立法會
Legislative Council

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Panel on Health Services

Minutes of special meeting
held on Wednesday, 19 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 Mrs Selina CHOW LIANG Shuk-yee, GBS, JP Hon CHAN Yuen-han, SBS, JP Hon Mrs Sophie LEUNG LAU Yau-fun, GBS, JP Dr Hon YEUNG Sum, JP Hon Andrew CHENG Kar-foo Hon Audrey EU Yuet-mee, SC, JP Hon Vincent FANG Kang, JP Dr Hon KWOK Ka-ki Dr Hon Fernando CHEUNG Chiu-hung
Members attending	:	Hon LEE Cheuk-yan Hon WONG Kwok-hing, MH
Members absent	:	Hon LI Kwok-ying, MH, JP (Chairman) Hon Fred LI Wah-ming, JP Hon LEUNG Kwok-hung
Public Officers attending	:	Item I Ms Sandra LEE, JP Permanent Secretary for Food and Health (Health) Mrs Ingrid YEUNG Deputy Secretary for Food and Health (Health)2

Mr Thomas CHAN
Deputy Secretary for Food and Health (Health) Projects

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

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I. Further discussion on the Healthcare Reform Consultation Document

Dr KWOK Ka-ki queried whether the Administration had abandoned its public revenue principle of "the rich pays more and the poor pays less" by reducing the tax burden of the wealthy through the lowering of the corporate profits tax rate and the standard rate of salaries tax, the waiving of the hotel accommodation tax and the exemption of duties on wine, beer and all other alcoholic beverages (except spirits) in the 2008-2009 Budget and asking the working population to contribute a certain percentage of their income to fund healthcare expenditure.

2. Deputy Secretary for Food and Health (Health)2 (DSFH(H)2) responded that there was no question of the Administration shifting the burden of public healthcare expenditure to the middle-class. The Chief Executive had pledged in his 2007-2008 Policy Address to increase government's recurrent expenditure on medical and health services from the present 15% to 17% by 2011-2012. The Financial Secretary (FS) had also pledged in the 2008-2009 Budget to draw $50 billion from the fiscal reserve to assist the implementation of healthcare reform. DSFH(H)2 pointed out that to meet the increasing public health expenditure by government funding, total public expenditure would have to be expanded to 22% of Gross Domestic Product (GDP) by 2033. To fund such a required increase in public expenditure could mean substantial increase in salaries tax and/or profits tax. This would depart from the principle of small government and low-tax regime, and erode Hong Kong's economic competitiveness.

3. Mr Andrew CHENG suggested integrating the Personal Healthcare Reserve (PHR) Scheme with the Mandatory Provident Fund (MPF) Scheme, so that participants could use their accrued savings from the two schemes to fund their

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healthcare needs through the mandatory regulated medical insurance before and after the age of 65.

4. Permanent Secretary for Food and Health (Health) (PSFH(H)) responded that to implement the suggestion made by Mr CHENG in paragraph 3 above would require legislative amendments, as participants of MPF scheme were presently not allowed to withdraw their accrued benefits until they reached the age of 65. Apart from this, actuarial study on the suggestion would need to be conducted to find out its implications in providing protection to participants during their working life and after their retirement.

5. Ms Audrey EU said that the resultant accrued positive deposit in the PHR account at 65 of an individual who started contributing 5% of his/her monthly income to the PHR at age 25, depicted in paragraph 13.5(c) of the Healthcare Reform Consultation Document (the Consultation Document), were unrealistic, as the calculation did not take into account the expected increase in the premium over time due to aging population and medical inflation as well as the fact that the individual might need to undergo one to two minor surgeries from age 25 to 64. Ms EU pointed out that should the rate of premium progression outpace the rate of salary progression and/or the rate of real investment return on the accrued savings of an individual, there would be no deposit left in his/her PHR account to continue to purchase the regulated medical insurance.

