立法會
Legislative Council

LC Paper No. CB(2)2648/11-12
Ref : CB2/PL/HS (These minutes have been seen by the Administration)

Panel on Health Services

Minutes of special meeting
held on Wednesday, 6 October 2010, at 11:00 am
in the Chamber of the Legislative Council Building

Members present	:	Dr Hon Joseph LEE Kok-long, SBS, JP (Chairman) Dr Hon LEUNG Ka-lau (Deputy Chairman) Hon Albert HO Chun-yan Hon Fred LI Wah-ming, SBS, JP Hon CHEUNG Man-kwong Hon Andrew CHENG Kar-foo Hon Audrey EU Yuet-mee, SC, JP Hon Cyd HO Sau-lan Hon CHAN Hak-kan Hon CHAN Kin-por, JP Hon CHEUNG Kwok-che Hon Alan LEUNG Kah-kit, SC Hon Albert CHAN Wai-yip
Members attending	:	Ir Dr Hon Raymond HO Chung-tai, SBS, S.B.St.J., JP Hon LEE Cheuk-yan Hon TAM Yiu-chung, GBS, JP Hon LI Fung-ying, SBS, JP Hon WONG Kwok-hing, MH Hon LEE Wing-tat
Members absent	:	Hon IP Kwok-him, GBS, JP Dr Hon PAN Pey-chyou

Public Officers attending	:	Item I Dr York CHOW Yat-ngok, GBS, JP Secretary for Food and Health Ms Sandra LEE, JP Permanent Secretary for Food and Health (Health) Prof Gabriel M LEUNG, JP Under Secretary for Food and Health Mr Thomas CHAN, JP Deputy Secretary for Food and Health (Health) 2
Clerk in attendance	:	Miss Mary SO Chief Council Secretary (2) 5
Staff in attendance	:	Ms Maisie LAM Senior Council Secretary (2) 6 Ms Sandy HAU Legislative Assistant (2) 5

Action

I. Healthcare Reform Second Stage Public Consultation
(LC Paper No. CB(2)2362/09-10(01))

At the invitation of the Chairman, Secretary for Food and Health ("SFH") introduced the Healthcare Reform Second Stage Consultation Document tabled at the meeting. Deputy Secretary for Food and Health (Health) 2 ("DSFH(H)2") then conducted a powerpoint presentation on the features of the proposed voluntary Health Protection Scheme ("HPS") as set out in the powerpoint materials (LC Paper No. CB(2)2362/09-10(01)) tabled at the meeting.

Role of private health insurance in healthcare financing

2. Citing Australia as an example, Mr CHEUNG Man-kwong pointed out that for the some 30 overseas countries where private health insurance ("PHI") played a prominent role as a means of reducing demand on public hospitals and thereby diminishing cost pressures on the public healthcare system, the ratio of total health expenditure to gross domestic product was higher than those countries with small PHI markets. In addition, PHI had

Action

resulted in medical inflation and rising premium as a result of higher medical charges and increased utilization, hence forcing the insured to fall back to the public system. This apart, the policy had caused brain drain from the public to private hospitals and pointed to the need for the public healthcare sector to improve its remuneration package to retain staff. In the light of the overseas experience, public subsidies to the proposed HPS might only benefit the participating insurers and healthcare professionals, rather than relieving pressure on the public system and enhancing long-term sustainability of the healthcare system.

3. Mr Andrew CHENG asked how the Administration could ensure that it could address the various problems encountered by the overseas countries in implementing PHI to ensure successful implementation of the proposed HPS. Dr Raymond HO enquired about the lessons that could be learnt from the overseas experiences in implementing PHI.

4. SFH advised that while the Administration had, among others, taken into consideration relevant overseas experience on PHI when formulating the proposals for HPS, it should be noted that the healthcare systems in different countries and the roles of PHI therein were unique. In view of the uniqueness underlying the policy towards PHI in different economies, it was impossible to transplant a system that worked in one place to another place and expected it to work just as effectively. However, their experiences had suggested that there was a need to include in the incentivized PHI scheme measures to combat moral hazard behaviours of the insured and private healthcare providers, as well as a stronger regulatory involvement on the part of the Government to ensure price transparency and safeguard consumer interests.

