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Legislative Council

LC Paper No. CB(2)1224/00-01
(These minutes have been
seen by the Administration)

Ref : CB2/PL/HS

LegCo Panel on Health Services

Minutes of meeting
held on Monday, 12 March 2001 at 8:30 am
in Conference Room A of the Legislative Council Building

Members Present	:	Hon Mrs Sophie LEUNG LAU Yau-fun, SBS, JP (Chairman) Dr Hon LO Wing-lok (Deputy Chairman) Hon Cyd HO Sau-lan Hon CHAN Yuen-han Hon Bernard CHAN Dr Hon YEUNG Sum Hon Andrew CHENG Kar-foo Hon LAW Chi-kwong, JP Dr Hon TANG Siu-tong, JP Hon LI Fung-ying, JP Hon Tommy CHEUNG Yu-yan, JP Hon Michael MAK Kwok-fung
Member Attending	:	Hon NG Leung-sing
Public Officers Attending	:	Dr E K YEOH, JP Secretary for Health and Welfare Dr Margaret CHAN, JP Director of Health Mr Gregory LEUNG, JP Deputy Secretary for Health and Welfare

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Dr William HO, JP
Chief Executive, Hospital Authority

Dr S P MAK, JP
Deputy Director of Health

Dr W M KO
Deputy Director, (Operations & Public Affairs)
Hospital Authority

Mr Jeffrey CHAN
Assistant Secretary for Health and Welfare

Clerk in Attendance : Ms Doris CHAN
Chief Assistant Secretary (2) 4

Staff in Attendance : Miss Mary SO
Senior Assistant Secretary (2) 8

I. Confirmation of minutes of meeting held on 12 February 2001
(LC Paper No. CB(2)1017/00-01)

The minutes of the above meeting were confirmed.

II. Date of next meeting and items for discussion
(LC Paper Nos. CB(2)1022/00-01(01) - (02))

2. Noting that the issue of "Review of rehabilitation services for mental patients", which was tentatively scheduled by the Panel on Welfare Services for discussion in April 2001, was similar to issue 4 (Mental health service) on the list of issues to be considered (LC Paper No. CB(2)1022/00-01(01)), members agreed to hold a joint meeting with the Panel on Welfare Services to discuss the two issues. The Chairman undertook to liaise with the Chairman of the Panel on Welfare Services on the timing for holding the joint meeting. Members further agreed to discuss the health issues in the "Report of the HKSAR of the People's Republic of China in the light of the International Covenant on Economic, Social and Cultural Rights" at the next regular meeting to be held on 9 April 2001.

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3. Mr Michael MAK urged the Administration to expeditiously introduce the subsidiary legislation under the Chiropractors Registration Ordinance, as it was stated in the action list (LC Paper No. CB(2)1022/00-01(02)) that the Administration intended to introduce such early this year. Deputy Secretary for Health and Welfare (DSHW) undertook to provide a progress report on the subject for the next meeting on 9 April 2001.

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III. Options for financing Health Care Service (Paragraphs 105 to 123 of the Consultation Document on Health Care Reform)

4. At the invitation of the Chairman, Secretary for Health and Welfare (SHW) took members through a paper, tabled at the meeting (see **Appendix**), which set out the attributable rate of growth of individual factors accounting for public health care expenditure growth projected by the Harvard team and the Administration respectively and the cost-control measures to be adopted by the Administration. In particular, SHW pointed out that the annual growth rates of public health care expenditure of 6.6% and 3.2% projected by the Harvard team and the Administration respectively were based on different time periods. The Harvard team's projection was based on figures between 1991 and 1996 whereas that of the Administration was based on the same between 1980 and 1996. In the Administration's view, which was also shared by many academics, using figures between 1991 and 1996 when public heath care was undergoing rapid expansion with the setting up of the Hospital Authority (HA) as the basis to project future health care expenditure was unreasonable. To ensure a more realistic financial projection on public health care expenditure, the Administration therefore considered it more reasonable to use public health care expenditure over a longer time period between 1980 and 1996.

