



中華人民共和國香港特別行政區政府總部食物及衛生局
Food and Health Bureau, Government Secretariat
The Government of the Hong Kong Special Administrative Region
The People's Republic of China

Our Ref. : L/M to FHB/H/1/5/4/2 Pt.2
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17 May 2012

Ms Elyssa WONG
Clerk to Subcommittee
Subcommittee on Health Protection Scheme
Panel on Health Services
Legislative Council Complex
1, Legislative Council Road
Central

Dear Ms WONG,

**Panel on Health Services
Subcommittee on Health Protection Scheme**

Follow-up to the meetings on 16 April and 30 April 2012

I refer to your letters of 18 April and 8 May 2012 on the captioned. The requested supplementary information is provided as follows –

- (a) Follow-up to the meeting of 16 April 2012: the supplementary information on item (c) is provided at **Annex A**. Together with our interim reply of 27 April 2012, all issues raised should have been addressed.
- (b) Follow-up to the meeting of 30 April 2012: the requested supplementary information on item (a), (c) and (d) is provided at **Annex B**. Information on item (b) will be provided as soon as practicable.

Yours sincerely,



(Miss H S Cheung)
for Secretary for Food and Health

C.C.

HA (Attn.: Dr W L CHEUNG and Ms Eva TSUI)

OCI (Attn.: Ms Pauline WOO)

**Administration's Response to
Follow-up to the meeting of Subcommittee on Health Protection
Scheme of the Panel on Health Services on 16 April 2012**

Item (c) –

Methodology and formula of HA for projecting its medical and nursing staff requirement; examples should be provided to illustrate the application of the methodology and formula in calculating the manpower requirement for a particular clinical specialty.

Administration's response

An overview of the methodology and results of the manpower requirement projection exercise conducted by the Hospital Authority (HA) in 2010 for doctors and nurses was already set out in the LegCo Panel on Health Services paper dated 11 July 2011 (LC Paper No. CB(2) 2298/10-11(02)). As stated in Panel paper, the future manpower requirements comprise two major components: (i) additional requirement generated by projected service growth, and (ii) replacement requirement generated by staff turnover (including retirement); with the latter component being considered when projecting the annual manpower intake requirements.

I. Service Workload Projection

All Specialties (except Obstetrics and Neonatology¹)

2. Two key parameters are used for estimating the future volume of HA services for all specialties (except obstetrics and neonatology), as follows:

- (a) HA-wide average age- and specialty-specific service utilization rates per population at base year for each type of service (i.e. inpatient, day-patient, outpatient, ambulatory and community services, etc.); and
- (b) Population projection figures compiled by the Census and Statistics Department (C&SD) of the Government.

¹ Future manpower requirement for obstetrics and neonatology services is estimated based on projected births in Hong Kong.

Table 1 Projected mid-year population by age group in Hong Kong

Age Group	Mid-year Population ('000)			
	Actual ⁽¹⁾		Projected ⁽²⁾	
	2008	2016	2021	2026
0-4	220.8	257.5	276.6	276.3
5-9	282.5	327.1	336.8	355.9
10-14	399.0	298.6	362.3	372.0
15-19	444.3	354.8	318.0	382.5
20-24	459.8	487.3	426.8	393.3
25-29	530.2	591.8	578.1	520.5
30-34	544.0	625.6	640.6	626.1
35-39	577.2	563.5	633.2	646.9
40-44	623.5	521.2	543.3	611.6
45-49	669.7	520.3	498.6	519.8
50-54	587.0	624.5	509.7	487.6
55-59	457.7	636.2	619.9	506.7
60-64	302.4	512.0	626.2	611.3
65-69	224.9	397.5	496.7	609.1
70-74	235.2	222.2	376.2	472.7
75-79	191.4	200.0	199.2	340.5
80-84	123.9	158.0	161.1	163.2
85 or above	104.2	151.9	180.7	198.0
Total	6,977.7	7,450.0	7,784.0	8,094.0
Children population (below 18)*	1,168.9	1,096.1	1,166.5	1,233.6
Elderly population (65 or above)	879.5	1,129.5	1,413.9	1,783.4

Sources: (1) Website of Census & Statistics Department

(2) Hong Kong Population Projections 2007-2036, Census & Statistics Department

* Population of age group 15-17 was estimated by pro-rata method based on population of age group 15-19.

