立法會
Legislative Council

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Panel on Health Services

Minutes of special meeting
held on Thursday, 13 March 2008, at 10:45 am
in the Chamber of the Legislative Council Building

Members present	:	Dr Hon Joseph LEE Kok-long, JP (Deputy Chairman) Hon Fred LI Wah-ming, JP Hon CHAN Yuen-han, SBS, JP Hon Andrew CHENG Kar-foo Hon Audrey EU Yuet-mee, SC, JP Hon Vincent FANG Kang, JP Hon LEUNG Kwok-hung Dr Hon KWOK Ka-ki Dr Hon Fernando CHEUNG Chiu-hung
Members attending	:	Hon Albert HO Chun-yan Hon LEE Cheuk-yan Hon Bernand CHAN, GBS, JP Hon Emily LAU Wai-hing, JP Hon WONG Kwok-hing, MH Hon LEE Wing-tat Hon Alan LEONG Kah-kit, SC Hon WONG Ting-kwong, BBS Hon TAM Heung-man
Members absent	:	Hon LI Kwok-ying, MH, JP (Chairman) Hon Mrs Selina CHOW LIANG Shuk-yee, GBS, JP Hon Mrs Sophie LEUNG LAU Yau-fun, GBS, JP Dr Hon YEUNG Sum, JP

Public Officers attending	:	Item I Dr York CHOW, SBS, JP Secretary for Food and Health Ms Sandra LEE, JP Permanent Secretary for Food and Health (Health) Mrs Ingrid YEUNG Deputy Secretary for Food and Health (Health)2 Hon Mr Ronald ARCULLI, GBS, JP Chairman of the Working Group on Healthcare Financing of the Health and Medical Development Advisory Committee Prof Gabriel LEUNG Professor, School of Public Health, The University of Hong Kong (Research Consultant for Health Expenditure Projection Studies)
Clerk in attendance	:	Miss Mary SO Chief Council Secretary (2) 5
Staff in attendance	:	Ms Amy YU Senior Council Secretary (2) 3 Ms Sandy HAU Legislative Assistant (2) 5 Ms Camy YOONG Clerical Assistant (2)1

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I. Briefing by the Secretary for Food and Health on Healthcare Reform Consultation Document

At the invitation of the Chairman, Secretary for Food and Health (SFH) introduced the Healthcare Reform Consultation Document tabled at the meeting. SFH's speech is at **Appendix I**.

2. Permanent Secretary for Food and Health (Health), Prof Gabriel LEUNG and Deputy Secretary for Food and Health (Health) 2 briefed Members on the

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following issues respectively with the aid of a powerpoint -

(a) service reform proposals;

(b) Hong Kong's projected future healthcare expenditure; and

(c) advantages and disadvantages of the six supplementary financing options for healthcare.

Powerpoint presentation materials on the above are in **Appendix II**.

3. Mr Ronald ARCULLI urged the public to enthusiastically discuss the proposed options in the Consultation Document in the coming three months. Mr ARCULLI pointed out that with the rapidly ageing population (the ratio of workforce to elderly population in Hong Kong would decline from 6:1 to 3:1 within the next 20 years) and rising medical costs brought about by advances in medical technology, it would no longer be a sustainable option to maintain status quo to finance public healthcare solely through government revenue. Hong Kong was now at a crossroads when it had to decide how its healthcare services and market structure should be reformed to make the healthcare system sustainable and more responsive to the increasing needs of the community.

Discussion

4. Mr LEE Cheuk-yan said that the middle-class would be the biggest loser if supplementary financing was introduced, as to do so was tantamount to adding an extra tax on this group of people. It was also doubtful whether supplementary financing would enable the middle-class to stay in, say, first class ward of private hospitals. Dr KWOK Ka-ki also said that it was unfair to place the burden of providing supplementary healthcare financing on the middle-class.

5. SFH responded that the middle-income group would be the biggest loser if nothing was done to sustain the healthcare system to meet the challenges due to an ageing population and rising medical costs brought about by advances in medical technology. Although those with middle-income or above were the ones paying tax to fund the public healthcare system, many of them were already purchasing private health insurance or paying out of their own pockets to use services provided by private healthcare providers because of the long waiting time for many public healthcare services. Hence, the middle-income group in effect received less under the present healthcare system. SFH further said that supplementary financing arrangements could bring the middle-income group more value-for-money healthcare services, more quality choices and more comprehensive healthcare protection. The middle-income group could continue to use highly-subsidised public healthcare services if they so choose, especially if

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struck by catastrophic illnesses or requiring complicated surgery or treatments, after the proposed healthcare reform.

6. Mr LEE Cheuk-yan noted from the materials provided by the Administration that Hong Kong's overall public health expenditure was projected to increase from about $38 billion in 2004 to about $78 billion in 2015. Mr LEE enquired about the rationale for coming up with such projection.

7. Prof Gabriel LEUNG explained that the health expenditure projection was conducted based on an adaptation of the United Kingdom Treasury's Wanless projection method, which took into account rising medical costs due to advances in medical technology and changes in the utilisation of healthcare services as a result of demographic changes. The projection was based on data sources such as the Population Projections published by the Census and Statistics Department and the past trend of Hong Kong's health expenditure data from 1989-1990 to 2004-2005. The projected increase of overall public health expenditure from about $38 billion in 2004 to about $78 billion in 2015, or from 2.9% of Gross Domestic Product (GDP) in 2004 to 3.7% of GDP in 2015, was attributable mainly to demographic changes particularly the rising share of elderly people in the population, as well as medical inflation determined having regard to international studies on the growth trend of health expenditure in advanced economies overseas and past trend of health expenditure in Hong Kong.

8. Mr WONG KWOK-hing asked -

(a) why no mention was made in the Consultation Document on the role of the Government and employers in making contributions to supplementary healthcare financing; and

(b) whether it was the Administration's intention not to take any action to address the shortcomings of the present healthcare system mentioned in the Administration's presentation until supplementary healthcare financing was introduced.

9. Responding to Mr WONG's first question, SFH said that the Administration was open-minded on who should contribute to supplementary healthcare financing. At this stage, the Administration would like to listen to the views of the public on the concepts of the healthcare reform, as well as the pros and cons of the supplementary healthcare financing options. As regards Mr WONG's second question, SFH said that in order to take forward the initiatives set out in Chapters 2 to 5 of the Consultation Document for addressing the shortcomings of the present healthcare system, it was necessary to reform the current healthcare financing arrangements by introducing supplementary financing to provide a steady source of supplementary funding to fully carry out and sustain these initiatives.

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10. Miss CHAN Yuen-han said that the Administration should come clean on what it intended to do to sustain public healthcare expenditure through supplementary financing. Miss CHAN further said that before asking the public for more money to finance public healthcare expenditure, the public must first be convinced that the Hospital Authority (HA) was run in a cost-effective manner.

11. SFH responded that the Administration had no hidden agenda on what it intended to do to sustain public healthcare expenditure through supplementary financing. The Administration's only strategy was to lay out all the options which it had studied in a frank and open manner for public discussion and, hopefully, through which would forge consensus among the public. SFH further said that to ensure the appropriate use of resources and operational efficiency, HA was subject to stringent internal and external audit. HA had been spending its funding in a prudent and cost-effective manner, for instance, only 1.9% of its budget was spent on central administration, but there was always room for improvement.

12. Dr KWOK Ka-ki urged the Administration to increase its expenditure on healthcare, which currently only accounted for some 14.3% of recurrent government expenditure and was on the low side in comparison with other developed economies, to address the shortcomings of the present healthcare system, before introducing supplementary healthcare financing.

13. SFH responded that in the process of developing Hong Kong's future healthcare system, the Government's commitment to public healthcare would only be increased and not reduced. The Government would continue to be the main financing source for healthcare services. The Chief Executive had pledged to increase government expenditure on healthcare from 15% to 17% of recurrent government expenditure by 2011-2012. SFH further said that a large budget surplus did not happen every year, and there was no guarantee that the surplus situation would continue. Past experience had already shown that the financial situation of the Government changed according to the economy. A one-off budget surplus was not something that could be relied on to meet recurrent healthcare expenses. The challenges faced by Hong Kong's healthcare system could not be simply resolved by a short-term increase in funding. In addition to increasing the resources for the healthcare system, there was also a need to undertake reforms on healthcare services. The Administration had already embarked on pilot projects for the various service reform set out in Chapters 2 to 5 of the Consultation Document viz: enhancing primary healthcare service, developing an electronic database of patient records, strengthening public healthcare safety net, and promoting greater public-private healthcare partnership. To sustain the improvements in healthcare services and to enhance the health of the community for the long term, it was necessary to introduce supplementary

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financing to provide a stable and sustainable funding source.

