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Panel on Health Services

Subcommittee on Health Protection Scheme

Background brief prepared by the Legislative Council Secretariat for the meeting on 28 February 2012

Health Protection Scheme

Purpose

This paper gives an account of the past discussions by the Panel on Health Services ("the Panel") on the Health Protection Scheme ("HPS").

Background

2. The Health and Medical Development Advisory Committee released a consultation paper entitled "Building a Healthy Tomorrow" in July 2005 on the future service delivery model of the healthcare system. While the respondents expressed diverse views on the proposed service delivery model, the majority of them agreed that it was high time to review the healthcare system to ensure its sustainability. In March 2008, the Government put forth a package of inter-related proposals for reform in the First Stage Healthcare Reform Consultation Document entitled "Your Health Your Life". The Consultation Document aimed at garnering the views of the public on the key principles and concepts of four proposals on the healthcare service reform, and the pros and cons of reforming the current healthcare financing arrangements through introducing six possible supplementary financing options: (a) social health insurance (mandatory contribution by workforce); (b) out-of-pocket payments (increasing user fees); (c) medical savings accounts (mandatory savings for future use); (d) voluntary private health insurance ("PHI"); (e) mandatory PHI; and (f) personal healthcare reserve (mandatory savings and insurance).

3. To tie in with the proposals, the Government would increase government expenditure on healthcare from 15% to 17% of the overall recurrent government expenditure by 2011-2012. The Financial Secretary also pledged in the 2008-2009 Budget to draw $50 billion from the fiscal reserves to take forward the healthcare reform, after the supplementary financing arrangements had been finalized for implementation.

4. The report on the first stage consultation on healthcare reform was released in December 2008. According to the Administration, despite the divergent views on healthcare financing, there was a general willingness among the public and stakeholders to continue deliberations on the issue of healthcare financing with a view to finding a solution. On 6 October 2010, the Government published the Healthcare Reform Second Stage Public Consultation Document entitled "My Health My Choice" in which a government-regulated, voluntary HPS, aiming at enhancing the long-term sustainability of the healthcare system, was proposed for public consultation. Under the proposal, insurers participating in HPS were required to offer standardized health insurance plans in accordance with the core requirements and specifications ("Standard Plans"). Participating insurers were also required to comply with scheme rules and requirements specified under HPS. Key features proposed to be encompassed under the Standard Plans of HPS included the following -

(a) no turn-away of subscribers and guaranteed renewal for life;

(b) age-banded premiums subject to adjustment guidelines;

(c) covering pre-existing medical conditions subject to waiting period and time-limited reimbursement limits;

(d) high-risk individuals insurable with a cap on premium loading (say 200%);

(e) sharing risks arising from accepting high-risk groups through High-Risk Pool industry reinsurance;

(f) offering no-claim discount up to 30% of published premiums;

(g) providing insurance plans renewable on leaving employment and portable between insurers;

(h) requiring the insurers to report all costs, claims and expenses;

(i) providing standardized health insurance policy terms and definitions; and

(j) establishing a Government-regulated health insurance claims arbitration mechanism.

5. The Healthcare Reform Second Stage Public Consultation Report was released on 11 July 2011. According to the Administration, members of the public supported regulating PHI and healthcare services through introducing HPS to improve market transparency, promote healthy competition, and enhance consumer protection. A three-pronged action plan would be adopted to take forward HPS, which included establishing a high level Steering Committee on Strategic Review on Healthcare Manpower Planning and Professional Development ("the Steering Committee") underpinned by a Coordinating Committee and six consultative sub-groups to conduct a strategic review on healthcare manpower planning and professional development; setting up a Working Group on Health Protection Scheme underpinned by a Consultative Group to formulate detailed proposals on the supervisory and institutional frameworks for HPS; and taking measures to facilitate the development of healthcare services and infrastructure. The Administration's plan was to complete the preparatory works by the first half of 2013, then proceed to draft and introduce HPS legislation, as appropriate. The implementation of HPS would take place the earliest in 2015.

Deliberations of the Panel

6. The Panel held seven meetings to discuss issues related to the proposed HPS and received the views of deputations at two meetings. The deliberations and concerns of members are summarized below.

Rationale and scheme concept of HPS

7. Members noted that one of the key features of HPS was the guaranteed acceptance of all applicants, including the high-risk groups such as the elderly and those with pre-existing medical conditions who were being excluded or priced out in the existing PHI market. Question was raised as to whether improving the existing PHI market through regulatory intervention by the Government was the primary objective of the proposed HPS.