3. The basic formula for deriving the future volume of each type of service of HA by specialty is (a) x (b):

Service workload by specialty

= summation of [(average age- and specialty-specific service utilization rates per population) X (projected population in the corresponding age group)]

II. Projection of Doctors Manpower Requirement

4. The setting and types of doctors' work duties in HA are very diverse, covering emergency treatment, inpatient ward round, on-site and off-site calls, operation and procedure, clinic consultation, outreach visits, etc. Not only do they vary across different specialties, the same doctor could be doing different tasks at different periods of his/her duty hours. For instance, medical and surgical doctors vary widely in their work profile in terms of time spent on different types of activities. The contrast is even greater when comparing with family medicine doctors and pathologists: family medicine doctors attend mainly to outpatient cases and do not normally perform ward duties, while most pathologists work in the hospital laboratories. Therefore, to take account these diversities, HA has adopted a specialty-based consultative approach when carrying out the manpower requirement projection for doctors. It is conducted in close collaboration with clinicians from the respective clinical specialty committees, who provided inputs on a set of parameters that underpinned the projection.

5. To estimate the required doctor manpower, the projected service workloads by specialty are first translated into time requirement (man-hours) for doctors in carrying out the workload. The basic steps and parameters involved are as follows:

- (a) **Identify specialty-specific doctor work profiles and the time required for each unit of work.** Together with clinicians of the respective specialties, the average time required for doctors in carrying out the tasks for each type of workload is worked out. This covers inpatient admission and ward round, outpatient consultation, operation, night-shift on-call, patient communication, clinical documentation, coaching and training etc.
- (b) **Estimate total doctor workload for each specialty.** This is expressed in terms of doctor man-hours required for carrying out the projected service workload across all types of activities as outlined in Section I. The formula is as follows:

$\begin{aligned} &\text{Total doctor workload (man-hours)} \\ &= \text{summation of } [(\text{time required for each unit of workload}) \times \\ &\quad (\text{projected volume of each category of service workload})] \end{aligned}$

- (c) **Determine the required number of doctors to cover the projected doctor workload for each specialty.** This is determined year by year and the formula is as follows:

$$\text{Required number of doctors} = \frac{\text{projected total doctor workload (man-hours)}}{\text{total work hours per doctor per year}}$$

The total work hours per doctor per year is derived based on the assumption that doctors carry out their duties in 42.3 out of the 52 weeks in a year, after discounting for rest days, annual leave, sick/maternity leave and training leave. This is an across-the-board parameter for all the specialties.

The total work hours per doctor per year for each specialty, where applicable, is then calculated by multiplying 42.3 weeks by a specialty-specific projection parameter on average work hours per week (between 44 and 65 hours).

6. Taking General Surgery as an example, the projected service workload for 2016 in HA is as follows:

	Projected Service Workload (2016)
Inpatient:	
- admission	65,000
- bed days occupied	511,000
Day Patient admission	58,000
Operation (covering ultra-major, major, intermediate and minor operation)	42,000
Procedure (e.g. endoscopic procedure)	123,000
Specialist Outpatient attendance	549,000

7. Apart from these projected service workloads, activities covering night-shift on-call, patient communication, clinical documentation, coaching and training, are also taken into account. The man-hours required for doctors in carrying out these workloads are derived by multiplying them with the corresponding projection parameter in terms of the average time per unit of workload. For example, the average time required per admission is 23 minutes, and that for operation is 294 minutes with a range of 45 – 900 minutes depending on the magnitude of operation.

By summing across all categories of service workloads, a total of 1 090 000 doctor man-hours is derived. This is translated into 430 doctor requirement for General Surgery for HA, based on the parameter that the total average work hours per doctor per year are 2 536 hours for General Surgery.

8. The projection results for each specialty, which have been reviewed and endorsed by the respective clinical specialty committees, are presented in Table 2. Accordingly, a total of 5 839 doctors would be required in 2016 in order to meet the projected service workload of HA under the base case scenario, which means that the estimation is derived without any assumptions on major changes in the healthcare system and economic variables over the projection horizon (no provision is made for future private sector capacity expansion and the two proposed centres of excellence etc.). As for years 2021 and 2026, the total doctor manpower requirements are 6 248 and 6 749 respectively under the base case scenario.