5. SHW highlighted the differences in the growth rates of various factors accounting for public health care expenditure growth projected by the Harvard team and the Administration. Although two such factors, i.e. population growth and aging-related utilisation rate, projected by the Harvard team to grow at an annual rate of 1.3% and 0.8% respectively were similar to the same projected by the Administration at a combined annual growth rate of 2.2%, two other such factors, i.e. non-aging related utilisation rate and residual, projected by the Harvard team to grow at an annual rate of 1.9% and 2.6% respectively were nevertheless at variance with that projected by the Administration at an annual growth rate of 1%. SHW said that the reasons for the wide discrepancy between the Administration's assessment and that of the Harvard team in terms of the attributable rates of growth of the non-aging related utilisation rate and residual factors, i.e. 1% versus 4.5%, were twofold. Firstly, the Administration had not included non-aging related utilisation rate as a factor in projecting public health

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care expenditure growth and had instead only taken account of the adoption of new technologies as the remaining factor in projecting growth of public health care expenditure in addition to population growth and aging-related utilisation rate. Secondly, the Harvard team had only considered factors which would drive cost increase and had not taken into account the following cost-control measures which would be adopted by the Administration to drive down costs -

Supply-side measures

(a) Development of community-based services to balance demand on hospital services;

(b) Rationalisation of service delivery network to minimise duplication;

(c) Improvement of productivity through service re-design;

(d) Structuring of health technology management to ensure cost-effectiveness;

Demand-side measure

(e) Appropriate utilisation of public services through pricing;

Both supply-side and demand-side measures

(f) Strengthening of primary care to balance the demand on specialist care services; and

(g) Development of clinical protocols to guide appropriate application of services and investigations.

6. On the reason why the Administration had disregarded the non-aging related utilisation rate as one of the factors for projecting public health care expenditure growth, SHW explained that it was unlikely that public health care services would undergo significant expansion in future as had happened during the years from 1991 to 1996. SHW pointed out that the reason why the Harvard team projected an annual 1.9% growth rate due to increase in non-aging related utilization was that it anticipated that the expansion of public health care services occurred during 1991 to 1996 would continue. As regards the reason for including the adoption of new technologies as one of the factors in projecting public health care expenditure, SHW explained that this was necessary given the aging population and increasing public aspiration for better quality health care services as people got more affluent. SHW further said that projecting cost increase in new technologies at 1% per annum was probably a conservative

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estimate, but this could only be achieved through the implementation of a robust technology management mechanism to ensure cost-effectiveness. It should also be noted that international experience had shown that health expenditures generally grew at an average rate of 1 to 2% due to technology adoption.

7. In summing up, SHW said that the financing of public health care system in future would be based on the followings -

(a) the Administration would continue to invest in public health care service based on the new population-based funding arrangement which had been agreed with HA. Subject to community needs and economic growth, additional resources would be allocated to public health care. For example, in 2001/02, additional resources had been set aside to improve primary care and services for discharged mental patients and purchasing of new psychiatric drugs, etc;

(b) Adoption of the seven cost-control measures mentioned in paragraph 5 above;

(c) Revamping the fees structure so that resources could be used on areas of greatest needs, which, in turn, could influence both provider and patient behaviour. For example, consideration would be given to charging fees for Accident and Emergency (A&E) services to minimise inappropriate use and misuse; and

(d) Establishing a Health Protection Accounts scheme to reduce the burden on future generations and to strengthen the long term financial sustainability of the public health care system.

In respect of (d), SHW said that the Health Protection Account was not an insurance plan, but was essentially a personal savings account to cover the future medical needs of the individual and the spouse when the individual reached the age of 65 or earlier in case of disability. It should be noted that savings from the Health Protection Account were not expected to be adequate in all cases to cover the medical expenses of the individual and the spouse, as they were intended to be used as a supplementary source of funds for the individual and the spouse to pay for their medical expenses after retirement. According to the Administration's estimation, if the proposed plan to require all workers from the age of 40 to 64 to put away appropriately 1 to 2% of their earnings to their own Health Protection Accounts was adopted, over $2 billion could be saved for the Health Protection Accounts per annum. SHW further said that the Administration had not come to any view on how the Health Protection Accounts scheme should be implemented, and was open to any suggestions from the public. SHW added that the Administration was currently in discussion with the private sector on how both

sides could collaborate and develop new health products, so as to provide patients with more choices in medical treatments. The insurance industry would also be encouraged to create new health care insurance policies to support these new products.