8. The Administration advised that the first stage public consultation held in 2008 reflected that the majority of the public had reservations about mandatory financing options and preferred having their own voluntary choices of healthcare

protection. They expected more choices of private healthcare services according to their own means and needs as an alternative to public healthcare services. In the light of this, the proposed HPS aimed to make available government-regulated health insurance to provide better choices to those who chose private healthcare services by enhancing consumer protection, price-transparency, quality assurance and market competition in both PHI and private healthcare markets. It also aimed to ease the pressure on the public healthcare system by encouraging more people to use private healthcare on a sustainable basis, and enhance the sustainability of the entire healthcare system, thus benefiting those who depended on the public system for their healthcare needs.

9. Some members held another view that a public entity should be set up to offer health insurance plans under HPS to ensure compliance with the HPS requirements, set the benchmarks for heath insurance plans under HPS as well as avoid oligopoly and promote competition.

10. The Administration advised that at this juncture, 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. The Administration however would not rule out the option of setting up a public entity to offer health insurance plans should there be a general lack of interests from the industry in offering health insurance plans under HPS or should the market not be performing efficiently and effectively.

11. Some members were of the view that the implementation of HPS would increase medical costs and drive up medical inflation, leading to premium escalation and benefiting the participating insurers and private healthcare providers.

12. According to the Administration, the implementation of HPS would help achieve the goal of making healthcare services more transparent and address the significant public-private imbalance in Hong Kong's healthcare system. The Administration would continue its efforts in containing medical costs, and patients would not be denied of proper medical care due to a lack of means following the implementation of HPS.

Benefit coverage of Standard Plans

13. Members noted that HPS Plans would be required to provide coverage for medical conditions requiring hospital admission or ambulatory procedures; the

associated specialist out-patient consultations and investigations as well as the advanced diagnostic imaging services; and chemotherapy or radiotherapy for cancer. Noting the call from many deputations for extending the benefit coverage of HPS to out-patient services, some members further suggested that the benefit coverage of HPS should also be extended to cover the first specialist consultation in general as well as physiotherapy that entailed high cost.

14. The Administration explained that 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. The inclusion of primary care under HPS might also lead to premium escalation. HPS was designed to be modular and insurers participating in HPS could offer other health insurance plans with top-up benefits and add-on components to cover such services. The public healthcare system would also provide a safety net of last resort for patients in need.

Savings for future premium

15. There was concern on the affordability of HPS. To better enable people to afford continuous health protection under HPS at older age when they needed it most, there was a suggestion that consideration should be given to creating a medical savings component under the Mandatory Provident Fund.

16. The Administration advised that taking into account the need to encourage the insured to stay on and to secure a pool of funding to cover future healthcare protection especially at old age, it had proposed for public consultation three options to encourage savings: (a) required in-policy savings; (b) optional savings accounts; and (c) premium rebate for long-stay. The Administration was open-minded on building in a medical savings component under the Mandatory Provident Fund to encourage savings by individuals for paying future premium at older age.

Subscription

17. Noting that HPS might lack the critical mass to be financially viable if it was unable to attract a substantial number of subscribers, question was raised on the number of subscribers to make HPS sustainable.

18. The Administration estimated that around several hundred thousands subscribers would make HPS sustainable. At present, around 2.42 million people in Hong Kong were covered by PHI. Some of them might choose to migrate to HPS plans. To attract individuals especially the young and healthy people to join HPS Plans, the Administration proposed the provision of

Government incentives for all new joiners of HPS Plans to enjoy maximum no-claim discount immediately upon joining HPS, or to encourage savings by individuals under HPS for paying future premium at older age.

19. Members held the view that the viability of HPS would depend on a critical mass of a balanced distribution of age and gender. Apart from the provision of scheme incentives, a mechanism for smooth migration of the existing health insurance policies into HPS Plans should also be put in place.

Service provision based on packaged charging

20. It was proposed that HPS Plans would be required to set reimbursement levels based on "diagnosis-related groups" ("DRG") packaged charging where available, thereby enhancing transparency and certainty of medical charges to the insured. Some members cast doubt over the ability of the Government to ensure an adequate supply of private healthcare services based on DRG packaged charging.

21. The Administration considered that DRG-based payment systems would work well in Hong Kong as they had been practised in other advanced economies for some 20 years. In addition, the new private hospitals to be developed at the four pieces of land earmarked for private hospital development (at Wong Chuk Hang, Tseung Kwan O, Tung Chung and Tai Po respectively) would also be required to provide services at DRG packaged charging in support of the implementation of HPS.

