立法會
Legislative Council

LC Paper No. CB(2)728/10-11
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Panel on Health Services

Minutes of meeting
held on Monday, 13 December 2010, at 8:30 am
in Conference Room A of the Legislative Council Building

Members present	:	Dr Hon LEUNG Ka-lau (Chairman) Dr Hon Joseph LEE Kok-long, SBS, JP (Deputy Chairman) Ir Dr Hon Raymond HO Chung-tai, SBS, S.B.St.J., JP Hon Fred LI Wah-ming, SBS, JP Hon CHEUNG Man-kwong Hon Andrew CHENG Kar-foo Hon LI Fung-ying, SBS, JP 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 IP Kwok-him, GBS, JP Dr Hon PAN Pey-chyou Hon Alan LEONG Kah-kit, SC Hon Albert CHAN Wai-yip
Members attending	:	Dr Hon Priscilla LEUNG Mei-fun Hon WONG Kwok-kin, BBS
Member absent	:	Hon Albert HO Chun-yan
Public Officers attending	:	Item IV Prof Gabriel M LEUNG, JP Under Secretary for Food and Health

		Mr Thomas CHAN Chung-ching, JP Deputy Secretary for Food & Health (Health) 2
		Mr Chris SUN Principal Assistant Secretary for Food and Health (Health) 3
Clerk in attendance	:	Ms Elyssa WONG Chief Council Secretary (2)5 (Des)
Staff in attendance	:	Ms Maisie LAM Senior Council Secretary (2)6
		Ms Priscilla LAU Council Secretary (2)5
		Ms Sandy HAU Legislative Assistant (2)5

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I. Confirmation of minutes
(LC Paper No. CB(2)484/10-11)

The minutes of the meeting held on 8 November 2010 were confirmed.

II. Information paper(s) issued since the last meeting
(LC Paper Nos. CB(2)498/10-11(01) to (02))

2. Members noted the following papers issued since the last meeting -

(a) referral dated 26 November 2010 from the Complaints Division on the commencement of provisions related to proprietary Chinese medicines in the Chinese Medicine Ordinance (Cap. 549); and

(b) letter dated 6 December 2010 from Dr Hon Priscilla LEUNG on the commencement of provisions related to proprietary Chinese medicines in the Chinese Medicine Ordinance.

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III. Discussion items for the next meeting
(LC Paper Nos. CB(2)483/10-11(01) to (02))

3. Members agreed to discuss the following items proposed by the Administration at the next regular meeting scheduled for 10 January 2011 at 8:30 am -

(a) Pilot project on outreach primary dental care services for elderly in residential care homes;

(b) Primary care development strategy – Primary care campaign; and

(c) Online checking of the eligibility of non-permanent Hong Kong Identity Card holders for subsidized public healthcare services.

4. Members noted that the subjects of "Oral chemotherapeutic drugs for cancer patients in public hospitals" and "Iron chelating therapy for Thalassaemia patients in public hospitals" would be discussed in the context of "Drug Formulary of the Hospital Authority" scheduled for discussion in February 2011.

5. Dr Priscilla LEUNG suggested that the Panel invite the trade to express views on the commencement of provisions related to proprietary Chinese medicines in the Chinese Medicine Ordinance. Members agreed to hold a special meeting on Monday, 17 January 2011, at 10:45 am for the purpose.

IV. Healthcare Reform Second Stage Public Consultation - Health Protection Scheme
(LC Paper No. CB(2)483/10-11(03))

Rationale and scheme concept of the Health Protection Scheme

6. In response to Mr Alan LEONG's enquiry about the rationale for introducing the Health Protection Scheme ("HPS"), Under Secretary for Food and Health ("USFH") replied that shortcomings of the existing health insurance market such as lack of control over future premium escalation, lack of transparency of underwriting criteria and application of premium loadings had discouraged or priced out many high-risk individuals including the elderly and persons with pre-existing medical conditions from getting health insurance protection. One of the aims of HPS was to

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eliminate the existing practice of excluding or pricing out high-risk individuals, and allow them to purchase health insurance plans subject to a reasonable premium loading.