14. Mr Vincent FANG said that the Liberal Party was supportive of the concepts of the healthcare reform, and hoped that more consideration could be given to the middle-class when deciding which supplementary financing to introduce. Mr FANG considered making public hospitals focusing more on its priority services such as acute cases and the treatment of complex illnesses, while leaving the private sector more room to develop was a move in the right direction to address the current significant public-private imbalance in the healthcare system. Mr FANG further said that the Administration should continue to increase its expenditure on healthcare above 17% of recurrent government expenditure beyond 2011-2012 where possible. Noting that the Financial Secretary had committed in the Budget announced in February 2008 that he would draw $50 billion from the fiscal reserve to assist the implementation of healthcare reform, Mr FANG asked when such sum could be released to assist the implementation of healthcare reform.

15. SFH responded that setting aside $50 billion from the fiscal reserve to assist the implementation of healthcare reform demonstrated the Government's commitment to share the responsibility for healthcare financing together with the community, and to increase the resources available to individual members of the community for healthcare. As the supplementary financing arrangements had yet to be finalised, no decision had been made on the areas to use the $50 billion at this stage. Part of the $50 billion could however be used, for instance, to provide each participant in a contributory supplementary financing scheme with individual start-up capital, which should benefit the contributing middle-class.

16. Dr Fernando CHEUNG criticised the Administration for using a scare tactic to make the public contribute money to supplementary financing, as evidenced by the fact that the contents of the Consultation Document mainly focussed on the six supplementary financing options. Instead of simply asking the public to contribute money to resolve the shortcomings in the present healthcare system, Dr CHEUNG was of the view that the Administration should find out how these shortcomings had come about and formulate targetted measures to tackle them. Dr CHEUNG said that it was unreasonable for the Administration to try to extract more money from the public when the median monthly salary in Hong Kong was only $19,000, and over 50% of the working population were earning less than $20,000 a month. Dr CHEUNG further said that ageing population only accounted for some 0.6% to 0.7% of healthcare expenditure in some overseas jurisdictions, and use of advanced medical technology would not necessarily entail higher medical cost.

17. SFH responded that there was no question of the Administration using a scare tactic to make the public contribute money to supplementary financing.

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The projection of health expenditure set out in Chapter 1 of the Consultation Document was based on established and objective statistics and data on both demographics and health expenditure. The projection clearly pointed to the need for supplementary financing source for healthcare to supplement government's funding to cope with increasing healthcare needs. The need to introduce supplementary financing source for healthcare was a common phenomenon, an issue faced by almost all advanced economies. SFH further said that discussion on healthcare financing had been dragged on for over 20 years. If no healthcare financing arrangements were introduced when the economy allowed it, the problem of inadequate funding would arise sooner or later. By then, Hong Kong would be unable to sustain quality public hospital service. Neither could additional resources be provided for the service reform. It was the public that would suffer in the end.

18. Ms Emily LAU said that with the large budget surplus and the even larger surplus in the fiscal reserve, the Administration should not wait for the introduction of supplementary financing arrangements in developing an electronic platform for sharing of health record. SFH clarified that the Government had committed to increasing funding for healthcare and the new money would be used for developing the electronic record sharing platform as well as other pilot projects for proposed service reforms which have already started.

19. Mr LEE Wing-tat said that to be equitable, the high-income group should contribute more towards supplementary healthcare financing. Mr LEUNG Kwok-hung expressed similar view. Ms Emily LAU also said that in order to make the middle-class willing to contribute towards supplementary financing, it was necessary to tell them what benefits that would bring them, and that both the Government and employers should be required to contribute.

20. SFH reiterated that the Administration was open-minded on who should contribute to supplementary financing, which should hinge on the choice of the community reflecting its societal values.

21. Dr KWOK Ka-ki asked whether consideration could be given to requiring employers to contribute two-thirds of the contributions towards the medical savings accounts of their employers if medical savings accounts as supplementary financing was adopted, as practised in Singapore.

22. SFH responded that it would not be feasible for Hong Kong to adopt the Singapore healthcare financing system in its entirety, as the healthcare system of the two places were different. For instance, public medical services in Hong Kong were 97% subsidised, whereas those in Singapore were at most 80% subsidised.

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23. Mr LEE Wing-tat was of the view that one major reason why the middle-class would be reluctant to contribute, say, 3% to 5%, of their monthly salary to supplementary financing was because many of them had already insured themselves and/or had been provided with insurance protection by their employers.

24. SFH responded that if mandatory private medical insurance was to be introduced, a transitional mechanism might be put in place for those who had already taken out health insurance themselves, or for employers who had provided medical insurance for their employees, so that they could migrate their existing insurance schemes to the mandatory private health insurance scheme regulated by the Government. Generally speaking, the terms under mandatory private health insurance scheme should be more favourable to the insured and the premium should be lower. However, if there were existing insurance schemes, including those taken out by employers to provide medical benefits to their employees that provided better terms than the mandatory one, exemption or other transitional arrangements could be considered.

25. Mr Alan LEONG said that in order to convince the public to accept supplementary healthcare financing, the Administration should provide information on how much it could achieve the initiatives set out in Chapters 2 to 5 of the Consultation Document to address the shortcomings in the present healthcare system based on the current financing arrangements, and the additional amount it would require to complete the remaining work of each of these initiatives. Noting that the split between public and private healthcare expenditure was 57% and 43% respectively, Mr LEONG asked how this would be changed following the introduction of supplementary healthcare financing.

26. SFH responded that he could not provide the information requested by Mr LEONG at this stage, as more time was needed to work out such. SFH however pointed out that not much could be achieved to address the shortcomings in the present healthcare system through the implementation of various service reforms if no supplemental financing was introduced to provide a stable and sustainable financing source for sustaining the reform for the longer term.

27. Mr Albert HO expressed disappointment about the lack of details in the six supplemental financing options.

28. SFH explained that as healthcare reform was a highly complex issue which involved many different aspirations, values and decisions of the society, a two-stage consultation approach was adopted to engage the public in taking forward the reform. During this first stage consultation, no particular option was recommended. Instead, public views would be sought on the key principles and concepts of the service reform proposals, and the pros and cons of possible

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supplementary financing options. On the basis of the views received during the first stage consultation, detailed proposals for the reform, including those of supplementary financing arrangements, would be formulated for a second stage consultation.

29. Ms Emily LAU hoped that more details could be provided by the Administration during the first stage consultation, so that more focussed discussion could be made.

30. Miss Mandy TAM queried whether a three-month first stage consultation period was adequate. Miss TAM also found the Administration's plan of cutting Salaries Tax by 1% in the next financial year on the one hand and seeking public views on introducing supplementary healthcare financing on the other incomprehensible. Miss TAM then asked about the measures which would be taken to address the uneven distribution of workload between the public and private sectors in the healthcare system, and whether consideration could be given to granting tax incentive to people who purchased their own medical insurance.

31. SFH referred Members to the possible measures to address the uneven distribution of workload between the public and private sectors in the healthcare system set out in Chapter 3 of the Consultation Document. As regards granting tax incentive to people who purchased their own medical insurance, SFH said that it was not feasible to simply provide tax incentives without some form of regulation over the varying existing schemes in the marketplace, many of which were rather inadequate in their coverage. However, the Administration would be prepared to consider such if there was a medical insurance scheme which could provide adequate safeguard to a large number of insurees.

32. Mr WONG Ting-kwong asked whether the Administration was willing to consider other supplementary financing options, in addition to those set out in the Consultation Document. SFH replied in the positive.

33. Miss CHAN Yuen-han said that the Administration might not need to introduce supplementary financing if primary care was enhanced and public-private imbalance in the healthcare system was rectified. In response, SFH said that healthcare reform could not be conducted piecemeal to achieve the desired effect.

Any other business

34. Members agreed to hold another meeting in March 2008 to further discuss the Consultation Document with the Administration.

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35. There being no other business, the meeting ended at 1:10 pm.