22. Members expressed concern on the quality of healthcare services provided if DRG-based packaged charging was adopted, as the benefit limits might put a constraint on the type and range of services offered by the service providers. There was also a concern that private healthcare service providers might abandon high-risk cases due to cost considerations. Questions were raised as to whether top-up coverage and co-payment would be provided under HPS as options for subscribers.

23. The Administration advised that as most complicated cases were handled by the Hospital Authority ("HA"), there was no cause for concern about giving up high-risk cases by private healthcare service providers. Members were also advised that co-payment, together with optional top-up coverage, had been incorporated in the design of HPS to provide more choice for the subscribers. Subscribers could choose optional top-up components, such as coverage of general out-patient services and better services and rooms and boards.

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

24. Members expressed diverse views on the Government's proposal to make use of the $50 billion earmarked in the fiscal reserves to take forward HPS. Some members welcomed the proposal to make use of the $50 billion to attract people to subscribe HPS while other members had reservations about the suitability of using the reserves to subsidize people who had already bought PHI to migrate to an HPS plan. Some members suggested that the Government should use the $50 billion on the public healthcare system to address the manpower shortage problem, instead of supporting the uptake of PHI. There was also a view that offering a tax deduction for the premiums, instead of making use of the $50 billion to provide fiscal incentives under HPS, could serve the same purpose of increasing the uptake of HPS Plans.

25. The Administration advised that it was open-minded on the offering of tax deduction for HPS premiums. However, it considered that no-claim discount, premium cap for high-risk individuals, premium discount for new joiners, required in-policy savings and premium rebate for long-stay were more direct and attractive incentives for joining HPS. It further pointed out that 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.

Supervisory framework for HPS

26. Casting doubt on the ability of the Government to effectively regulate the profit and surcharge of the insurers under HPS, some members were concerned whether there would be government control over the setting of the premium and administration fee of the Standard Plans under HPS to avoid the driving up of medical costs. In particular, some members pointed out that some individual healthcare service providers might charge different fees for insured and non-insured patients. There was a need for the Administration to allay the concern of the public on the non-transparent and highly variable charges by private practitioners.

27. The Administration responded that measures underpinned by legislation would be developed to require the participating insurers and private healthcare service providers to be transparent in the setting and adjustment of premiums, insurance costs and medical charges. Key stakeholders, including the insurance sector, would be engaged to steer the formulation of proposals for HPS. The Administration however expressed reservations about regulating the ratio of administrative fee through legislation as such an arrangement would

reduce competition and might result in a situation that all insurers would set their administrative fee at the maximum permitted level.

Healthcare capacity

28. Members were concerned about the capacity of the private healthcare sector to cope with the increase in demand arising from the implementation of HPS.

29. The Administration advised that the known redevelopment projects of existing private hospitals and the development of new private hospitals under planning would double the number of hospital beds in the private sector in five to seven years' time, thus enabling the sector to meet the projected demand for private healthcare services arising from HPS.

30. Holding the view that catering for local healthcare needs should be the first and foremost consideration when developing the medical industry and implementing HPS, members urged the Administration to specify in the lease conditions of the four sites earmarked for private hospital development the minimum percentage of beds or bed days for use by local residents. There was also a suggestion that the Administration should cap the maximum proportion of obstetric service beds in the new private hospitals to be developed at these sites.

31. The Administration advised that in designing the special development requirements for the four sites as conditions for disposal of the sites, it had taken into account the need to support HPS, including the service scope (such as the types of speciality), the standard of service (such as the number of beds), price transparency and the requirement to provide services at packaged charges. The Administration was in the process of hammering out the detailed special requirements to ensure their feasibility. It was expected that the lease conditions would include requirements on the minimum percentage of beds or bed days for use by local residents and the provision of beds of a mix of specialties without slanting towards the obstetric service.

32. On whether the lease conditions of the four sites would be subject to review and variation by the Administration as and when necessary, the Administration advised that any modification to the lease conditions would require mutual agreement of the Government and the purchaser or grantee concerned.

Healthcare manpower

33. There was grave concern that an expansion of the private healthcare sector would lead to an increasing number of experienced doctors in HA switching to

the private hospitals, undermining the ability of HA to cater for needy patients who had to depend on the public system for their healthcare needs.