7. Mr Albert CHAN cast doubt over the capability of the Government to effectively regulate the private health insurance ("PHI") and the private healthcare market under a voluntary system and considered the proposed HPS a form of "transfer of benefit" to large insurance companies. He urged the Administration to abandon the policy of "big market, small government" and set up a public entity to provide mandatory health insurance.

8. USFH responded that the first stage public consultation reflected that the majority of the public had reservations about mandatory financing options and preferred having their own voluntary choices of healthcare protection. He said that at present, about 10% of all in-patient services in terms of bed-days was provided by the private sector and around 2.56 million people (i.e. about one-third of the population) were covered by PHI, with a total premium of around $10 billion per annum. However, shortcomings of the current private insurance market had deprived many individuals of more choices of value-for-money healthcare services. The proposed HPS was aimed to better ensure the quality and more choices of private healthcare services apart from public healthcare. USFH further pointed out that as shown in figure B.8 of the Healthcare Reform Second Stage Consultation Document, the reported underwriting profit margin for PHI plans was relatively low and an underwriting profit margin of minus 5% was recorded in 2005. While the performance had reported a profit since 2007, the highest underwriting profit margin was merely 5%.

9. In response to the Chairman's enquiry as to whether the primary objective of the proposed HPS was to improve the existing PHI market through regulatory intervention by the Government, USFH replied that the proposed HPS was aimed to enhance consumer protection, price-transparency, quality assurance and market competition in both PHI and the private healthcare market.

Provision of health insurance

10. Mr CHEUNG Man-kwong asked whether consideration could be given to setting up a public entity to offer health insurance plans under HPS to ensure compliance with the requirements of HPS and set the benchmarks for health insurance plans under HPS.

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11. Dr PAN Pey-chyou shared the view of Mr CHEUNG Man-Kwong. He said that the Hong Kong Federation of Trade Unions also considered that the Government should run a public entity to offer health insurance plans under HPS to avoid oligopoly and promote competition, with a view to facilitating the public's access to value-for-money private insurance protection. The profit gained by the public entity could also be ploughed back into the public healthcare system for service improvement.

12. USFH advised that at this juncture, the Administration considered that its role should be restricted to improving the existing private insurance services and supervising the implementation of HPS to safeguard consumer interests. There was concern from members of the public that any involvement of the Government in the health insurance market would result in crowding out other private insurers. That said, should there be a general lack of interests from the industry in offering health insurance plans under HPS, the Government would consider setting up its own mechanism to provide the public with more choices of health insurance plans. USFH added that the Administration would not rule out the option of setting up a public entity to offer health insurance plans under HPS.

13. Noting the above response, Mr CHEUNG Man-kwong suggested that the Administration should consider the feasibility of having both the public entity and private insurers offering health insurance plans under HPS to enhance consumer protection. USFH said that a dedicated agency underpinned by legislation would be established to supervise the implementation and operation of HPS. He reiterated that the Administration would not rule out the option of setting up a public entity to offer health insurance plans if the market was not performing efficiently and effectively.

14. In response to Dr Joseph LEE's enquiry as to how the dedicated agency could promote competition in PHI, USFH replied that the legislation would provide a platform for balanced participation and a mechanism to enhance price transparency and ensure an adequate supply of services. With the provision of a proper regulatory infrastructure, HPS would provide a more sustainable platform for the development of the PHI industry that would help reinforce consumer protection and promote healthy competition.

15. Mr CHAN Kin-por remarked that given the already very low underwriting profit margin for PHI plans which currently stood within a range of 3% to 5% as well as the stringent core requirements and specifications for health insurance plans offered under HPS ("HPS Plans"), there was concern from the industry that it might not be viable to

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participate in HPS. The Administration might eventually need to set up a public entity to offer health insurance plans under HPS. Mr CHAN requested the Administration to provide in writing information on Australia's experience in encouraging voluntary PHI as a means of reducing demand on public hospitals and thereby diminishing cost pressures on the public healthcare system, as well as the findings of a study on PHI by the Organisation for Economic Cooperation and Development in 2001-2004 to facilitate members' understanding of the viability of HPS. USFH agreed.