6. PSFH(H) explained that the figures depicted in paragraph 13.5(c) of the Consultation Document, which were based on the features set out in paragraph 13.2(c) of the same, were for illustrative purposes only. On the basis of the views received during the first-stage consultation on the PHR scheme, detailed proposals for the scheme would be developed for second-stage consultation. PSFH(H) further said that if a participant in the PHR scheme did not have the means to continue to purchase the regulated medical insurance, the public healthcare system would continue to serve as a safety net for them. Although the intention of the PHR scheme was to accrue the deposit in the PRH account, after premium deduction, to meet one's own future healthcare needs and pay for healthcare expenses after retirement, the Administration was open-minded on allowing a participant in the PHR scheme who had exhausted the benefit limits of his/her insurance due to catastrophic or complex illnesses requiring costly treatment to use the reserve in his/her PRH account to pay for the medical bills arising from such illnesses before retirement.

7. Deputy Secretary for Food and Health (Health) Projects (DSFH(H)Projects) supplemented that the viability of the PHR scheme to serve as a healthcare protection scheme for its participants both before and after their retirement would depend on the design of the scheme in terms of the size of PHR population, rate of deposit to PHR and coverage of regulated insurance. The illustrative figures as

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set out in the consultation document have already factored in future premium progression due to age profile and medical costs.

8. Responding to Ms Audrey EU's enquiry on the coverage of the regulated medical insurance, DSFH(H)Projects said that the initial thinking was to cover all in-patient services and specialist out-patient services that provided benefits at around 80th percentile of current private hospital charges at the general ward level. General out-patient services were not recommended to be covered under the regulated medical insurance. This was because the risk of requiring such services was rather evenly spread among the vast majority of the population, and thus there was little risk-sharing effect in subscribing an insurance to cover such services. Moreover, such services were relatively more affordable to the public and for which voluntary top-up insurance could be purchased as necessary.

9. Miss CHAN Yuen-han said that the service reforms set out in 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, should not tie in with that of supplementary healthcare financing. Dr KWOK Ka-ki expressed a similar view, saying that the Administration should immediately release the $50 billion pledged by FS to assist in the implementation of the service reform proposals. Miss CHAN Yuen-han further said that the Administration should improve the cost-effectiveness of the Hospital Authority (HA) before asking the public for more money to finance public healthcare expenditure.

10. PSFH(H) responded that actions had been taken to take forward the various service reforms. For instance, a Steering Committee on Electronic Health Record Sharing had been established to study issues relating to the development of the infrastructure of the electronic health record sharing system, such as its institutional set-up, the legal implications and privacy concerns, and the technical standards. The Administration had also embarked on various pilot projects to take forward the reform proposals of enhancing primary care and promoting public-private partnership in healthcare, such as the pilot schemes on the provision of elderly health care vouchers, purchasing primary care services from the private sector in Tin Shui Wai North, and the provision of subsidies to patients to undertake cataract surgeries in the private sector.

11. PSFH(H) further said that HA had been adopting a number of measures over the years to balance its budget and enhance efficiency. The public healthcare system had over the years sustained efficiency gain of around 1% per year on average. 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 inclusive of the operation and maintenance of the electronic patient record system. While the Administration would continue to enhance the

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efficiency and cost-effectiveness of the public healthcare services, it was necessary to introduce supplementary financing to provide a stable and sustainable funding source to sustain improvements in healthcare services and to enhance the health of the community in the long term.

12. Mr LEE Cheuk-yan, Mr WONG Kwok-hing and Miss CHAN Yuen-han considered it unfair to place the burden of providing supplementary healthcare financing on the working population. They asked why no mention was made in the Consultation Paper on the role of the Government and employers in making contributions to supplementary healthcare financing.

13. PSFH(H) stressed that the Administration was open-minded on the financing options and no specific group was targeted. 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 various supplementary healthcare financing options. After considering the views obtained in the first stage of the consultation, the Administration would formulate detailed reform proposals, including those of supplementary financing arrangements, and further seek the views of the public. PSFH(H) further said that in the process of developing the future healthcare system, the Government's commitment to public healthcare would only be increased and not reduced. The Government would continue to be the major pillar for supporting healthcare finances and would uphold its long-established policy that no one should be denied adequate healthcare through a lack of means.

14. Mr LEE Cheuk-yan asked whether family members of participants in the PHR scheme would be offered any protection. Mr Vincent FANG raised a similar question.

15. PSFH(H) responded that while the PHR scheme was intended to apply to a specified group of the population (e.g. those whose income was above a certain level), the scheme would allow these participants the option to extend voluntarily the protection offered by the scheme to their family members. PSFH(H) further stressed that public healthcare services would remain as an essential safety net for the whole population, and those who had not joined the PHR scheme could continue to access subsidised public healthcare services.