8. Dr YEUNG Sum objected to the establishment of a Health Protection Accounts scheme, having regard to the facts that the economy had not yet fully recovered and that the working population had just started to contribute 5% of their salaries to the Mandatory Provident Fund (MPF) Scheme. As the Administration had a reserve of over $400 billion, and coupled with the fact that it intended to adopt a series of cost-control measures to drive cost down and revamp fees structure of public health care services, Dr YEUNG questioned the need for asking the public to contribute 1 to 2% of their salaries to subsidise the public health care system. Dr YEUNG then enquired whether, similar to the MPF Scheme, people earning salaries below and above a certain level would be exempted from contributing to the proposed Health Protection Accounts scheme; and whether the Administration would cover the medical bills of the individual and the spouse if the savings of the individual from the Health Protection Account had exhausted.

9. SHW agreed that it was not the right time to implement a Health Protection Accounts scheme, given that the economy had not yet fully recovered. Nevertheless, in view of the increasing demands which the aging population, advances in medical technology and rising public expectations for quality health services would put on the public health budget, the Administration considered it now timely to seek the public views on the Health Protection Account scheme, the objectives of which were to reduce the burden on the next generations and to strengthen the long-term financial sustainability of the public health care system. SHW assured members that the Administration had no intention to implement the proposed scheme until at least the economy had fully recovered. He envisaged that the implementation of a Health Protection Accounts scheme would take many years to complete.

10. SHW reiterated that the Administration had not come to any view on the features of the Health Protection Accounts scheme. Subject to the community's view on the proposed scheme, the Administration would commission a study on it in 2001/02 to examine in detail its feasibility for application in Hong Kong. The study would take about 18 months to complete, and the public would be consulted on its findings and recommendations in due course. SHW further explained that the reason why it was necessary to implement a Health Protection Accounts scheme was because the public health care system could no longer be financially sustainable in the long term through taxation alone. Moreover, although user fees could be raised to fund the public health care system, due regard must be given to ensure that the increased fees would remain affordable by the general

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public. As the Health Security Plan proposed by the Harvard team had not been well received by the public, the proposed Health Protection Accounts scheme was therefore the best option which the Administration could think of to help finance the public health care services, i.e. savings from the Health Protection Accounts could serve as the principal supplementary funding source to meet cost increases in new technologies which were anticipated to grow at an annual rate of 1%.

11. Dr YEUNG further enquired whether consideration would be given to allocating more public revenue to health care so as to do away with the need for implementing a Health Protection Accounts scheme. SHW responded that there was not much room for increasing such allocation, as Hong Kong's public health care expenditure, representing 14.7% of the total recurrent public expenditure, was considered to be on the high side compared with our neighbouring countries. Moreover, a balance needed to be struck to meet other needs of the society such as education, social welfare and infrastructure. SHW reiterated that the reason for implementing a Health Protection Accounts scheme was that it was no longer adequate to rely on one source of income to finance the public health care system. This was in line with international experience which had shown that a high quality health care system could only be sustained in the long term through a combination of funding sources.

12. Noting the Administration's intention to charge fees for A&E services, Miss LI Fung-ying enquired about the level of such fees and the timetable for implementation. Referring to paragraph 114 of the Consultation Document which stated that a second safety net, similar to the existing Samaritan Fund, would be built up to assist patients of insufficient financial means, Miss LI enquired whether these patients would need to apply for financial assistance from the second safety net every time they needed it and whether there would be sufficient fund in the second safety net to pay the medical bills of the patients in need.