5. SFH further explained that at present, while slightly more than one third of Hong Kong's population was covered by PHI, over one third of the hospital admissions of these people still pertained to the public sector for various reasons. There was a significant public-private imbalance with around 40% of doctors serving in the public sector taking care of over 90% inpatient services in terms of bed-days. To ensure the long-term sustainability of the healthcare system, the proposed HPS was designed to improve market transparency, offer better protection, value-for-money services to consumers, as well as an alternative to those who were willing and might afford to pay for private healthcare services. SFH assured that the Administration would continue to uphold the public healthcare system as the safety net for the whole population. By enabling more people to have access to private healthcare, HPS would relieve the pressure on the public healthcare system so that it could better focus its resources on target service areas and population groups, especially low-income families, under-privileged groups and other needy patients.

Action

6. Mr LEE Cheuk-yan sought clarification on whether the public healthcare system would focus, among others, mainly on illness that entailed high cost, required advanced technology and multi-disciplinary professional team work, in addition to serving as an essential safety net for the population as a whole. SFH replied in the positive, adding that given an ageing population, the public system could not be made sustainable over the long-run without strengthening the role of the private sector in meeting the healthcare needs of the population alongside the public system.

7. Mr CHAN Hak-kan asked whether chronic disease patients, who were one of the major population groups of the current public healthcare system, could benefit from the implementation of HPS.

8. SFH advised that by making PHI and private healthcare services an affordable and value-for-money choice, HPS would enable individuals who were willing and able to pay for private healthcare services to choose private services as an alternative to public services. With more people choosing private services through HPS, HPS could help ease the pressure on the public system, thereby shortening the waiting time of those in need, including chronic disease patients, for public healthcare services.

9. Ms Cyd HO remained concern that the implementation of HPS would cause medical charges, drug prices and remuneration for medical personnel to spiral upwards, driving up medical inflation. This apart, the rise in medical costs and claims might also lead to premium escalation to a level beyond the means of the general public for using private healthcare.

10. Mr LEE Cheuk-yan expressed a similar view, adding that voluntary PHI would cause brain-drain from the public sector, affect the quality of public healthcare services and drive overall healthcare costs up. In particular, he was concerned about its risk in leading to overuse of healthcare or abuse due to moral hazards.

11. SFH advised that at present, the setting of the medical charges and drug prices and their adjustment were left entirely to market forces. There had been significant increase in medical charges and drug prices of the private healthcare sector in recent years due to better economic conditions and rising demand for private services. With the implementation of HPS, it was expected that the consumer protection, price transparency, quality assurance and market competition in both PHI and the private healthcare market could be enhanced. SFH further advised that the core benefit coverage of the Standard Health Insurance Plans ("Standard Plans") under the proposed HPS would focus on basic and unanticipated medical needs requiring essential but costly treatment, i.e. inpatient treatments and ambulatory procedures. Primary care was not included as a core requirement under the Standard Plans because the utilization of primary

Action

care was highly elective and more prone to moral hazards. For similar reasons, it was proposed not to include specialist services and diagnostic imaging in general that were not required for hospital admissions or ambulatory procedures in the Standard Plans.

12. Mr Fred LI sought information on the estimation of the Administration on how far the waiting queues for public healthcare services could be relieved with the implementation of HPS.

13. SFH responded that while the implementation of HPS could help divert to the private healthcare sector some of the healthcare needs, in particular those from individuals who had already subscribed to PHI, that would otherwise have to be met by the public healthcare system, it would be difficult to estimate at this stage the increase in demand for private healthcare services as an alternative to public services. It was however worthy to note that past statistics showed that demand for private healthcare services would fluctuate according to economic conditions. Hence, the existing imbalance between the public and private healthcare system could not be adequately addressed without making PHI and private healthcare services a more attractive option.

14. Mr Fred LI expressed dissatisfaction with the Administration's response. He urged the Administration to set out clear indicators for measuring the effectiveness of HPS in easing the pressure on the public healthcare system.

15. SFH advised that it was hoped that the implementation of HPS could gradually change the imbalanced situation between the public and private healthcare sectors in the provision of inpatient services. The ratio was presently 90:10. With the introduction of the HPS and barring unforeseen circumstances, it should help induce a gradual improvement of the ratio (say, to 80:20) in the long-term. Dr Raymond HO cast doubt on whether the public-private imbalance could be adequately addressed even the ratio of the provision of inpatient services between the public and private healthcare sectors would be adjusted to the said level when the ratio of doctor distribution between the public and private sectors remained at about 40:60.