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Benefit coverage of Standard Plans

16. Pointing out that many employer-provided PHI policies included out-patient covers subject to some form of co-payment, the Chairman asked whether consideration could be given to extending the benefit coverage of HPS to out-patient services with co-payment, instead of excluding the out-patient services from the core requirements for HPS Plans as currently proposed.

17. USFH responded as follows -

(a) HPS was designed to be modular, i.e. participating insurers were required to offer standardized health insurance plans in accordance with the core requirements and specifications ("the Standard Plans"), but they were free to design appropriate health insurance plans to offer top-up benefits or integrate additional components to suit consumers' needs; and

(b) it should be noted that the more services that were required to be covered by HPS Plans, the higher the premium. Whilst the Administration attached great importance to the enhancement of primary care which included general out-patient services and dental care, it did not propose to include primary care as a core requirement under HPS because primary care was relatively more affordable and out-patient demand was far more predictable than in-patient needs. There was concern that the inclusion of primary care under HPS might lead to premium escalation.

18. The Chairman remarked that many deputations attending the special meeting of the Panel on 11 December 2010 had called for extending the benefit coverage of HPS to out-patient services. He requested the Administration to provide in writing information on the additional premium level if out-patient service was included as a core requirement under HPS.

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19. Dr PAN Pey-chyou asked whether consideration could be given to covering also the first specialist consultation in general as well as physiotherapy that entailed high cost. He also expressed concern that the proposal to cover medical conditions requiring hospital admission or ambulatory procedures might lead to injudicious use of such services.

20. USFH advised that physiotherapy arising from medical conditions requiring hospital admission or ambulatory procedures were proposed to be covered by HPS Plans. While appreciating that some patients might find specialist consultation costly, USFH advised that the Administration was wary of the moral hazard this could create and the extra burden others would have to shoulder as the costs involved were shared out among a wider pool of people. He pointed out that insurers participating in HPS could offer top-up components to cover such services, and the public healthcare system would provide a safety net of last resort for patients in need.

Subscription

21. Ms Audrey EU pointed out that the Australian experience indicated that a sizeable take-up rate must be achieved for PHI to function well and be sustained in the long run. In the light of this, she asked the Administration how it could appeal to some five hundred thousands healthy individuals to subscribe the HPS Plans at younger age and stay on with their plans in order to make HPS financially viable.

22. USFH advised that healthy individuals should consider joining HPS at younger age for the following reasons -

(a) healthy and young individuals would most likely be able to enjoy the no-claim discount ("NCD") offered under HPS. Participating insurers would be required to offer 10% NCD on the published premium for their Standard Plans for each year in which an insured individual had not made any claims, up to a maximum of 30% for three consecutive years without claim. It was proposed that NCD should be made available at all times for those aged below 30;

(b) insurers might impose high premium loading for late entrants who joined HPS at older age due to their increasing health risk. Given that the amount of loading would be calculated on the basis of the health conditions of the insured at the time he/she joined the health insurance, the younger an individual joined HPS, the lower his/her premium loading; and

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(c) it was proposed that the Government would provide incentives, making use of the $50 billion, to encourage savings by individuals under HPS for paying future premium at older age. Possible saving options included "required in-policy savings", "optional savings accounts" and "premium rebate for long-stay", and the Government incentives would be proportional to the length of the individual continuously staying insured under HPS, up to a certain percentage of the premium for the relevant Standard Plan.

23. In response to the Chairman's concern about whether the introduction of NCD would result in subscribers avoiding to use healthcare services even when they had medical needs, USFH said that there was no cause for such concern. On the contrary, overseas experience suggested that NCD would help deter possible abuses like unnecessary admissions/procedures which would increase claims and premium for all the insured.