13. Responding to Miss LI's first question, SHW said that the Administration would not set down a timetable for increasing the fees and charges of public health care services until after the freeze on public sector fees and charges had been lifted. In the interim, a full-scale review of the fees structure of the public health care system was being conducted by the Administration. The aim of the review was to examine how to target Administration's subsidy to various services in the most appropriate manner, as it was believed that public funds should be channeled to assist lower income groups and to services of major financial risks to patients. The review would also examine how the relative priorities of services provided might be reflected in the subsidy level and how inappropriate use and misuse of services could be minimised. Following the review and the consequent revision of the fees structure, charges would continue to be affordable but could be effective in influencing patient behaviour to minimise inappropriate use and misuse. The

revised fees structure would also influence the distribution of workload between the public and private sectors.

14. As regards Miss LI's second question, Deputy Director, Operations & Public Affairs, Hospital Authority (DDHA) said that currently patients attending all hospitals managed by HA could apply for assistance from the Samaritan Fund. Financed by donations and administered by HA, the purpose of the Samaritan Fund was to provide financial assistance to needy patients in meeting expenses required in the course of medical treatment which were not included in the hospital maintenance or out-patient consultation fees in public hospitals and clinics. Currently, in the general wards of public hospitals, patients were charged a flat-rate maintenance fee of $68 per day. However, with the continued advancement of medical science and technologies, there were certain new drugs, implants and appliances, the costs of which were not covered by the maintenance fee at the time when they were first introduced. As less expensive and equally effective treatment options were still available, patients were required to purchase these new items by their own funds. DDHA further said that patients who had indicated that they had difficulty in meeting the costs of the items would be referred to the medical social worker for assessment of their eligibility for assistance. A patient whose income was below the Median Monthly Domestic Household Income (derived from surveys conducted regularly by the Census and Statistics Department) would normally receive assistance from the Samaritan Fund. In considering patients' financial status, the patients' liquidable savings would be assessed on a household basis.

15. SHW said that although it was the Administration's intention to require patients wishing to apply for financial assistance from the second safety net to undergo assessment by a medical social worker to ascertain their eligibility for assistance, every effort would be made to ensure that such a procedure would be as simple as possible so as to avoid creating unnecessary inconvenience to the patients. For example, a financially-stricken kidney patient who had to visit a hospital on a fortnightly basis to undergo dialysis treatment might not need to apply for financial assistance for each dialysis treatment. SHW assured members that as the Administration would continue to uphold the long-held policy of ensuring that no one would be denied adequate medical care because of insufficient means, the second safety net was targeted at patients who had insufficient earnings or who had difficulty to pay for even the heavily-subsidised services because of serious or chronic illnesses.

16. Dr LO Wing-lok requested the Administration to provide more information on how it came up with an estimated annual 1% growth rate of new technologies and the reason for discounting the non-aging related utilization rate as one of the factors accounting for public health care expenditure growth. Dr LO further expressed concern as to whether the second safety net would be able to help all

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patients of insufficient financial means so that they would not be denied adequate medical care.

17. SHW reiterated that the Harvard team had projected an annual 1.9% growth rate due to non-aging related utilisation was because it had based such a growth on figures from 1991 to 1996 when the public health care system was undergoing rapid expansion with the setting up of HA. SHW further reiterated that projecting expenditure growth arising from new technologies at an annual rate of 1% was reasonable, as such a growth rate was comparable to the international experience which suggested that health expenditures generally grew annually at an average rate of 1 to 2% due to technology adoption alone. Moreover, the implementation of a structured health technology management and collaboration with the private sector should help to maintain the cost increase in new technologies to 1% per annum. On collaboration with the private sector, SHW cited an example that HA would consider purchasing fewer number of expensive equipment if the usage of such equipment was believed to be low and that the same equipment was or would be purchased by the private sector. Responding to the concern raised by Dr LO about patients of insufficient means being denied adequate medical treatment, SHW said that there was no cause for such a concern as the fees of public health care services would continue to be affordable by the general public even after the revamping of fees structure. In this connection, the provision of the second safety net was simply to assist patients who had insufficient earnings or who had difficulty in paying for even the heavily-subsidised services because of serious or chronic illnesses. Dr LO expressed regret at the Administration's reluctance to provide more detailed information on the data and assumptions used to come up with its financial projection of public health care expenditure up to 2016. SHW responded that he would be happy to discuss with Dr LO and other interested persons on the matter in more detail after the meeting.