Table 2 Projected manpower requirement for doctors in HA by specialty (base case scenario)

Specialty	Doctor requirements			
	2008 (Actual)	2016	2021	2026
Accident & Emergency	434	517	554	596
Anaesthesiology	346	398	435	473
Clinical Oncology	127	148	164	181
Ear, Nose & Throat	81	91	97	102
Family Medicine	504	587	645	714
Medicine	1,119	1,246	1,319	1,455
Neurosurgery	87	96	102	107
Obstetrics & Gynaecology	216	260	266	268
Ophthalmology	144	177	194	214
Orthopaedics	297	354	366	391
Paediatrics	316	337	344	340
Pathology	203	238	254	273
Psychiatry	293	337	359	380
Radiology	238	312	356	405
Surgery ⁽¹⁾	525	622	665	712
Others	107	120	127	138
Overall	5,035	5,839	6,248	6,749

⁽¹⁾ Includes cardiothoracic surgery.

III. Projection of Nursing Manpower Requirement

9. In manpower projection, all nurses are broadly categorized into two streams: general nurses and psychiatric nurses. The same set of service workload projections as outlined in Section I is used to translate into nursing manpower requirement of general and psychiatric streams at different clinical settings. The process is similar to the doctor manpower projection model, but unlike doctors, nurses normally station at a single service setting during their duty hours. The projection exercise is conducted in close collaboration with nurse representatives, who provided inputs on a set of parameters and assumptions underpinning the projection.

10. To estimate the required nurse manpower, the projected service workloads are classified into either ward-based or non-ward based activities under the general and psychiatric streams. It involves the following steps and parameters:

(a) **Identify the key nursing service components at different settings for general and psychiatric streams.** Together with the nurse representatives, the service settings within the modeling framework for each stream are classified as follows:

- General stream:
 - Ward-based: acute ward, extended care ward, special ward, operating theatre, etc.
 - Non-ward based: specialist outpatient clinic, general outpatient clinic, day hospital, community service, etc.
- Psychiatric stream:
 - Ward-based: psychiatric ward and mentally handicapped ward.
 - Non-ward based: specialist outpatient clinic, day hospital, community service, etc.

(b) **Estimate total workload for each service setting.** This is obtained by summing up for each service setting the projected service workload outlined in Section I across all specialties. For example, the formula for calculating the projected workload of acute wards is as follows:

Projected workload in acute wards
 = summation of [projected acute bed days of each specialty]

- (c) **Devise the projection parameters.** HA has developed a ward workload assessment tool since 2007-08 to estimate nursing manpower requirements. The model takes into account the prevailing number of patients and the dependency level of patients for nursing care via a four-category patient-nurse dependency tool. The dependency categories are derived from patients' need for direct nursing care. The higher the dependency, the more nursing time is required. Other workload factors are also included, such as nursing time in providing patient education, counseling and care planning as well as non-bedside nursing work such as care coordination and liaison. In addition, other specific factors that impact on nursing workload, such as patient turnover (including admission, discharge and transfer of patients) are also taken into consideration. The projection parameters in terms of required number of nurses per service setting are derived based on this assessment tool after discounting for rest day and leave, and assuming nurses work 44 hours per week on average. For non-ward-based service settings, the model takes into account its actual workload in the base year and the projection parameter is also expressed in terms of required number of nurses per service setting.
- (d) **Determine the required number of nurses to cover the projected workload for each stream.** This is determined year by year and the formula is as follows:

Required number of nurses
 = summation of $\left[\frac{\text{Projected service workload}}{\text{Actual service workload in base year}} \times (\text{c}) \text{ of each service setting} \right]$

11. The following illustration example shows the calculation of projected nursing manpower requirement for a general ward with 40 bed numbers based on the patient nurse dependency distribution and an assumed 85% bed occupancy rate.

Specialty	Patient Nurse Dependency (PND) distribution				Bed Occupancy Rate	Bed No.	Estimated Nurses Required	
	PND I (lowest)	PND II	PND III	PND IV (highest)			Normal Scenario	Busy Scenario (1)
Medical	26%	32%	22%	20%	85%	40	22.3	25.3
Surgical/ Orthopaedics	25%	35%	24%	16%	85%	40	22.1	25.1

(1) Add 15% busy loading for wards with more than 17 patients Admission/ Discharge/ Transfer (ADT) per day and 50% turnover of patients against bed day occupied (BDO).