Service provision based on packaged charging

24. Noting that four pieces of land had been earmarked for new private hospital developments, Mr CHEUNG Man-kwong asked the Administration to consider making the requirement to provide services at packaged charging as part of the land grant conditions.

25. USFH responded that in designing the development requirements for the new private hospital developments at the four pieces of land earmarked for such (at Wong Chuk Hang, Tseung Kwan O, Tung Chung and Tai Po respectively), the Administration would take into account the need to support HPS, including, among others, the requirement to provide services at packaged charging based on the diagnosis-related groups ("DRG") structure.

26. Mr CHAN Kin-por expressed grave concern over the view of some private healthcare service providers attending the special meeting of the Panel on 11 December 2010 that their quality of service might be undermined if DRG-based packaged charging was to be introduced to contain cost. USFH said that DRG-based packaged charging would in no way undermine the quality of medical services, and stressed that it was incumbent on all healthcare professionals to act in the best interest of their patients.

27. Dr Joseph LEE enquired how the Administration could ensure an adequate supply of private healthcare services based on DRG packaged

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charging. USFH advised that DRG-based payment systems had been introduced in various overseas economies, such as Australia, Canada, New Zealand, the United Kingdom and the United States, for some 20 years. He considered that such charging scheme would work equally well in Hong Kong.

28. The Chairman remarked that the Hospital Authority ("HA") had not been successful in adopting DRG methodology although it had introduced the charging mechanism for years to cover a range of public medical services provided in public hospitals for its internal costing and resource allocation purposes.

High-risk pool reinsurance mechanism

29. Mr Alan LEONG noted that one reason for some of the deputations attending the special meeting of the Panel on 11 December 2010 to support the proposed HPS was its guaranteed acceptance of all applicants, including the high-risk groups such as the elderly and those with pre-existing medical conditions who were usually denied health insurance and considered uninsurable. Yet, he also noted from some deputations that the trade had little information on the operation of the "High Risk Pool" ("HRP") which was aimed to help insurance companies to share out risks and hence enabling them to accept subscribers with pre-existing medical conditions. He enquired how the proposed HRP could achieve the aim of enabling the high-risk groups to have access to health insurance plans under HPS while ensuring their financial viability.

30. USFH explained that HRP was a reinsurance mechanism. Under the proposed mechanism, the policies of high-risk individuals with premium exceeding three times its published premium would be transferred to HRP. The premium income, claim liabilities and profits/loss of these policies would be accrued to HRP instead of the insurance companies concerned. This would avoid premium escalation for other HPS subscribers due to more high-risk individuals joining. USFH added that the Government would also consider injecting fund into HRP if it could not be self-sustaining due to a higher than normal proportion of high-risk individuals joining HPS.

Migration of existing health insurance

31. The Chairman enquired about the arrangement to help policy holders with existing health insurance to migrate to HPS Plans.

32. USFH advised that the proposed HPS was designed to be modular. Apart from offering the Standard Plans, insurers were free to design

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appropriate top-up benefits on additional components to suit consumers' needs. Individuals and employers who chose to migrate to HPS Plans might freely choose an appropriate plan offered by insurers that suited their own needs. Based on discussions with the insurance industry, insurers participating in HPS should be in a position to facilitate seamless migration of policy-holders from their existing insurance policies to HPS Plans.

33. Deputy Secretary for Food & Health (Health) 2 supplemented that participating insurers would be required to offer both existing individual and group policy-holders upon renewal an option to switch their existing health insurance policies to an appropriate HPS Plan which must meet or exceed the requirements for Standard Plans with no less coverage and benefits. For existing group policy-holders who were mainly employers, the insurers might offer additional components to suit individual employers' needs. For existing individual policy-holders, the insured could enjoy advantages offered by HPS including NCD, portability, coverage of pre-existing medical conditions subject to waiting period, etc. after migrating to HPS Plans. The Chairman requested the Administration to provide in writing how existing group health insurance policies could migrate to HPS Plans.