Council Business Division 2
Legislative Council Secretariat
4 June 2008

立法會 CB(2)1364/07-08(01)號文件

立法會衞生事務委員會
2008 年 3 月 13 日特別會議

醫療改革公眾諮詢
食物及衞生局局長發言稿

主席、各位議員：

今日我向大家提交市民大眾期待已久的醫療改革諮詢文件，展開公眾諮詢，為期三個月。

2. 眾所周知，醫療改革問題複雜，影響深遠。因此，我們今次的諮詢文件嘗試由淺入深向公眾論述香港所面對的問題及解決問題的不同方案。

3. 大家檯面上有一套文件，一共三份 —

- 一份是一頁的單張，簡述我們面對的主要問題。
- 另一份是一本小冊子，主要簡述解決問題不同方案的利弊，及嘗試解答市民大眾心裏的一些疑問。
- 第三份是諮詢文件的詳細報告，內有一份報告摘要。

4. 此外，我們亦在網上發布我們對問題進行深入研究的相關報告，包括外國的經驗等研究資料。對問題希望作更深入了解的議員、新聞界的朋友、學者以及市民大眾，可以到我們的網站查閱。

5. 主席，完成這套諮詢文件，我局花了差不多兩年半時間。因此，我很感謝主席你同意召開這次特別會議，讓我們有整整兩小時向各議員及市民大眾講解這份諮詢文件。

6. 我們打算用大約一小時作簡介，餘下的一小時會回答議員的提問。我會先談談改革的理念及方向。然後，我的同事會介紹改革建議的詳情。

7. 醫療改革，無庸置疑是關乎每一位市民、關乎我們下一代、關乎香港長遠未來的一項跨代工程。茲事體大，政府會秉持開放的態度，誠心、虛心聽取民意，同市民一起討論，一起尋求解決方案。

8. 今次推出的醫療改革諮詢文件，是 2005 年《創設健康未來》諮詢文件的延續，是針對我們看到現行醫療制度的問題，提出一整套改革醫療服務、市場結構和融資安排的建

議。現在開始的是第一階段諮詢，是希望徵詢市民對兩個重大課題的意見－

- 一是醫療服務改革的主要原則和理念。
- 二是各種醫療輔助融資方案的利弊。

9. 我們會按收集到的意見，制訂改革的詳細建議，稍後再進行第二階段諮詢。

10. 這種分上、下集的諮詢方式，可令整個社會有充裕時間對問題作理性、深入的探討。市民的意見亦可在政府政策制定過程中得到充分的考慮。

11. 在此，我必須強調，不論醫療制度如何改變，政府不會改變三項基本原則：

（一） 政府會繼續維持一貫的公共醫療政策，確保不會有市民因為經濟困難而得不到適當的醫療服務。

（二） 政府會繼續照顧低收入家庭和弱勢社群的醫療。這一點，政府責無旁貸。

（三） 公營醫療系統將繼續是全體市民，包括負擔能力較高的中產人士的醫療安全網。 這即是說，當醫療改革經諮詢得以落實後，即使在新的融資安排下，我們的政策是會繼續容許所有市民，包括經濟條件較好的市民繼續使用公營醫療服務。屆時，每次生病時，市民可自行決定選擇使用公營還是私營醫療服務。因此，醫療改革只會增加市民的選擇，不會減少原有的保障。我們更會在現有基礎上繼續改善公營醫療安全網。

12. 我亦必須清楚指出，我們所指的醫療改革，不是翻天覆地的改革，而是按部就班、漸進式，為改良現有制度的改革。原有的優勢一定會得到保留、得到強化。

13. 主席，變，是為了改善我們的醫療制度，令全港大眾能夠得到更全面的醫療、更多的選擇、更大的保障，令市民更加健康。市民健康，生活就可以更加美好。而改革的前路，掌握在市民手裏。我們諮詢文件的主題「掌握健康、掌握人生」，所指的就是這個意思。

14. 變，不是為了減輕政府的財政負擔，將責任推到市民身上。相反，在發展我們未來醫療制度的過程中，政府對醫療的承擔，只會增加，不會減少。事實上，大家已知道 —

- 行政長官經已承諾將醫療撥款佔政府經常開支的比例，由 15%增加至 17%。預計到 2011-12 年度每年撥款實際數額達 400 億元，比現時多大約 100 億元。數額將來還可以因經濟增長、政府預算擴大而增加。

- 而財政司司長亦經已承諾，不論最後融資安排如何，會從財政儲備中撥出 500 億，推動醫療改革。舉例來說，假若經諮詢落實的安排是涉及供款的輔助融資方案，這筆資金可以用作市民個人的啟動資金。

以上充分表明政府對醫療的承擔、對改革的決心。

15. 有人會問，我們的醫療制度究竟出了甚麼毛病，因而須要改革呢？的確，現時的醫療制度，一直為市民提供優質的醫療服務，但我們亦看到有不少地方未盡完善，例如：

- 第一，基層醫療並不全面，預防護理得不到應有的重視，在提升市民對自己健康的認識及責任上亦不周全；
- 第二，公營醫療系統不少地方出現服務樽頸問題，部份服務輪候時間愈來愈長；
- 第三，公私營市場失衡，缺乏充份良性競爭，病人選擇少；
- 第四，病歷不能在公立醫院和私家醫院、乃至醫生之間互通，造成資源浪費，亦為醫生及病人帶來不便；
- 第五，公共醫療安全網對患上重病而需要昂貴醫藥的人，保障未夠完善。

16. 除了服務層面出現上述問題之外，醫療開支亦正不斷上升。人口急劇老化，令致醫療服務需求急升；醫療科技日新月異，病人得益本身固然是好事，卻同時抬高醫療成本。醫療開支不斷增加，速度快過經濟增長，佔整體經濟的比重不斷上升。這情況不是香港獨有，環觀世界所有經濟發達的地方，都面對同樣的問題。

17. 要解決這些問題，在改革醫療服務的同時，我們必須解決醫療資源的問題。否則資源緊絀會成為提升醫療服務水平

和質素的一大障礙。

18. 諮詢文件提出引入輔助融資，正正是為了支持醫療改革、為了改善現有服務的一項必須的措施。

19. 我剛才已經提過，政府對醫療的承擔只會增加、不會減少。所以我們提出輔助融資，並不是要減少政府的承擔，而是要提供額外資源，用來推行改革，以持續改善服務水平和質素。

20. 此外，醫療市場結構的改革，亦需要透過引導資源的流向去促成。資源所到之處，服務自然可得到改善，架構亦可相應作出調整。因此，引入輔助融資，加以適當的配套，可令不論使用公營或私營醫療服務的市民均能得益。

21. 可能議員已注意到近來我們正推出一些新的安排，例如資助病人到私營界別進行白內障手術、在天水圍採購私營基層醫療服務、推行長者基層醫療券、推動醫管局和私家醫院之間的電子病歷互通先導計劃，以及注資 10 億元入「撒瑪利亞基金」。這些其實都是與諮詢文件內提出的服務改革一脈相承，可以視之為改革服務安排和市場結構的一些試點。

22. 如果我們不趁現在香港經濟環境許可的時候，改革醫療經費安排，經費不足問題早晚會出現。到時，我們既不能維持優質公立醫院服務，亦不能為各項服務改革提供所需的額外資源，更不能改變市場結構。損失的是市民大眾。

23. 有人會問，可以不變嗎？維持優質醫療服務，在現行經費安排下，加稅是無可避免。加稅還是融資供款？說到底，資源其實最終都是來自市民。選擇加稅而不是融資供款，錯失的是一次改革醫療服務及市場結構的大好良機。

24. 我自上任以來，一直思考醫療資源的問題。我經常問，到底應該如何集結資源、分配資源、使用資源，才可以為市民持續提供更好的醫療服務、更大的醫療保障呢？怎樣才可在加強照顧基層市民的同時，為其他市民，特別是負擔能力較高的中產人士提供更多優質的選擇呢？

25. 我四出取經，到過瑞典、英國、法國、瑞士、德國、南韓、澳洲、紐西蘭，發現每個國家的醫療經費安排都因當地文化及稅制的差異而各有不同。經兩年多以來的深入研究，我發現沒有一套海外現成的方案是完全適合香港使用。

26. 我們研究了六種輔助融資方案，發現各有利弊。但我相信市民的智慧，深信與市民一起作公開討論是解答醫療融資問題的唯一方法，亦是作出一個對市民未來、對香港未來的重要決定的最佳方法。

27. 主席，我不時收到善意的提醒，指醫療融資，困難重重。但作為醫生，我希望可以為病人盡早診治，說服病人接受最有效的治療方法。作為局長，我有責任將我見到醫療制度所面對的問題，向公眾解釋，並及早提出解決方案。

28. 有人會問，可以等嗎？我們從研究得知，現時的醫療經費安排，在政府承諾將加大投放資源後，勉強可支持多幾年。可以說，現今的醫療系統在今屆政府任內不會崩潰。但將問題留待下任政府才處理，行政長官、政務司司長、財政司司長和我一致認為這不是一個負責任的做法，社會亦會因而付出沉重的代價。所以提出醫療改革的同時，特區政府決心一併處理融資問題，使到市民將來仍然能夠得到優質醫療保障，而我們的下一代亦可享有同樣的保障。