18. Mr Michael MAK enquired whether people using the A&E services in future would be charged $150 as reported by the media. Noting that the Administration was currently in discussion with the insurance industry on developing new health care insurance policies, Mr MAK urged the Administration to be aware of the moral hazard which usually came with health care insurance and enquired about the measures which would be taken to address the problem. As SHW had mentioned earlier at the meeting that in future over $2 billion of public care health care services would be funded by the proposed Health Protection Accounts scheme annually, Mr MAK enquired how the Administration had come up with such a figure. In view of the huge amount of money which would be contributed towards the proposed Health Protection Accounts scheme, Mr MAK was of the view that the Administration should commission an actuarial study on the proposed scheme and provide information on how the contributions made towards the proposed scheme would be managed.

19. SHW responded that he could not give a reply at this stage as to how much A&E services would be charged in future, as the Administration was currently conducting a full-scale review of the fees structure of the public health care system. However, in order to minimise inappropriate and misuse of A&E services, the Administration intended to set the fees of A&E services higher than that of the general out-patient clinics. SHW assured members that in doing so, due regard would be given to ensuring that the fees of A&E services would be affordable by the general public and that payment would be waived for people on Comprehensive Social Security Assistance. Responding to Mr MAK's concern raised about the problem of moral hazard which usually came with health care insurance, SHW said that the Administration was well aware of the problem and would discuss with academics and other related parties on how to address this matter. SHW further said that the Administration recognised the potential contribution of voluntary insurance as one of the sources of providing supplementary funding to the health care system and that it could provide greater choice to patients. To this end, the Administration was currently in discussion with the private sector on developing new products which would appeal to better-off patients and with the insurance industry on creating new health care insurance polices to support these new products. The Administration would also discuss with the insurance industry the possibility of allowing people to use their savings from their Health Protection Accounts when they reached the age of 65 to purchase medical and dental insurance plans from the private insurers.

20. Mr Andrew CHENG said that the Administration appeared to be forcing the public to accept the proposed Health Protection Accounts scheme, having regard to the statement made in paragraph 107 of the Consultation Document that to expect a major increase in the allocation of public revenue to health care would be unrealistic, although it was also stated in paragraph 113 of the same that the Administration had no intention of reducing its commitment to the financing of the public health care system. Mr CHENG echoed Dr LO Wing-lok's request for the Administration to provide members with information on the data and assumptions used in coming up with its financial projection of public health care expenditure up to 2016. He said that in the absence of such information, it would not be possible for members to make a decision as to whether the proposed Health Protection Account scheme should be supported. Noting that the Harvard team projected that if no changes were made to the public health care system, including the financing aspect, the health care expenditure as a percentage of the total recurrent public expenditure would need to increase from the existing 14.7% to as much as 28.4% by 2016, Mr CHENG enquired what the Administration's assessment was in this regard.

21. SHW responded that the Harvard team's projection of public health care expenditure growth was an over-projection, as explained in paragraphs 4 to 6 above. He cited as an example that the Harvard team's projection of public health

care expenditure in 2001/02 was $58.934 billion, whereas the budget for public health care expenditure in 2001/02 as announced by the Financial Secretary on March 2001 was $33.9 billion. SHW further said that if no change was made to the existing public health care system with the exception of slightly increasing the fees and charges of public health care services and implementing a series of cost-control measures to drive cost down, and assuming that the economy would grow at an annual rate of 3% up to 2016 and that the health care expenditure as a percentage of the total recurrent public expenditure would remain basically the same, the Administration estimated that there would be a shortfall of $7 billion by 2016 as opposed to $27 billion as told by the Harvard team to the media recently. DSHW supplemented that the Administration was of the view that the 3% annual real economic growth should be able to cover the increase in public health care expenditure brought about by the aging population which was projected to grow at an annual rate of 2.2% in the next few years. As health care expenditure as a percentage of the total recurrent public expenditure would remain basically the same as of now and having regard to the fact that the 3% annual real economic growth rate would by and large be used on covering the increase in public health care expenditure brought about by the aging population, the Administration considered it necessary to implement a Health Protection Accounts scheme to supplement the increasing public health care expenditure brought about by the need to invest in new technologies, which was projected to grow at an annual rate of 1%.