16. Mr Andrew CHENG pointed out that an over-reliance on voluntary PHI could lead to a sharp increase in healthcare costs as in the case of the United States. Noting that the supplementary financing option of medical savings accounts (mandatory savings for future use) had also received relatively high support among other options during the first stage public consultation in 2008, he sought explanation for the decision to introduce a voluntary rather than a mandatory financing option.

Action

17. SFH responded that according to the first stage public consultation, 58% of the respondents supported medical savings accounts while 71% supported voluntary PHI. Based on the outcome of the consultation, the Government developed the proposed HPS along the principle of voluntary participation.

18. Mr Albert HO noted with concern that while the proposed HPS would require the making use of the $50 billion fiscal reserve to provide incentives to encourage the participation of the public, it was uncertain whether its implementation could ease the pressure of the public system significantly. The proposed HPS had therefore failed to achieve the original objective of the healthcare financing reform which was to channel the available resources into the healthcare system in order to meet the challenges to future public finances due to an ageing population and increasing service demand.

19. SFH advised that cost containment, as well as the demand for and supply of healthcare services, were the key issues needed to be addressed in order to resolve the healthcare financing problem. While HPS alone could not be a complete solution on its own in solving the challenges to the long-term sustainability of the healthcare system, it would serve as a positive step in rationalizing the long-term resource allocation within the healthcare system by addressing a number of shortcomings of the current PHI and private healthcare service markets. SFH stressed that at present, Hong Kong's per capita total health expenditure as a percentage of per capita gross domestic product remained low at the level of around 5% when compared with other developed countries. However, if the current PHI and private healthcare service markets were left as they were, it would result eventually in the population's healthcare burden falling back on the public sector, leading to a significant increase in the public health expenditure.

20. Mr Albert HO considered that the Administration could address the shortcomings of the existing PHI and private healthcare markets with or without the implementation of HPS by stepping up regulation and supervision of these markets. Ms Audrey EU held a similar view.

Provision of health insurance plans under HPS

21. Mr Albert CHAN asked whether consideration could be given to setting up a public entity to offer health insurance plans under HPS to ensure that public subsidies to HPS would not turn out to be benefiting the participating insurers and private healthcare service providers.

22. SFH responded that the proposed HPS was designed to be modular. While participating insurers were all required to offer standardized health insurance plans in accordance with the core requirements and specifications,

Action

they were free to design appropriate health insurance plans of their own offering top-up benefits or integrating additional components beyond the core requirements and specifications to suit consumers' needs. While the Administration would formulate the core requirements and specifications for the Standard Plans and supervise their operation, it was considered that market forces would be the best tool to ensure the development of a broad range of competing top-up health insurance plans under HPS to suit different needs of consumers.

23. Mr CHAN Kin-por pointed out that at present, the underwriting profit margin for PHI plans, which stood at around 3% to 5% in recent years, was already vey low. Given the stringent core requirements and specifications for the HPS Plans, he enquired how the Administration could convince the insurance industry that the HPS requirements were workable and it was viable to participate in HPS. The Administration might eventually need to set up a public entity to offer health insurance plans under the HPS framework should most insurers not be interested in offering such plans, which in his view, would be less efficient and cost-effective.

24. SFH advised that the Administration had been working closely with the insurance industry when designing and assessing the feasibility of the proposed features of HPS. The current proposal had already taken the interest of the industry into account. It was hoped that the insurance industry would take into consideration the importance of HPS as a positive step in enhancing the sustainable development of the healthcare system as a whole when deciding whether to participate in HPS.

Proposed HPS features

25. Mr WONG Kwok-hing enquired whether HPS subscribers would lose the protection under HPS if they switched jobs or became unemployed and thereby were unable to continue to afford the premium. Dr Raymond HO and Ms LI Fung-ying were also concerned about whether short-term breaks in subscription would be allowed if the insured were temporarily unemployed.

26. SFH responded that under the current proposal, insurers participating HPS had to provide full portability of Standard Plans between insurers. Employees could continue subscription of the plans originally provided by their employers after switching jobs or on retirement, carrying over their coverage for pre-existing medical conditions and any no-claim discounts ("NCD"). As regards the cases where the insured became unable to pay the premium due to temporary unemployment, the public healthcare system would continue to serve as the safety net for these people. It was hoped that they could continue to afford the protection when they rejoined the

Action

workforce and due regard would be given to the amount of premium they had already paid.