29. 我出身自公營醫療系統，經歷過醫療制度過去數十年的

發展，我清楚知道我們現在到了關鍵時刻，需要作出一個符合整體社會長遠利益的決定。為此，我們整體社會必須以長遠的眼光，審視醫療制度和融資安排。改革的目標，必須是令優質醫療服務能夠持續下去。

30. 主席，我的策略只有一個，就是開誠布公，將所有我們研究過的方案一併拿出來，希望能夠同市民攜手，以理性、務實的態度審視問題、一同討論、凝聚共識。

31. 最後，我希望向健康與醫療發展諮詢委員會及諮詢委員會其轄下醫療融資工作小組的成員表示由衷感謝。他們對問題作出了深入詳細的分析，亦提出具建設性及寶貴的建議，對諮詢文件的制訂，作出了莫大貢獻。

32. 過去亦有很多不同界別的人士向我們提出了寶貴的意見、關注。我亦希望在此向他們表示感謝。他們包括在座不少的議員，醫療衞生界、新聞界的同事，乃至學者、論政團體等等。

33. 我亦要多謝我局的同事，沒有他們的熱誠和衝勁，恐怕諮詢文件仍未能完成。

34. 接下來 —

- 我首先請李淑儀常任秘書長簡介我們的服務改革建議。
- 接着，梁卓偉教授會介紹本港未來醫療開支推算的研究報告。他是香港大學公共衞生學院教授，是這方面的專家，亦是我們健康及醫療發展委員會轄下醫療融資工作小組的成員。
- 接著楊副秘書長會介紹諮詢文件內各種輔助融資方案的利弊。
- 然後夏佳理先生會談談這些方案的理念。他是醫療融資工作小組的主席。

〔接續〕

35. 主席，在未回答議員提問前，我希望補充一點。今天的討論只是諮詢的開始。未來三個月諮詢期，我們會馬不停蹄，走訪各個界別、團體組織、區議會等，向市民作詳盡解釋、聽取市民的意見，亦會通過各種不同渠道，包括問卷調查、專題小組、書面意見等，滙集市民的意見。

36. 未來三個月，我們亦會就醫療改革的不同課題，帶領社會進行主題式的深入討論。這樣的安排，有助市民透過聚焦討論，凝聚共識。

37. 主席，我期望市民的主流共識是同意推行醫療改革，而醫療改革的成果是每一位市民都能受惠。首先，對基層市民而言，醫療改革必須為他們帶來更大的健康保障，他們輪候服務的時間亦必須要縮短。對中產階層而言，醫療改革必須為他們帶來更多物有所值的醫療服務、更多優質選擇、更全面的健康保障。

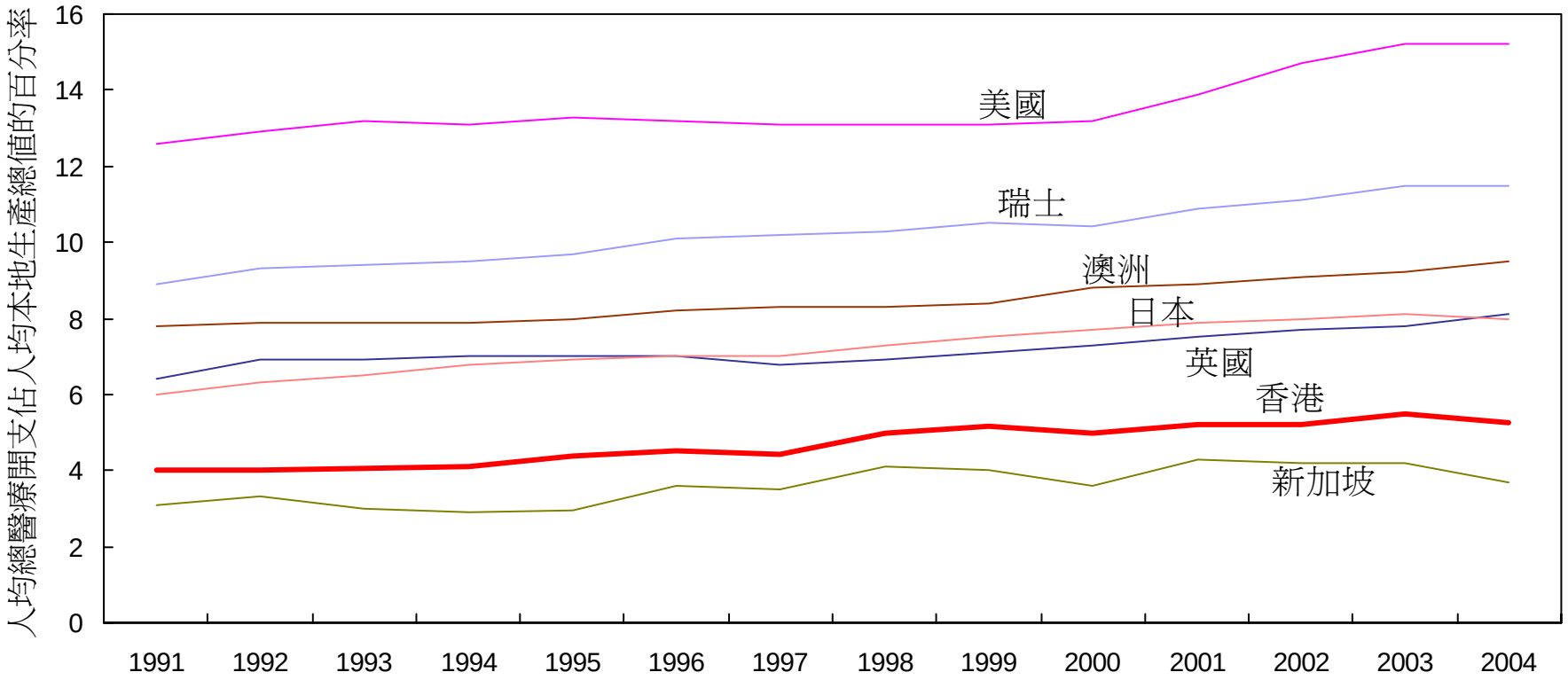
38. 我相信各位議員亦會同意，今次諮詢對香港社會非常重要，我希望議員可以坦誠與我們交換意見，與市民、政府一起找尋最適合香港的方案。