22. Mr LAW Chi-kwong opined that HA would become a health management organisation and the Administration its employer, following the implementation of the new population-based funding mechanism. As money would be deducted from their personal accounts under the proposed Health Protection Accounts scheme whenever the persons concerned and their spouse used services in the public sector and that money would be reimbursed to the persons concerned if they chose services in the private sector albeit at the public sector rates from the accumulated savings, Mr LAW was of the view that it was of paramount importance that the operation of the proposed Health Protection Accounts scheme must be underpinned by an efficient mechanism, particularly if the Administration wished to convince private insurers to introduce health care insurance plans to cater for this particular group of people. In this regard, he noted that the Administration had stated at previous meetings of the Panel the proposed Health Protection Accounts scheme was one way of providing patients with more choices given that the individual could use savings from the proposed scheme to purchase medical and dental insurance plans from private insurers. Mr LAW also said that although the Harvard team advocated the "money follows the patient" concept so as to provide more choices to patients, it was regrettable that that the Consultation Document did not address such a issue.

23. SHW responded that HA's role as an executor of the Government policy on

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health care would remain unchanged following the implementation of the new population-based funding mechanism, as the formulation of health care policy would continue to be under the purview of the Health and Welfare Bureau (HWB) and assisted by the Department of Health (DH). In respect of the latter, SHW explained that with DH taking on the role of an advocate for health, it would work in concert with HWB to seek political commitment, policy and systems support and social acceptance for different health goals and programmes. With regard to the operation of the proposed Health Protection Accounts scheme, SHW said that the Administration would draw reference from the operational experience of the Mandatory Provident Fund Schemes Authority, with the aim of avoiding wastage and duplication of efforts at all levels.

24. SHW further said that the adoption of a computer-based Health Information Infrastructure would help to facilitate the development of a lifelong health record for each individual. On the question of providing more choices to patients, SHW said that the Administration was of view that there was a demand for private providers as they allowed a choice of doctors and were more easily accessible than the service in the public sector. In this connection, the Administration was in discussion with the private sector on developing new products which would appeal to better-off patients. For example, the private sector could provide a certain health care service, which was not of an urgent nature and which entailed long waiting time in the public sector, at a packaged rate. To provide an added incentive for better-off patients to use the private providers, the insurance industry would be encouraged to create new health care insurance plans to support these new products. SHW further said that as savings from the Health Protection Accounts could be used to purchase medical and dental insurance plans from private insurers, the insurance industry could explore the feasibility of introducing plans which would only cover primary care provided by the private sector, thereby reducing their risk as the more expensive hospital services would be borne by the insured.

25. Mr Bernard CHAN noted that the provision of health care services in Hong Kong was tantamount to a national health insurance, having regard to the fact that at present about 94% of the heath care services in Hong Kong were provided by the public sector which in turn was heavily subsidised by public revenue. Given that Hong Kong had a low taxation system and having regard to the aging population and rising public expectation for better quality health services, he shared the Administration's concern that Hong Kong's health care services could not be financially sustained in the long term through public revenue alone. In this connection, Mr CHAN enquired about the provision of health care services in other countries which also practised a low taxation system similar to Hong Kong.

26. SHW responded that no other places had a heavily-subsidised public health care system like Hong Kong and also practised a low taxation system. SHW

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further said that, generally speaking, two types of health care system were practised in developed countries. In the first type, public money was used to purchase services provided by the private sector as practised in the United States of America (USA), while in the other type, the government was responsible for all provision of health care services as practised by the United Kingdom. As regards Singapore, although it had a higher taxation system than Hong Kong, people using the public health care system were required to shoulder a larger share of the costs than the people of Hong Kong. Responding to Mr CHAN's further enquiry as to whether consideration would be given to adopting the USA system, SHW said that a very stringent regulatory system would need to be put in place before such a system could be adopted in Hong Kong. SHW however pointed out that many experts had criticised the USA health care system as lacking in distinction between the public and private sectors.