27. Noting that consideration was being made to building in a savings component in the health insurance plans under HPS ("HPS Plans") where the savings would be used for paying future premiums, Mr WONG Kwok-hing suggested that the proposed savings component could be integrated with the Mandatory Provident Fund ("MPF") scheme to enable participants to use their accrued savings from the MPF scheme to pay the HPS premium at older age.

28. Ms Audrey EU sought clarification as to whether the insured had to contribute, apart from the premium for the HPS Plans, an additional amount to serve as savings for paying future premiums.

29. SFH advised that the Administration was open-minded on the savings arrangements. At present, three possible savings options with different degrees of freedom on the savings arrangements and use of savings were proposed, i.e. required in-policy savings; optional savings accounts under the bank or MPF accounts of the insured; and premium rebate for long stay. Subject to finalization of the HPS design for implementation, the $50 billion earmarked in the fiscal reserve to support healthcare reform could be utilized to provide, among others, government incentives to encourage savings by individuals for paying future premium at older age.

30. In response to Mr Albert CHAN's enquiry about whether drug expenses for hospital treatments would be covered under the HPS plans, SFH replied in the positive.

31. While agreeing that benchmarking based on diagnosis related groups ("DRG") with transparency in charges would be instrumental in enhancing payment certainty of private healthcare services, Mr CHAN Kin-por cast doubt on whether private hospitals would be willing to adopt packaged charging in providing healthcare services as they were running at near full capacity and would have little motivation to change their charging practices.

32. In response to Ms LI Fung-ying's enquiry about the definition of high-risk subscribers, SFH advised that the insurers had their own definitions of high-risk individuals. At present, these people often could not get health insurance or the premium could be prohibitively high.

33. Ms LI Fung-ying considered the proposed age-banded arrangement of requiring the insurers to allow people aged 65 or above to subscribe to HPS Plans within the first year of introduction, but with no cap on their premium plus loading unfair to those elders who remained healthy.

Action

34. SFH responded that statistics showed that the health risk of individuals aged 65 or above would be much higher than those aged below 65. At present, only about 4% of the population aged 65 or above was covered by PHI.

35. Dr LEUNG Ka-lau sought explanation on offering a time-limit window for joining by those aged over 65.

36. DSFH(H)2 responded that there would be excessive risks to the proposed HPS and causing premium escalation for all if individuals at older age were accepted into HPS Plans at any time. Hence, it was necessary to introduce a time limit for joining by those above the age limit in order to manage the risk profile and ensure the viability of HPS Plans. The limit would also encourage people to consider procuring health insurance coverage at an earlier stage.

37. In response to Dr LEUNG Ka-lau's enquiry about whether the healthy insured were required to share out the premium of the high-risk individuals under the HPS framework, DSFH(H)2 advised that it was proposed that a high risk pool, i.e. a Government-regulated reinsurance mechanism operated by the industry and funded by the premium of high-risk policies, would be introduced under HPS. Injection by the Government into the high-risk pool would be considered where necessary. Hence, the current proposal would allow the higher risk individuals to join HPS plans without requiring other healthy insured to pay excessive premium.

38. Referring to the proposal of offering all new joiners of HPS Plans to enjoy maximum NCD, i.e. up to 30% discount on the Standard Plan premium immediately on joining, Dr LEUNG Ka-lau asked whether the insured would still be able to enjoy the discount after making a claim and whether NCD would be offered for the top-up components provided by the insurers. He also enquired whether the discount was to be funded by government subsidies.

39. DSFH(H)2 advised that the proposal of the Administration was to require insurers to offer 10% NCD on the published premium for their Standard Plans for each year in which an insured individuals had not made any claims, up to a maximum of 30% for three consecutive years without claims. The discount would reset to 0% at next policy renewal upon making a claim. It was proposed that government incentives would be provided in this regard. That said, insurers might offer deeper NCD for Standard Plans than the required level. They were also at liberty to decide whether and how to offer NCD for top-up components and charge higher premium, provided that the premium of the Standard Plans with top-up

Action

components would not be lower than the corresponding published premium for the Standard Plans.