39. 多謝各位。

香港醫療開支的現況與推算

香港大學公共衛生學院
香港大學李嘉誠醫學院

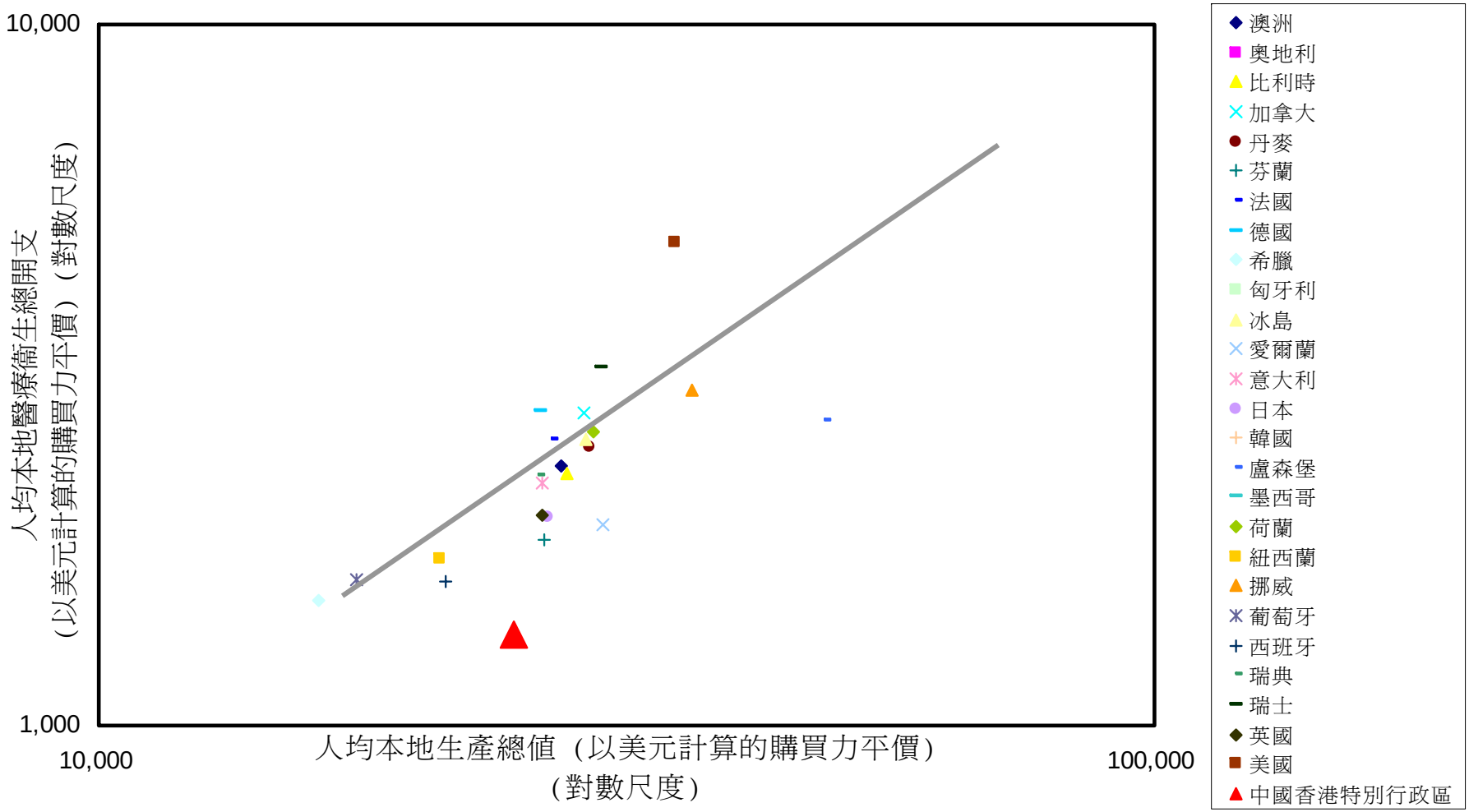
1991年至2004年人均總醫療開支佔人均本地生產總值的百分率



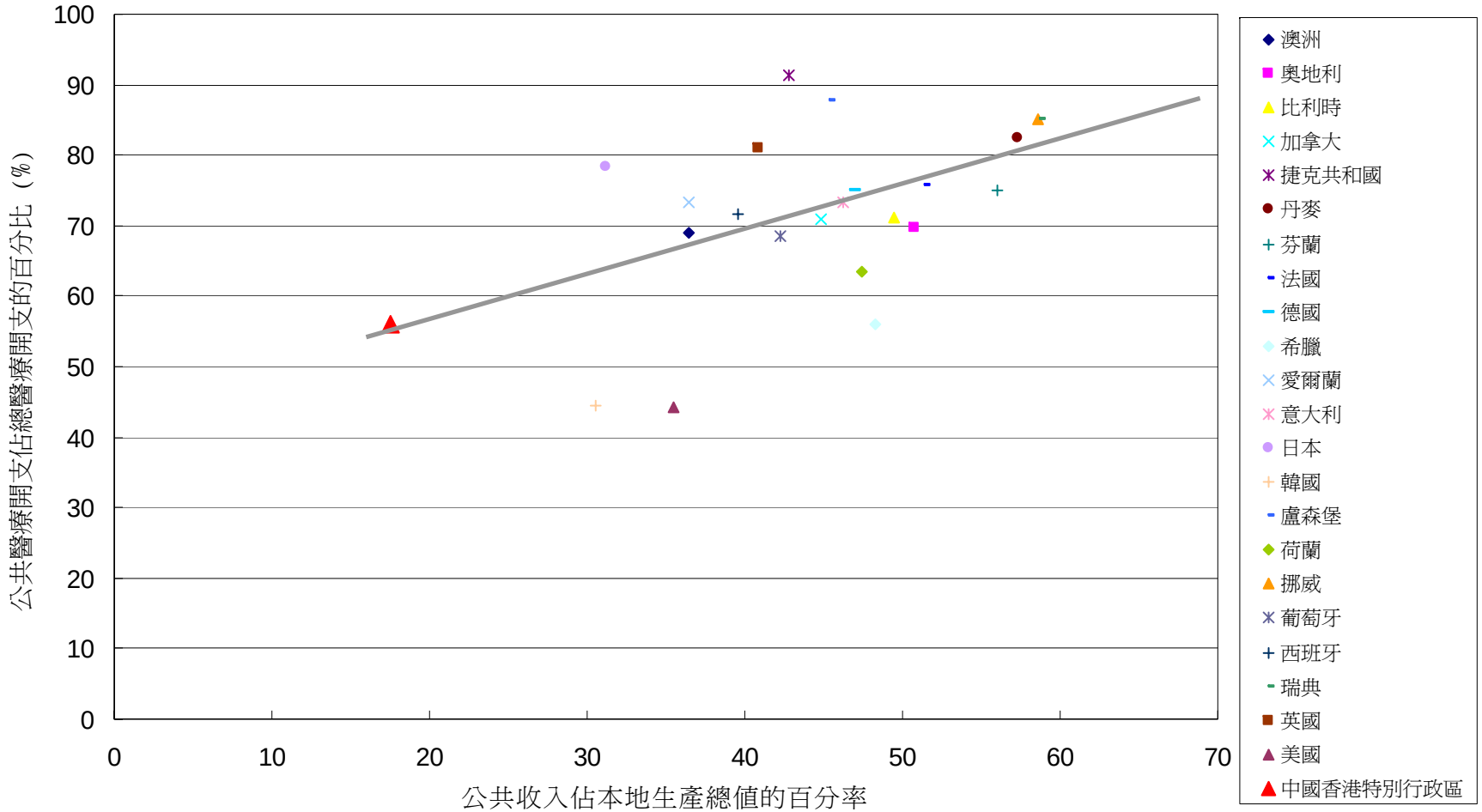
資料來源：

1. 經濟合作及發展組織二零零七年醫療數據(二零零七年十月)
2. 世界衞生組織——國家醫療衞生開支帳目文獻系列
3. 新加坡政府衞生部，以及《新加坡醫療經濟、政策和問題》(Health Care Economics, Policies and Issues in Singapore) (杜文興(Toh Mun Heng)、Linda Low著)
4. 一九九零至二零零四年香港的《本地醫療衞生總開支帳目》。