34. The Administration advised 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%. As an important role of HA was to train healthcare professionals for the territory, turnover was natural as some of these professionals might choose leave HA after training. The Administration assured members that a steady increase in the supply of healthcare personnel would be expected in the coming years, as there would be an enhanced supply of medical and nurse graduates by 2015.

35. The Administration further advised that a strategic review would be conducted by the Steering Committee which comprised, among others, renowned overseas experts, local dignitaries of healthcare professions, officials from the Education Bureau and representatives from the publicly-funded institutions providing training for healthcare professionals. The Steering Committee would assess manpower needs in the various healthcare professions, and review the existing professional standards and regulatory structure for various healthcare professions. It would formulate its recommendations by the first half of 2013.

36. Noting that the terms of reference of the Steering Committee would include reviewing the existing regulatory structure for healthcare professions, some members were concerned about the change to the existing regulatory structure to be brought about by the strategic review. In particular, they were concerned whether the strategic review would seek to bring about change to the principle of professional autonomy of the healthcare professions and the role of HA in healthcare manpower planning and development.

37. The Administration advised that the review was not aimed to change the principle of professional autonomy of the healthcare professions or the role of HA. The Steering Committee would review and identify areas requiring attention under the existing regulatory structures, including those concerning complaints and regulation of professional conduct in the existing mechanisms of the statutory regulatory bodies. It would also formulate plans to ensure manpower supply and professional qualities to meet future needs of both public and private healthcare sectors.

<u>Establishment of a dedicated office to take forward HPS proposal</u>

38. Members expressed different views on the Administration's proposal of creating two supernumerary directorate posts for leading and overseeing a

dedicated HPS Office to be set up in early 2012 on a time-limited basis for three years at the Panel meeting on 24 November 2011. Some members expressed support for the establishment of the HPS Office to coordinate planning and implementation of HPS, conduct review on healthcare manpower planning and professional development, and facilitate the healthcare services development. They considered that there was a need to improve the public healthcare system, and the setting up of a dedicated HPS Office could facilitate further study on the details and financial viability of HPS before taking forward the reform initiatives. There was also a view that given that PHI had become an increasingly popular form of health protection, it was incumbent upon the Government to introduce HPS as a tool for reforming PHI and private healthcare services markets.

39. Some other members objected to the Administration's proposal. While they agreed that the Administration should strengthen the long-term planning for healthcare manpower and step up its effort to regulate PHI and private healthcare services, they questioned the reason for putting these responsibilities under the purview of the HPS Office. Given that there was no clear consensus amongst Members of the Legislative Council ("LegCo") and members of the public on the implementation of HPS, they considered it not opportune to consider the establishment of the HPS Office. There were doubts on the effectiveness of HPS to relieve pressure on the public healthcare sector, and concerns that the implementation of HPS would aggravate the high wastage of healthcare professionals in public hospitals.

40. In response to the Panel members' suggestion made at the meeting on 24 November 2011, the Administration has subsequently renamed the HPS Office as Healthcare Planning and Development Office ("HPDO") to reflect more accurately the work of the office. The staffing proposal for the creation of two supernumerary posts for three years in the Food and Health Bureau was submitted to and approved by the Establishment Subcommittee and the Finance Committee on 7 December 2011 and 6 January 2012 respectively. As advised by the Administration, a total of 15 non-directorate civil service posts would be created to support the HPDO which had been set up under the Food and Health Bureau in January 2012.

Recent developments

41. The Administration is in the process of commissioning a consultancy study on HPS in order to provide professional and technical support to the Working Group and Consultative Group on Health Protection Scheme. The consultant will perform a comprehensive review, survey and analysis of the

current market situation of PHI in Hong Kong; and propose a feasible, sound and detailed design for implementing the HPS.

Relevant papers

42. A list of the relevant papers on LegCo website is in the **Appendix**.

Council Business Division 2
Legislative Council Secretariat
27 February 2012

Appendix

Relevant papers on
Health Protection Scheme

Committee	Date of meeting	Paper
Panel on Health Services	6.10.2010 (Item I)	Agenda
Panel on Health Services	11.12.2010 (Item I)	Agenda Minutes
Panel on Health Services	13.12.2010 (Item IV)	Agenda Minutes
Panel on Health Services	11.7.2011 (Item II)	Agenda Minutes
Panel on Health Services	8.8.2011 (Item II)	Agenda Minutes
Panel on Health Services	24.11.2011 (Item I)	Agenda Minutes
Panel on Health Services	13.2.2012 (Item IV)	Agenda

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