemia (introduced in June 2010)
5. Etanercept for rheumatoid arthritis / ankylosing spondylitis / juvenile idiopathic arthritis (introduced in April 2007) / psoriatic arthritis (introduced in December 2009)
6. Infiximab for rheumatoid arthritis / ankylosing spondylitis (introduced in April 2007) / psoriatic arthritis (introduced in December 2009) / Crohn’s Disease (introduced in October 2008)
7. Imatinib for chronic myeloid leukaemia / gastrointestinal stromal tumour (introduced in January 2005) / acute lymphoblastic leukaemia (introduced in October 2008)
8. Nilotinib for Imatinib-resistent chronic myeloid leukaemia (introduced in June 2010)
9. Oxaliplatin for adjuvant resected colon cancer (introduced in December 2009)
10. Pemetrexed for malignant pleural mesothelioma (introduced in June 2010)
11. Trastuzumab for HER 2 over-expressed metastatic breast cancer (introduced in April 2007) / HER 2 positive early breast cancer (introduced in December 2009)
12. Rituximab for malignant lymphoma (introduced in October 2008) /maintenance therapy for relapsed follicular lymphoma (introduced in June 2010) / refractory rheumatoid arthritis (introduced in December 2009)
13. Erlotinib for EGFR mutation-positive non-small cell lung cancer (second line) (introduced in July 2011)
14. Gefitinib for EGFR mutation-positive non-small cell lung cancer (second line) (introduced in July 2011)
15. Temozolomide for Glioblastoma Multiforme (used together with radiotherapy) (introduced in July 2011)
16. Growth Hormone
17. Interferon

Annex D

Existing Sliding Scale in determining a patient's maximum contribution to drug costs

(A) Annual Disposable Financial Resources ($)	(B) Contribution Ratio (%)	(C) Maximum Annual Contribution from Patient ($) (C = A x B)	(D) Annual Disposable Financial Resources after deducting Annual Contribution ($) (D = A - C)
0 - 20,000	-	0	0 - 20,000
20,001 - 40,000	-	1,000	19,001 - 39,000
40,001 - 60,000 #	-	2,000	38,001 - 58,000
60,001 - 80,000	5	3,000 - 4,000	57,000 - 76,000
80,001 - 100,000	7.5	6,000 - 7,500	74,001 - 92,500
100,001 - 120,000	10	10,000 - 12,000	90,001 - 108,000
120,001 - 140,000	12.5	15,000 - 17,500	105,001 - 122,500
140,001 - 160,000	15	21,000 - 24,000	119,001 - 136,000
160,001 - 180,000	17.5	28,000 - 31,500	132,001 - 148,500
180,001 - 200,000	20	36,000 - 40,000	144,001 - 160,000
200,001 - 220,000	22.5	45,000 - 49,500	155,001 - 170,500
220,001 - 240,000	25	55,000 - 60,000	165,001 - 180,000
240,001 - 260,000	27.5	66,000 - 71,500	174,001 - 188,500
260,001 - 280,000	30 *	78,000 - 84,000	182,001 - 196,000
280,001 - 380,000	30 *	84,000 - 114,000	196,001 - 266,000
380,001 - 480,000	30 *	114,000 - 144,000	266,001 - 336,000
480,001 - 580,000	30 *	144,000 - 174,000	336,001 - 406,000
580,001 - 680,000	30 *	174,000 - 204,000	406,001 - 476,000
680,001 - 780,000	30 *	204,000 - 234,000	476,001 - 546,000
780,001 - 880,000	30 *	234,000 - 264,000	546,001 - 616,000
880,001 - 980,000	30 *	264,000 - 294,000	616,001 - 686,000
980,001 - 1,080,000	30 *	294,000 - 324,000	686,001 - 756,000
>1,080,001	30 *	as calculated	

 # For the patients whose annual disposable financial resources are under $60,000, their annual contribution is fixed, and so the formula of calculating the applicant's annual contribution (annual disposable financial resources X contribution ratio) does not apply to them.

** Capped at a flat contribution ratio of 30%*

Annex E

Simplified Sliding Scale in determining a patient's maximum contribution to drug costs

(A) Annual Disposable Financial Resources ($)	(B) Contribution Ratio (%)	(C) Maximum Annual Contribution from Patient ($) (C = A x B)	(D) Annual Disposable Financial Resources after deducting Annual Contribution ($) (D = A - C)
0 - 20,000	-	0	0 - 20,000
20,001 - 40,000	-	1,000	19,001 - 39,000
40,001 - 60,000 #	-	2,000	38,001 - 58,000
60,001 - 100,000	5	3,000 - 5,000	57,000 - 95,000
100,001 - 140,000	10	10,000 - 14,000	90,001 - 126,000
140,001 - 180,000	15	21,000 - 27,000	119,001 - 153,000
180,001 - 220,000	20	36,000 - 44,000	144,001 - 176,000
220,001 - 260,000	25	55,000 - 65,000	165,001 - 195,000
260,001 - 280,000	30 *	78,000 - 84,000	182,001 - 196,000
280,001 - 380,000	30 *	84,000 - 114,000	196,001 - 266,000
380,001 - 480,000	30 *	114,000 - 144,000	266,001 - 336,000
480,001 - 580,000	30 *	144,000 - 174,000	336,001 - 406,000
580,001 - 680,000	30 *	174,000 - 204,000	406,001 - 476,000
680,001 - 780,000	30 *	204,000 - 234,000	476,001 - 546,000
780,001 - 880,000	30 *	234,000 - 264,000	546,001 - 616,000
880,001 - 980,000	30 *	264,000 - 294,000	616,001 - 686,000
980,001 - 1,080,000	30 *	294,000 - 324,000	686,001 - 756,000
>1,080,001	30 *	as calculated	

 # For the patients whose annual disposable financial resources are under $60,000, their annual contribution is fixed, and so the formula of calculating the applicant's annual contribution (annual disposable financial resources X contribution ratio) does not apply to them.

** Capped at a flat contribution ratio of 30%*