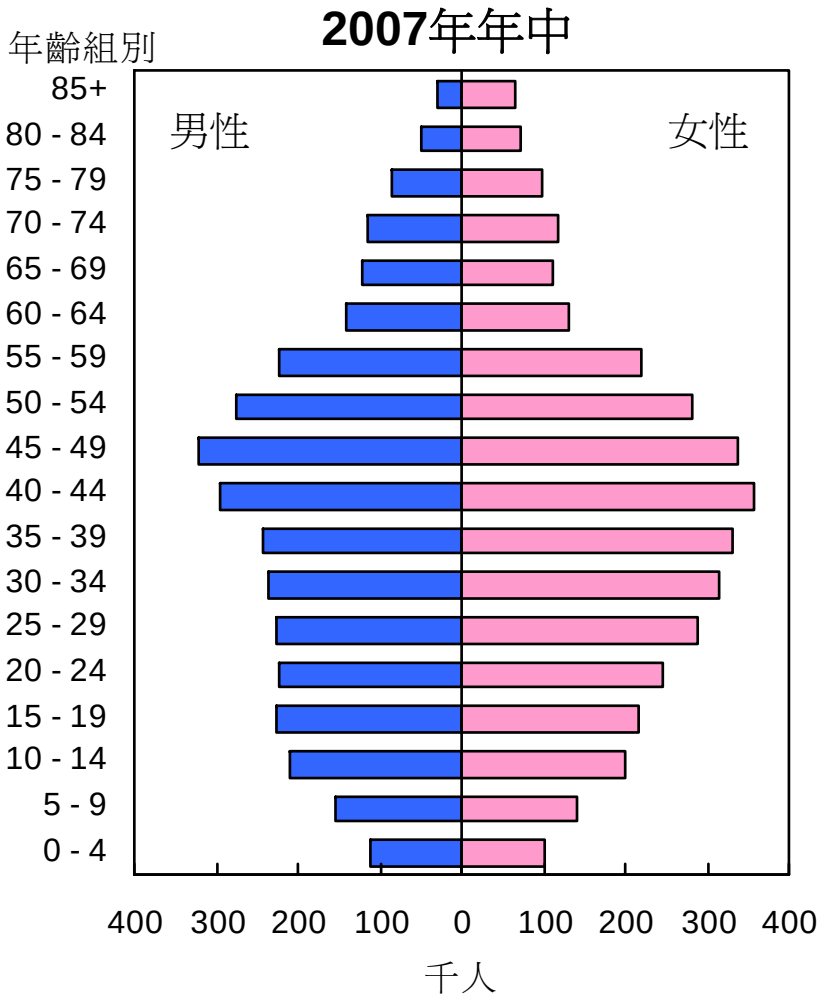
與經濟合作及發展組織成員國比較
香港的醫療開支相對較低

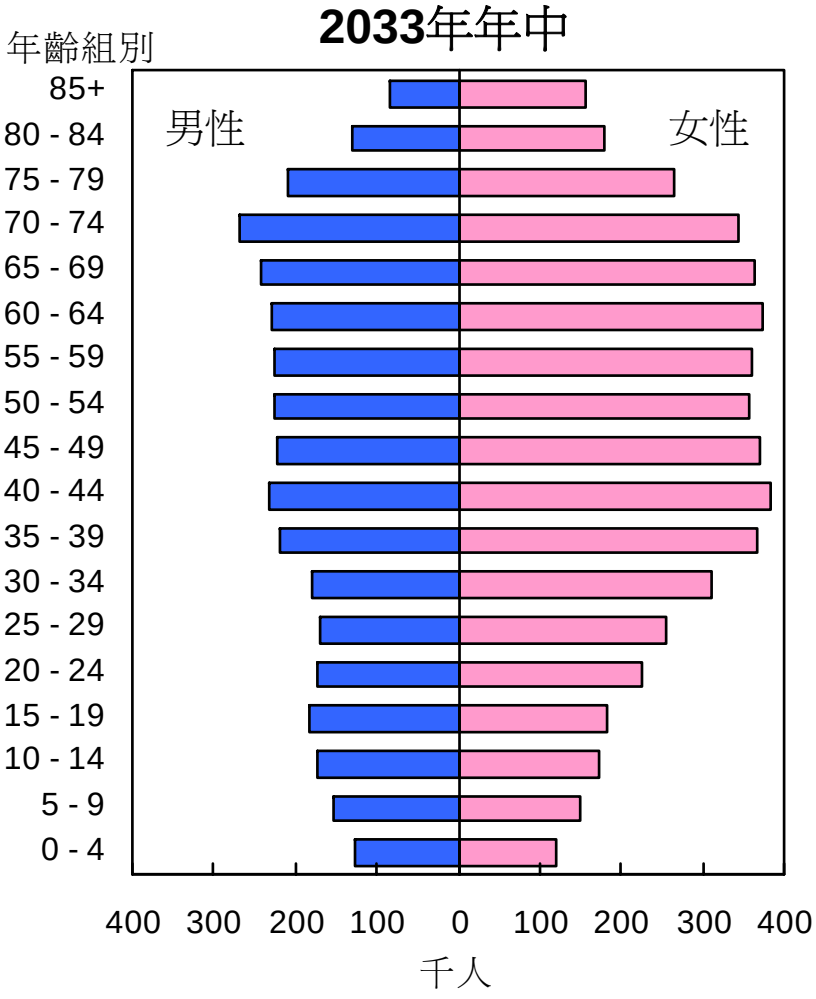


…然而各地的公共醫療開支跟其公共收入水平是相稱的



人口金字塔

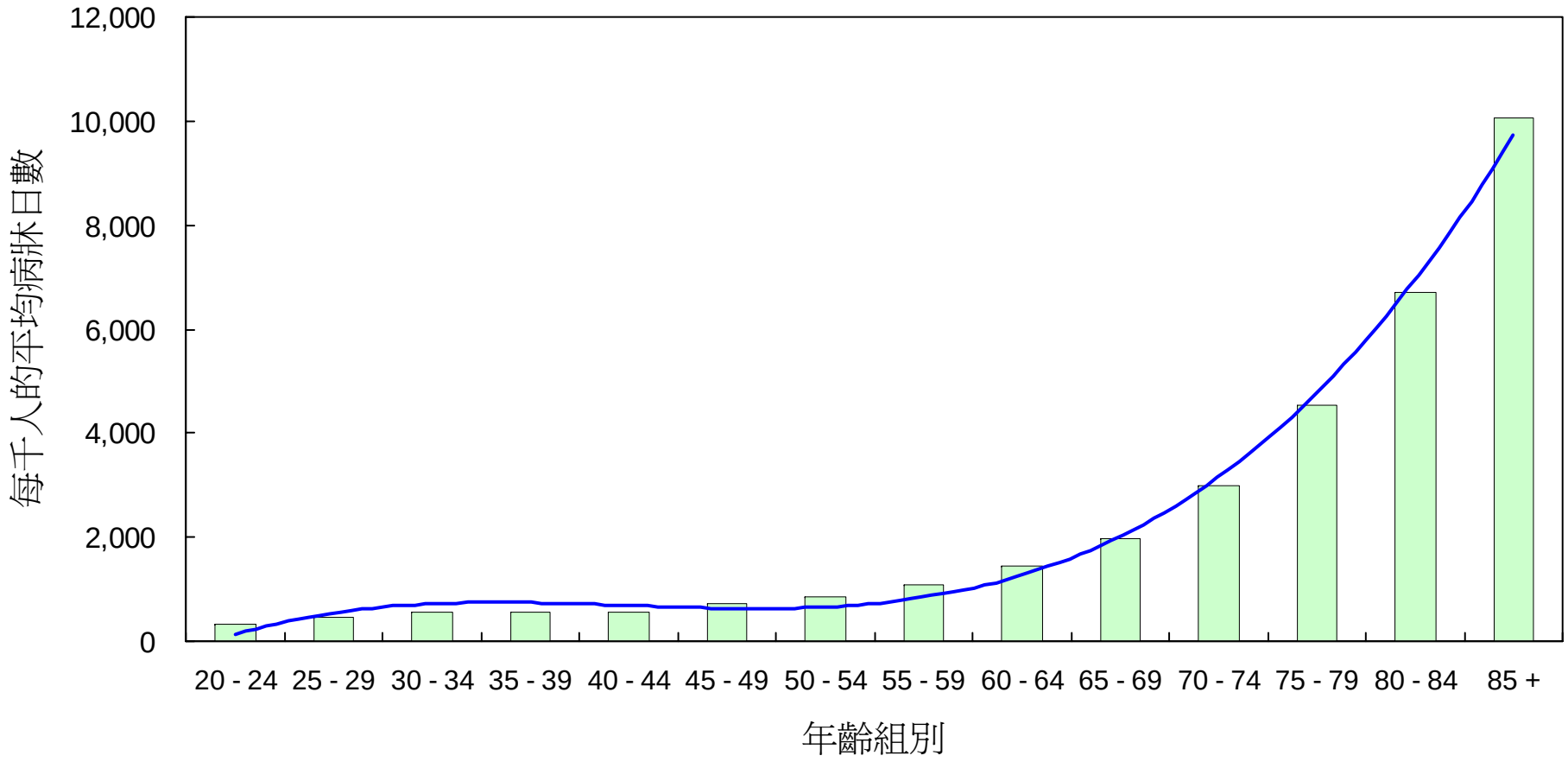




資料來源：

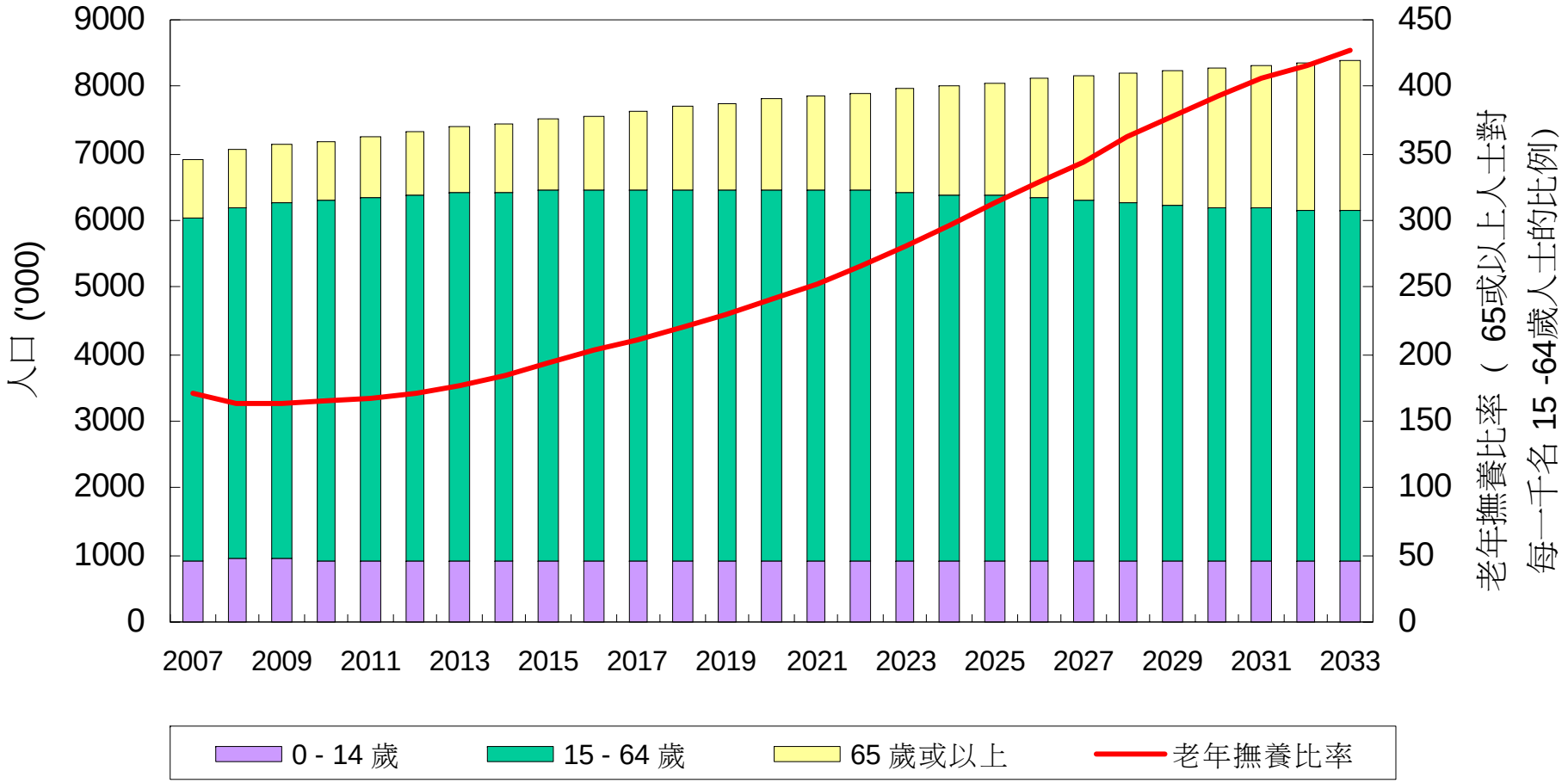
1. 政府統計處2007年年中人口統計
2. 政府統計處《香港人口推算2004-2033》

按年齡計算的公立醫院病牀平均日數 (2006)



資料來源：醫院管理局的數據

總人口及老年撫養比率的推算



資料來源： 政府統計處《香港人口推算2004-2033》

推算方法

- 英國財政部旺勒斯預測方法（Wanless projection method）