27. Mr NG Leung-sing enquired about the progress made in the training of family medicine doctors, having regard to the fact that it was mentioned in the Consultation Document that the effectiveness of primary health care could be gradually enhanced by the promotion and adoption of family medicine practice.

28. SHW responded that to facilitate the development of family medicine, HA would, in 2001/02, pilot the practice of family medicine in five general out-patient clinics to be transferred from DH and increase the number of family medicine trainees in HA from 210 to 316. In the longer term, it was the Administration's intention that about half of the doctors recruited to the public sector would be trained in family medicine and primary care. SHW further said that HA would also explore ways to improve collaboration with the private sector in the development of family medicine practice. The possibility of contracting out some of HA's services to private sector should not be excluded.

29. Referring to paragraph 136 of the Consultation Document which stated that the public sector should explore ways to improve collaboration with the private sector, Mr NG further enquired about the measures which would be taken by the Administration in this regard. SHW responded that apart from encouraging the private sector to develop new products which could lure better-off patients to use its services, the adoption of common clinical protocols and the development of an electronic Health Information Infrastructure linking up all relevant providers in the community should also help to ameliorate the compartmentalised health care system in Hong Kong.

30. Ms Cyd HO expressed objection to the implementation of a Health Protection Accounts scheme, as it would not only be unable to help the needy, it could not be effective in making better-off patients use services in the private sector because of the huge price differences between the public and private sectors. Ms HO further said that, unlike taxes whereby people with higher income had to

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pay more, the proposed scheme was unfair to low-income people as every individual had to contribute 1 to 2% of his/her earnings across the board under the scheme.

31. SHW responded that there was no question that a Health Protection Accounts scheme would be unfair to low-income people, having regard to the fact that public health care services would continue to be heavily-subsidised by public revenue through taxation. SHW further said that the Administration's initial thinking was that it would follow the system of the MPF Scheme whereby people earning less than $4,000 a month would be exempted from making contributions to the Health Protection Accounts scheme. Consideration would also be given, as suggested by some respondents, to the Government contributing on a dollar-to-dollar basis to the accounts of those earning less than $4,000 a month.

32. Miss CHAN Yuen-han echoed members' views expressed in opposition to the implementation of a Health Protection Accounts scheme. Miss CHAN further said that the proposed scheme would not help to reduce the present uneven distribution of workload between the public and private sectors, and would have the effect of worsening the present uneven distribution of workload between the two sectors. In her view, a better way was to restructure the existing public health care system so as to contain the growth of public health care expenditure.

33. SHW reiterated that discussion was being held with the private sector on ways to reduce the community's reliance on the public sector. He further said that the Administration had no intention to monopolise the provision of health care services, and the implementation of a Health Protection Accounts scheme was intended to be a source of supplementary funding to the heath care system.

34. There being no other business, the meeting ended at 10:45 a.m.

Legislative Council Secretariat
6 April 2001

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Appendix

Health and Welfare Bureau

Financial Projection on public health care expenditure

Factors driving cost increase	Annual % growth of public health care expenditure		
	Harvard Model		Government's assessment
		Sub-total	
Population growth	1.3%	2.1%	2.2%
Aging –related utilization rate	0.8%		
Non-aging related utilisation rate	1.9%	4.5%	1.%
Residual factors: ➢ Technological advances ➢ Number of diagnostic procedures per visit etc	2.6%		

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Health and Welfare Bureau

Cost-control measures

Supply-side measures

- Develop community-based services to balance demand on hospital services
- Rationalisation of service delivery network to minimize duplication
- Improvement of productivity through service re-design
- Structured health technology management to ensure cost-effectiveness

Demand-side measures

- Appropriate utilization of public services through pricing

Both supply-side and demand-side measures

- Strengthen primary care to balance the demand on specialist care services
- Development of clinical protocols to guide appropriate application of services and investigations