Subscription

40. Noting that a sizeable take-up rate had to be achieved for HPS to be sustained in the long run, Mr Fred LI enquired about the type and the number of subscribers in order to make HPS financially viable. Ms Audrey EU raised a similar question.

41. SFH advised that a significant number of subscribers, in the range of at least a few hundred thousand, were required to make HPS sustainable. It was hoped that some of the one-third Hong Kong people who had subscribed to PHI would choose to migrate to the HPS Plans. Mr CHAN Kin-por pointed out that the viability of the proposed HPS would be greatly enhanced if it could attract a million of subscribers.

42. Ms LI Fung-ying was of the view that efforts should first be made to incentivize the some 66% of population who was currently not covered by PHI to subscribe to HPS, rather than attracting those who had taken out health insurance policies already to migrate to the HPS Plans, so as to increase the population coverage of PHI and thereby further ease the pressure on the public healthcare system.

43. SFH stressed that the proposed HPS was aimed at, among others, providing better protection to those who were able and willing to pay for PHI and private healthcare services, with a view to enabling them to use private healthcare on a sustained basis. The public healthcare system could then better focus on its target service areas.

44. Dr LEUNG Ka-lau asked whether consideration could be given to including the some five hundred thousands civil service eligible persons, who were currently entitled to medical treatment and services that were provided by the Government or HA free of charge, under the HPS framework.

45. SFH responded that while the Civil Service Bureau was provided with the consultation document for consideration, the main target group of HPS for migration was individuals who were currently covered by PHI.

Supervisory structure

46. Mr WONG Kwok-hing asked about the measures to be put in place to prevent the participating insurers from charging high administrative fees and commission so as to ensure that premium payment would go towards claims rather than being eaten up by overheads.

Action

47. Mr Fred LI was concerned that the proposal to publish guidelines on premium adjustment under the HPS supervisory framework and give the participating insurers the flexibility to determine on their own the premium level could not effectively prevent unreasonable premium escalation under HPS. He considered that more vigilant measures would be required to guard against excessive premium escalation.

48. Dr Raymond HO also expressed concern about the affordability of health insurance premium for HPS subscribers over the long run, which was instrumental to the sustainability of HPS. Mr LEE Cheuk-yan raised a similar concern.

49. SFH advised that a new dedicated agency would be established to supervise the implementation and operation of HPS. Insurers participating in HPS would be required to provide transparent information on insurance costs including claims, administrative expenses and commission, which would be a reference for formulating premium adjustment guidelines for HPS Standard Plans.

50. Mr CHAN Hak-kan was concerned that HPS might encourage overuse of healthcare due to moral hazards. In addition, private hospitals might be tempted to only accept cases that would generate high profit. SFH responded that there was no cause for such concern, adding that under the proposal, the Administration would strengthen its role to supervise the quality and standards of PHI and private hospital services.

Use of the $50 billion earmarked fiscal reserve

51. Mr Fred LI asked whether the Administration would increase the $50 billion fiscal reserve that had been set aside for the healthcare reform in accordance with the inflation rate.

52. SFH replied in the negative, adding that the $50 billion was not aimed at accumulating and providing funds but kick starting the healthcare reform after the supplementary healthcare financing arrangements were finalized for implementation. The Administration would consider making use of the $50 billion to provide incentives to encourage the public to participate in HPS on a sustained basis by injecting into the high risk pool, offering premium discount for new subscribers and encouraging savings for future premium.

53. Noting that the $50 billion fiscal reserve would be used up in some 20 years, Dr Raymond HO was of the view that the Administration should provide further funding to support the operation of HPS as and when necessary.

Action

54. SFH responded that if HPS was successful in achieving its objectives, he saw no reason why the future terms of Government would not provide additional resources to continue its operation.

55. Holding the view that the chance for the insured to fall back to the highly-subsidized public services was high, Mr Andrew CHENG considered that the Administration should make use of the $50 billion fiscal reserve to improve the public healthcare system.

56. Pointing out that the repeated calls for improving the public healthcare system and extending the coverage of the Drug Formulary of the Hospital Authority ("the Formulary") had remained unaddressed, Mr Albert HO said that he could not see the justifications to make use of the public money to encourage savings for future premium, as well as inject into the high-risk pool with a view to compensating the participating insurers for the increased risk the high-risk individuals brought to the pool. He suggested that consideration could be given to offering a tax deduction for HPS premium, instead of making use of the $50 billion earmarked from fiscal reserve to provide financial incentives under HPS.