- 主要推動成本的因素
  - 年齡
  - 性別
  - 單位成本
    - 包含了改變醫療開支的某些主要成因，例如公眾的期望、技術的轉變，以及生產力的潛在提升等影響
  - 服務使用量
    - 根據人口轉變而推定，並假設各年齡及性別組的指定使用量和醫療服務品質維持不變

推算方法 – 公式

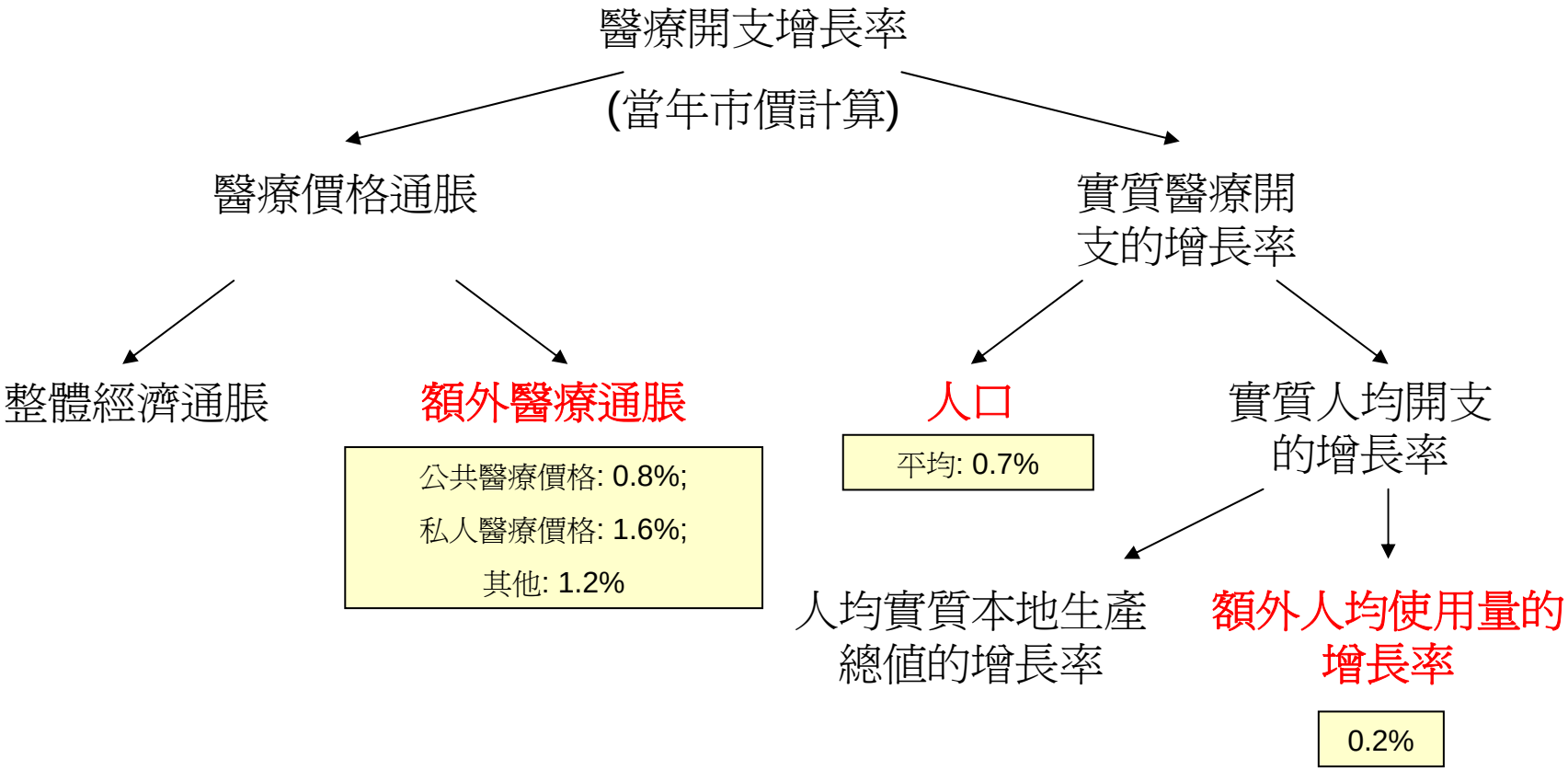
$$\text{總醫療開支}(TEH)_i = \sum_{j,k} p_{ij} a_{ijk} c_{ijk} + \sum_{j} p_{ij} d_i$$

而 p_{ij} = i 年人口及 j組年齡性別
a_{ijk} = i年服務使用量 ， j 組年齡性別， k類醫療服務
c_{ijk} = i年單位成本， j 組年齡性別， k類醫療服務
d_i = i年人均其他醫療開支