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34. Mr IP Kwok-him asked about the migration arrangements for existing life insurance policies with medical riders to HPS Plans.

35. USFH advised that the protection provided by medical riders might not be comprehensive enough. If the existing policy holders of these policies, who were mainly individuals, preferred to enjoy the more comprehensive coverage and advantages offered by HPS, they could switch to HPS Plans.

Use of the $50 billion fiscal reserve earmarked to support healthcare reform

36. Holding the view that using the $50 billion to provide financial incentives under HPS might lead to higher healthcare costs and medical inflation, Mr CHEUNG Man-kwong asked whether consideration could be given to using the $50 billion to improve public healthcare services. Dr Joseph LEE shared this view and requested the Administration to use part of the $50 billion to improve public healthcare services.

37. Mr IP Kwok-him considered it important for the Administration to make it clear to the public how the injection of the $50 billion into HPS as scheme incentives could bring benefit to the public healthcare system. Mr CHAN Hak-kan urged the Administration to continue to uphold the public healthcare system as the safety net for patients with chronic illness

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and the low-income group.

38. USFH stressed that the Government would not reduce its commitment to public healthcare services, as evidenced by the increase in the annual recurrent expenditure on health from $30.5 billion in 2007-2008 to $36.9 billion in 2010-2011, an investment of over $15 billion in healthcare infrastructure and equipment and the strengthening of the safety net, as well as a target increase of the health budget from 15% in 2007-2008 to 17% of government's total recurrent expenditure by 2012. Following the first stage public consultation, the Government would continue to increase its commitment to healthcare as it took forward the various service reform proposals, including enhancing primary care and development of electronic health record sharing. USFH further said that the Administration would maintain its long-established healthcare policy that no one should be denied adequate healthcare through lack of means. The Administration would continue to uphold the public healthcare system as an equitable and accessible safety net for the population as a whole.

39. Ms Audrey EU enquired whether the offer of a tax deduction for HPS premiums, instead of making use of the $50 billion to provide fiscal incentives under HPS, could serve the same purpose of increasing take-up of HPS Plans. She expressed reservations about the suitability of using the reserves to subsidize people who had already bought PHI to migrate to an HPS Plan. She suggested that the $50 billion could be used to improve existing public healthcare services for the direct benefit of patients. Mr CHAN Hak-kan opined that the offer of a tax deduction for HPS premiums would provide incentive for the middle class to subscribe to HPS Plans.

40. USFH advised that the Administration was open-minded on the offering of tax deduction for HPS premiums. He however pointed out that the proposal was to use part of the $50 billion to inject into HRP to buffer the excess risks arising from the participation of high-risk individuals in HPS Plans. If the $50 billion was not used to provide scheme incentives such as allowing high-risk individuals to join HPS Plans without requiring other healthy insured to pay excessive premium, it might not be able to ensure viability or achieve the objectives of HPS.

41. Mr CHAN Hak-kan enquired whether the Administration would consider the proposal of the Democratic Alliance for the Betterment and Progress of Hong Kong to set aside part of the $50 billion for investment to generate investment income on a recurrent basis, as the $50 billion would be used up in some 20 years. Mr CHEUNG Kwok-che also expressed concern about the future arrangements when the $50 billion was exhausted.

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42. USFH said that this was a matter falling within the purview of the Financial Services and Treasury Bureau which had well-established policies on the use of funds and what investment strategy should be adopted.

43. As regards the sustainability of HPS, USFH advised that if HPS was successful in attracting young and healthy individuals to subscribe at the time it was rolled out and continue to stay on their plans, this would save them on premium payments in the long run, and protect them against financial losses arising from catastrophic illness. It followed that the need for financial support from the Government to ensure the sustainability of HRP and the overall scheme would be much smaller. USFH added that he could not see why the future terms of Government would not provide additional resources to continue the provision of scheme incentives to ensure the viability of HPS if it had been implemented for two decades and was successful in enhancing the long-term sustainability of the healthcare system.