57. Pointing out that individuals who paid public healthcare through tax and at the same time paid for their own private healthcare through health insurance were in effect subject to double taxation, Dr LEUNG Ka-lau enquired whether consideration could be given to offering tax reduction for individuals who had already taken out PHI.

58. SFH advised that additional resources had been allocated to HA to improve its services. The drug list in the Formulary would also be regularly reviewed under an established mechanism having regard to the principles of efficacy, safety and cost-effectiveness. SFH further explained that current health insurance products in the market tended to favour healthy subscribers over risky individuals. The proposal of making use of the $50 billion to inject into the high-risk pool would enable the high-risk individuals to enjoy equal opportunities to access health insurance and private healthcare services if they so wished.

59. As regards the suggestion to offer a tax deduction for health insurance premium in general or HPS in particular, SFH advised that the design of the proposed HPS would ensure that its subscribers would still be able to afford health insurance at an older age when they needed it most. Tax incentives, however, did not incentivize premium payment after retirement when the insured might no longer have an income while their premium was much higher. In addition, tax incentives were by nature regressive and only relevant to a relatively small proportion of the higher-income population.

Action

60. Ms Audrey EU raised objection to the Administration's proposal to subsidize people who had already bought PHI to migrate to a HPS Plan. Mr LEE Cheuk-yan also considered it inappropriate as a matter of principle to provide public subsidies to those who could afford to subscribe to PHI and use private healthcare services, which in his view, would eventually benefit the participating insurers and private healthcare service providers. Noting that the Administration aimed to increase the health budget to 17% of its recurrent expenditure in 2012, he asked whether it was the Administration's intention to cap the health budget at 17%.

61. SFH responded that it was the commitment of the current term of Government to increase the health budget to 17% of its recurrent expenditure in 2012. It was hoped that the commitment of the next term of Government to healthcare would continue to increase.

Healthcare capacity and manpower

62. Holding the view that the implementation of HPS would cause brain drain in the public healthcare system and result in longer waiting time for public hospital services, and hence those relying on the public system would suffer, Mr CHEUNG Man-kwong urged the Administration to strengthen the supply of healthcare manpower and set a parameter in respect of the healthcare personnel-to-patient ratio.

63. SFH advised that efforts had continuously been made by HA to improve its services and strengthen its healthcare manpower. However, without taking measures to address the significant public-private imbalance in the healthcare system by making private healthcare more value-for-money and enabling more people to choose private services, an increase in healthcare manpower alone could not lead to shortening of waiting queue for the highly-subsidized public healthcare services.

64. Mr CHAN Hak-kan enquired whether the capacity, in particular the number of hospital beds, and manpower of the private healthcare sector was able to meet the increase in demand arising from HPS.

65. Holding the view that ensuring adequate supply of healthcare manpower to support the delivery of healthcare services and having in place healthy competition in the private healthcare service market would be essential to the success of HPS, Mr CHAN Kin-por enquired about the steps to be taken by the Administration to address these issues.

66. SFH said out that doctors serving in the private sector were only taking care of 10% of inpatient services presently. Several existing private hospitals had recently completed their expansion projects or had plans to expand or were expanding their hospitals. Another four reserved sites had

Action

also been planned for development of private hospitals by phases. Hence, the healthcare capacity in terms of number of beds of the private sector was expected to increase by a considerable percentage in the coming years. In terms of healthcare manpower, continuous efforts would be made to increase the number of student places for doctors, nurses and other healthcare disciplines to strengthen the healthcare workforce. For instance, there would be an increased supply of some 2 000 nurse graduates each year for the coming three years.

67. Ms Cyd HO asked whether consideration could be given to allowing the non-professional personnel to take up some simple healthcare duties so as to reduce or contain costs. SFH expressed reservations about the proposal, as the discharge of healthcare duties should not based on the cost factor.

Way forward

68. In view of the complexity of the issue, Ms Cyd HO suggested that the Panel should continue to follow up the discussion with the Administration by topics to facilitate more focused discussion. The Chairman advised that the Panel could consider the future meeting arrangement in the next legislative session.

II. Any other business

69. There being no other business, the meeting ended at 1:28 pm.

Council Business Division 2
Legislative Council Secretariat
30 July 2012