預計的醫療服務使用量、單位成本及人均其他醫療開支由以下公式代表：

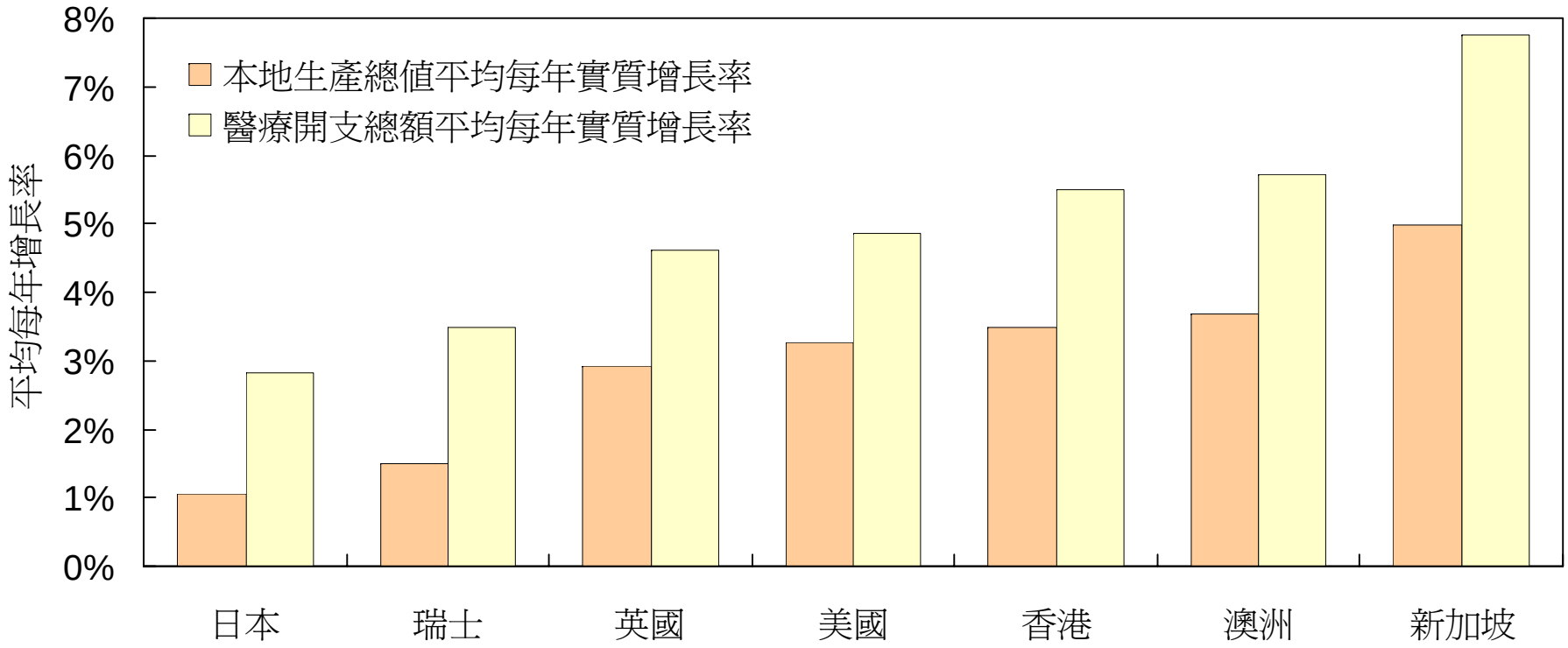
$$a_{ijk} = a_{0,j,k}(1+u_k)^i, \quad c_{ijk} = c_{0,j,k}[1+(g+v_k)]^i, \quad d_i = d_0[1+(g+w)]^i$$

$a_{0,j,k}$ = 醫療服務使用量的基數
$c_{0,j,k}$ = 單位成本的基數
d_0 = 人均其他醫療開支的基數
u_k= 使用k 類醫療服務數量的每年增長率 (%)
v_k= k 類醫療服務的單位成本的每年增長率 (扣除人均本地生產總值增長率)(%)
g = 人均本地生產總值的每年增長率
w =人均其他醫療服務的每年增長率(扣除人均本地生產總值增長率)(%)



資料來源： *Huber M.* 經濟合作及發展組織成員國的醫療開支趨勢, *1970-1997*. 醫療融資評論 *21(2):99-117, 1999.*

1995 年至2004年醫療開支總額及本地生產總值各平均每年實質增長率



資料來源：

1. 經濟合作及發展組織二零零七年醫療數據(二零零七年十月)
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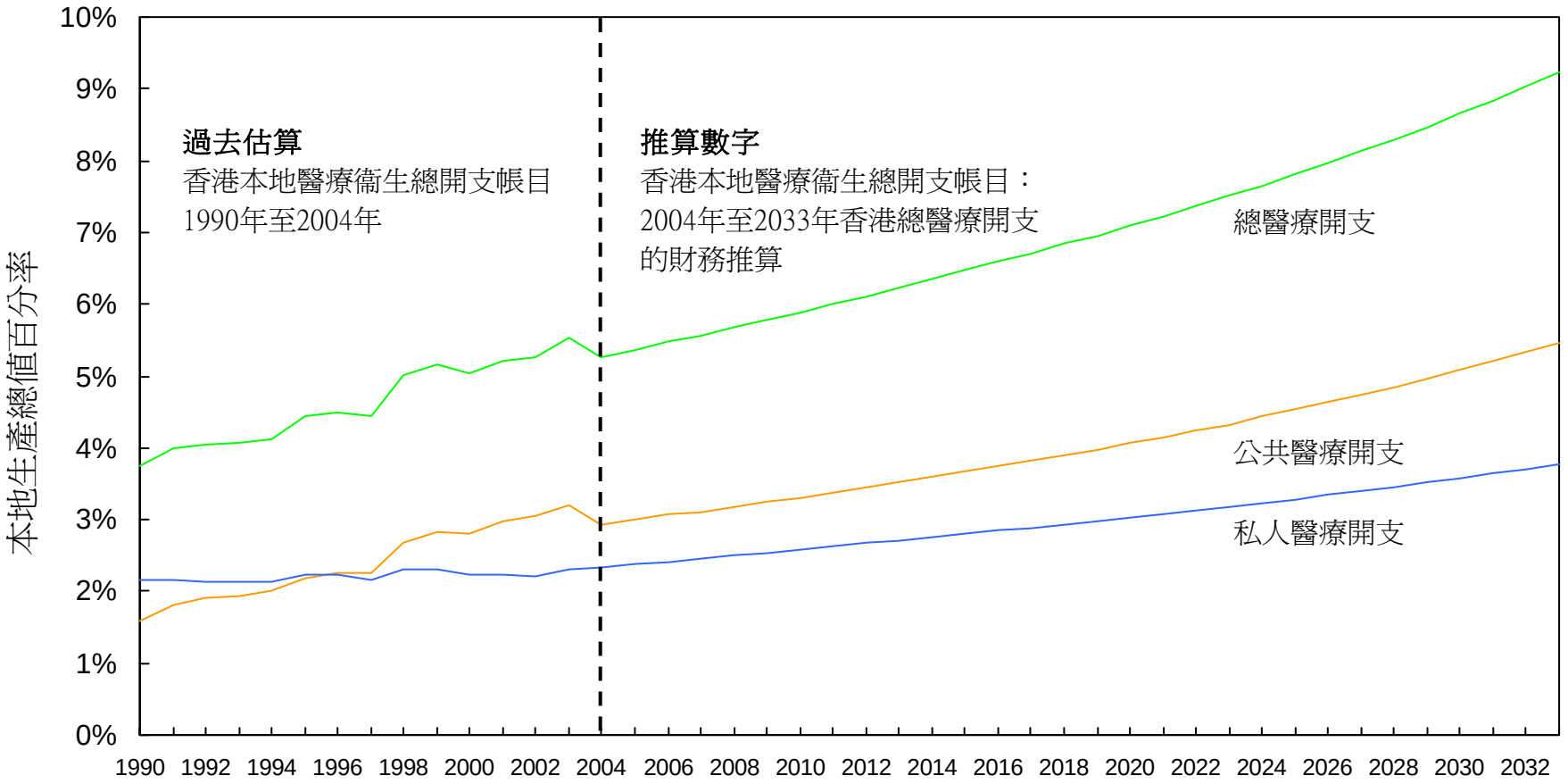
4. 一九九零至二零零四年香港的《本地醫療衞生總開支帳目》。

醫療衞生開支佔本地生產總值的百分率
1990年 至 2033年



資料來源：

1. 1989/90 – 2004/05年度香港的《本地醫療衞生總開支帳目》
2. 香港本地醫療衞生總開支帳目：二零零四至二零三三年香港總醫療開支的財務推算

限制

- 由於不明朗因素會隨時間而增加，因此推算模型的結果須審慎地詮釋爲長期趨勢，而非按年的實際開支水平。

- 精算模型並不能計算求診行爲由於政策干預所產生的改變。這計算或需加入計量經濟模型的元素，但因現有統計數據的限制，這些模型（如美國的聯邦醫療服務中心（前身爲健康保健財政管理局）所設計的模型），並未能應用於本港。

摘要及涵意

- 由1989/90至2004/05年度，總醫療開支由佔本地生產總值的3.5%增加至5.2%，相等於每年達7%的實質增長率，而同期本地生產總值的每年實質增長率爲4.3%，即醫療開支增長率比本地生產總值增長率平均高出2.7個百分點。

- 雖然與經濟合作及發展組織成員國比較，香港的整體醫療開支及公共開支（以佔本地生產總值的百分比而言）相對較低，但整體醫療開支與公共開支以及公共收入的水平相稱。

摘要及涵意

- 本精算模型指出，若根據現時的趨勢，2033年的總醫療開支將佔本地生產總值的9.2%。而公共醫療開支則佔本地生產總值的5.5%，大約相當於屆時公共開支總額的27.3%（假設公共開支佔本地生產總值20%）。
- 由2004至2033年的總醫療開支的每年實質增長率推算爲5.4%，較推算中假設的本地生產總值3.4%高出兩個百分點。
- 人口老化及有關的醫療使用量，以及技術普及（反映在淨醫療通脹率上），均是長期整體開支增長的主要因素。