44. Dr PAN Pey-chyou asked whether the $50 billion fiscal reserve would be included in the calculation of increasing the health budget to 17% of the Government's recurrent expenditure in 2012. USFH replied in the negative.

Manpower planning for healthcare services

45. Ms LI Fung-ying was concerned that an expansion of the private healthcare sector would lead to an increasing number of experienced doctors in HA switching to the private hospitals, thereby adversely affecting the quality of services provided by the public healthcare sector. Dr Joseph LEE expressed concern on the level of additional manpower required in the coming years to meet the increasing demand for public and private healthcare services.

46. USFH responded that while some specialties of HA recorded a higher turnover in the past year, the annual turnover rate of doctors in HA was within the normal range of 3% to 5%. It should also be noted that there would be a steady increase in the supply of healthcare personnel in the years to come. For instance, the respective number of nurse graduates and medical graduates from University Grants Committee ("UGC") funded programmes would be increased from the present 1 000 and 250 to about 2 000 and 320 in 2012-2013. The Administration would continue to discuss with UGC on the need to increase the first-year intake places for health professionals.

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47. Dr Joseph LEE asked whether the Administration intended to address the problem of shortage of nurses by only increasing the supply of enrolled nurses through the re-opening of certain nurse training schools in HA, instead of increasing the supply of registered nursing graduates from degree courses by UGC-funded institutions. USFH pointed out that many enrolled nurses would pursue continuous learning and attend training programmes for conversion to registered nurse.

Capacity of the public and private healthcare system

48. Pointing out that the hospital beds of existing private hospitals had already reached their full capacity, Mr Alan LEONG expressed concern that the implementation of the proposed HPS would drive subscribers to HPS Plans to procure private services at public hospitals instead of choosing services from the private hospitals, thereby creating a two-tier service structure in the public healthcare system.

49. USFH responded that several existing private hospitals had recently completed their expansion projects or had plans to expand or were expanding their hospitals. In addition, a few new private hospitals were currently under planning, including one at Clear Water Bay. Another four reserved sites had also been planned for development of private hospitals by phases, starting from 2011. Consequently, the number of hospital beds in the private sector could be approximately doubled in five to seven years' time.

50. Ms LI Fung-ying was concerned that the anticipated increase in the demand for private services provided by HA due to the introduction of the proposed HPS would inevitably stretch the resources and capacity of the public system, and eventually undermine its ability to cater for the low-income and under-privileged groups.

51. USFH responded that there was no cause for such concern, as a triage system was in place in HA to ensure that patients classified as urgent cases would be attended to within a reasonable time frame.

Way forward

52. Dr Raymond HO asked whether the Administration had confidence to strike a proper balance amongst the divergent views of different sectors of the community received during the consultation period on the proposed HPS.

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53. USFH advised that as reflected in the first stage public consultation, about 65% of the public agreed that there was a need to reform the healthcare financing arrangements to address the long-term sustainability of the healthcare system. Although among those who agreed with the need for reform, there were divergent views on the means through which this could be achieved, the majority had reservations about mandatory financing options and preferred having their own voluntary choices of healthcare protection at this stage. To examine the feasibility of such a voluntary supplementary financing scheme, the Administration had established a Consultancy Group on Voluntary Supplementary Financing Scheme in November 2009 involving stakeholders of relevant sectors including the consumer representatives and patient groups, medical profession, insurance sector, and employer groups to advise on the formulation of the scheme. It was against this background that the Administration had formulated the design and details of HPS for a three-month public consultation until 7 January 2011, with a view to arriving at a consensus. The Administration would revert to the Panel on the outcome of the consultation within this legislative session.

Conclusion

54. In closing, the Chairman requested the Administration to take heed of the views expressed by members and revert to the Panel on the outcome of the consultation within the current legislative session.

55. There being no other business, the meeting ended at 10:43 am.

Council Business Division 2
Legislative Council Secretariat
7 January 2011