16. Dr Fernando CHEUNG said that most of the six supplementary healthcare financing options set out in the Consultation Document in effect amounted to a hypothecated healthcare tax on the working population. He further said that the middle class would be the biggest loser if supplementary healthcare financing was introduced.

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17. PSFH(H) responded that of the six supplementary healthcare financing options, only the social health insurance option was in the nature of a hypothecated tax with all contributions being paid into a social health insurance fund to finance the whole population in using public and private healthcare services covered by the social health insurance. The out-of-pocket payments option (i.e. increasing the user fees for using public healthcare services) was essentially a user-pays model. The options of medical savings accounts, voluntary/mandatory private health insurance, and PHR scheme were individual contributory models rather than tax-like models. Under these options, all contributions would be paid into the personal account of the participant for his own use.

18. Dr Fernando CHEUNG noted from the Consultation Document that Hong Kong's overall public health expenditure was projected to increase from about $38 billion in 2004 to about $187 billion in 2033, and enquired how much of such projected increase was attributed to an ageing population. PSFH(H) agreed to provide the information requested by Dr CHEUNG in writing after the meeting.

[*Post-meeting note:* The Administration's response was issued vide LC Paper No. CB(2)2137/07-08(01) on 11 June 2008.]

19. Miss CHAN Yuen-han said that before asking the public for more money to finance public healthcare expenditure, the Administration should increase its expenditure on healthcare, which currently accounted for only some 14.3% of recurrent government expenditure.

20. PSFH(H) reiterated that the Government's commitment to public healthcare would only be increased and not reduced, as evidenced by CE's pledge to increase government expenditure on healthcare services from 15% to 17% of recurrent government budget by 2011-2012. PSFH(H) further said that currently public healthcare expenditure accounted for some 2.8% of Hong Kong's GDP. Although the figure might appear on the low side when compared with other developed economies, it should be pointed out that countries where public healthcare expenditure took up a higher percentage of GDP than Hong Kong had in place a higher tax regime.

21. Dr YEUNG Sum was of the view that healthcare reforms, including those on supplementary financing arrangements, should be underpinned by the following principles: (a) protecting middle-income families struck by catastrophic illnesses; (b) providing the low-income and underprivileged groups with more choice of quality healthcare services; (c) there should be an element of risk-pooling, and (d) both employers and employees should contribute. Dr YEUNG considered that, in terms of supplementary financing arrangements, the above principles could best be realized through the implementation of a social

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health insurance model, under which low-income earners should be exempted from making contributions and the exempted contributions should be shouldered by the Government. Dr YEUNG further opined that apart from injecting $50 billion from the fiscal reserve, the Administration should also appropriate a specified percentage of the investment income from the Exchange Fund each year for healthcare financing.

22. PSFH(H) responded that the Administration shared Dr YEUNG's views on the need to improve public healthcare services for the low-income and underprivileged groups and provide better protection to middle-income families struck by catastrophic illnesses. If the Administration could successfully reform the existing market structure and financing arrangements to effectively reduce the heavy pressure on the public healthcare system, the freed-up resources could be used to improve the existing services in the public healthcare system, e.g. to reduce the waiting time of specialist services and improve the coverage of standard public services, which would benefit the low-income and underprivileged groups. The freed-up resources would also provide room for considering improvements to the current safety net, for instance, by catering more to the needs of families with patients struck by complex illnesses requiring costly treatments. In this connection, the Administration might explore the idea of introducing a personal limit on medical expenses as part of the safety net mechanism to protect these families against financial ruin. PSFH(H) further said that while public discussions had focused on supplementary financing arrangements, the Administration also attached great importance to reforming the existing healthcare system to make it more responsive to the increasing needs of the community, especially enhancing primary and preventive care to improve the health of the population.

23. Mr Vincent FANG said that he supported the Consultation Document in principle as he agreed that there was a need to tackle the challenges to the public healthcare system brought about by ageing population and rising medical costs to ensure adequate protection of the health of the community in the long term. However, he pointed out that there was a lack of details on the financing options to facilitate more in-depth discussion. Should an option involving mandatory private health insurance be adopted, Mr FANG asked whether the Administration would consider administering such a scheme itself rather than setting up a regulatory framework to regulate private insurers, and what measures would be taken by the Administration to prevent providers over-supplying and patients over-using healthcare services.

24. PSFH(H) assured members that, should the insurance options be adopted, the Administration would put in place stringent regulatory measures to regulate medical insurance offered by insurance companies for the protection of consumers. In Switzerland, insurance companies were not allowed to make profits from their

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compulsory health insurance activities. However, they were allowed to recoup the administrative fees entailed, the level of which was subject to regulation. They were also at liberty to offer their members a variety of other insurance products, like supplementary health insurance, life and accident insurance products that were profit-making. PSFH(H) further said that the Administration was aware that mandatory private health insurance might be subject to abuse. Should such an option be adopted, the Administration, in designing the scheme, would build in a mechanism to discourage injudicious use of healthcare services, for instance, by requiring co-payments or deductibles to be paid, especially for services that are prone to inappropriate use or abuse.

25. Mrs Selina CHOW said that there were various reasons why the middle class was wary of the introduction of mandatory private health insurance. Many of them had already taken out private health insurance themselves and were concerned whether they might migrate their existing insurance scheme to the mandatory health insurance scheme. They were also concerned about rising premium over time as well as high administrative fees charged by private insurers. Measures should be taken to allay these concerns of the middle class. Mrs CHOW further urged the Administration to expeditiously provide tax deduction to health insurance premium to encourage the public to take out private insurance. Dr KWOK Ka-ki expressed a similar view.

26. PSFH(H) responded that 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 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. It was envisaged that the supplementary financing arrangements could bring the middle-income group more value-for-money healthcare services, more quality choices and more comprehensive healthcare protection. The Administration would have in place a stringent mechanism for regulating private insurance schemes in areas such as administrative fees. As regards premium, it was expected to increase over the years due to the increasing age profile of the participants in the insurance and rising medical costs. The Administration had made a projection on increase in premium under certain scenarios, details of which were available on the website on Healthcare Reform Consultation (http://www.beStrong.gov.hk).

27. Referring to table D.2 in Appendix D to the Consultation Document setting out a comparison of source of financing of healthcare expenditure in Hong Kong and selected countries, Dr Fernando CHEUNG said that in Hong Kong the public healthcare sector currently accounted for around 54.8% of total healthcare expenditure, which was lower than of many advanced economies such as Australia, Canada, Finland and the United Kingdom. Dr CHEUNG said that the figures in

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the table did not point to serious imbalance of public-private healthcare services as stated by the Administration.

28. PSFH(H) explained that the imbalance in public-private healthcare services lay mainly in hospital services. While private sector providers were the major suppliers of primary care services, they had limited hospital capacity, with 90% of the hospital beds being in public hospitals. The public health care sector currently accounted for over 90% of total secondary and tertiary in-patient care (in terms of bed-days), for which the Government subsidised around 95% of the costs. This had imposed enormous pressure on public hospital facilities and had led to long waiting times for patients and increased workload for staff. If nothing was done to address the public's over-reliance on public hospital services, there was a real risk that the level and quality of services in public hospitals would decline.

29. Dr KWOK Ka-ki and Mr LEE Cheuk-yan were concerned that should mandatory private health insurance be implemented, employers who had been providing their employees with private health insurance would stop doing so, and the burden of paying the insurance premium would be shifted to the employees. Mr LEE also expressed concern that mandatory private health insurance would lead to expansion of private services in public hospitals, compromising the resources for and quality of general class public services in the public hospitals.

30. PSFH(H) assured members that the provision of private services in public hospitals would not result in less resources being available for general class public services. She further said that should participants of mandatory private health insurance choose to use private services in public hospitals which were currently charged on a full cost-recovery basis, the insurance would be charged with the full cost of such services, in the same way as the insurance would be charged for private sector services used by the insured. PSFH(H) further reiterated that the public healthcare sector would remain as the safety net for the whole population, targeting its services in the following areas: acute and emergency care; services for low income and under-privileged groups; illnesses that entailed high cost, advanced technology and multi-disciplinary professional team work; and training of health care professionals.

II. Any other business

31. There being no other business, the meeting ended at 12:45 pm.

Council Business Division 2
Legislative Council Secretariat
18 September 2008