12. The projection results for each stream, which have been reviewed and endorsed by the nurse representatives, are presented in Table 3. Accordingly, a total of 23 575 nurses would be required in 2016 in order to meet the projected service workload of HA. This is the base case scenario, which means that the estimation is derived without any assumptions on major changes in the healthcare system and economic variables over the projection horizon (no provision is made for future private sector capacity expansion and two centres of excellence etc.). As for years 2021 and 2026, the total nurse manpower requirements are 24 957 and 26 911 respectively under the base case scenario.

Table 3 Projected manpower requirement for nurses in HA by stream (base case scenario)

Stream	Nurse requirements			
	2008 (Actual)	2016	2021	2026
General	17,518	21,119	22,370	24,186
Psychiatric	1,953	2,455	2,587	2,725
Overall	19,471	23,575	24,957	26,911

**Food and Health Bureau
Hospital Authority
May 2012**

Administration's Response to
Follow-up to the meeting of Subcommittee on Health Protection
Scheme of the Panel on Health Services on 30 April 2012

Item (a)(i) -

Justifications for the Administration's position that the factors of (1) ageing population, (2) development of more advanced medical technologies and (3) introduction of new services would lead to a soaring demand in doctor manpower and hence a shortage of doctors.

Administration's response

2. Hospital Authority (HA) provides a full spectrum of essential and necessary healthcare services, acting as the healthcare safety net for the whole community, through public hospitals under its aegis. It also provides primary care services through its general out-patient clinics (GOPCs), and is responsible for the effective and efficient delivery of a wide range of highly subsidized preventive and rehabilitative medical care.

3. The number of doctors in HA increased from 3 491 in 1998-99 to 5 052 in 2010-11, representing an increase of 45% or an annualized growth rate of 3%¹. This increase is necessary in view of service growth (at an annualized rate of 2-3%) and a host of other forces which have an impact on the manpower situation in HA, including an aging population that results in more intense use of HA services by the elderly, as well as the advent of more advanced medical technologies requiring more specialist time, investigations, interventions and treatment, e.g. ultra-sound/CT/MRI examinations and cancer treatment.

4. During the period from 1998-99 to 2010-11, to cope with escalating and new demands in healthcare needs and rising public expectation, HA has:

- (a) achieved significant growth in service outputs. For instance, in-patient services increased from 1.04 million in 1998-99 to 1.42 million in 2010-11 in terms of discharge and death; and specialist outpatient attendances increased from 5.34 million in 1998-99 to 6.63 million in 2010-11.

¹ The increase in the manpower of doctors should take into account the reduction of weekly working hours over the years. From September 2006 to December 2011, the percentage of doctors working for over 65 hours per week on average dropped from 18% to 4.8%.

Both reflect an over 20% increase over the period or an annualized service growth rate of 2 to 3%. This is higher than the growth rate of the Hong Kong population over the same period, which increased by 7% from 6.5 million in 1998-99 to 7 million in 2010-11 (or 1% annualized population growth).

In addition, HA has commenced family medicine training in 1997 and set up family medicine specialist clinic (formerly known as integrated clinic). HA also took over the management of all GOPCs from the Department of Health (DH) in 2003 on top of the 10 GOPCs previously managed by the HA. As a result, primary care attendances increased by six-fold from 0.76 million in 1998-99 to 5.26 million in 2010-11, representing an annualized growth rate of 18%.

- (b) managed more elderly patients, resulting in more intense use of HA services. The relative risk of an elderly person being hospitalized is about four times that of a non-elderly person, and the complexities of the illnesses of elderly people are also more profound. The service impact arising from the aging population is reflected by a higher number of admissions of the elderly and a longer length of stay, which is 9.7 days on average for an elderly patient compared to 5.3 days for a non-elderly patient.
- (c) deployed more advanced technologies or investigations, which consumed more specialist time, interventions and treatment. For example, radiological examinations (including Ultra-sound, Computed Tomography, Magnetic Resonance Imaging) increased from 3 million to 4 million (2.5% p.a.) and pathological workload units soared from 132 million to 208 million (3.9% p.a.) from 1998-99 to 2010-11.
- (d) introduced multimodality combined treatment for cancer patients including chemotherapy, radiotherapy, interventional radiology apart from surgical resection, which requires multidisciplinary work and specialist time for regimen alignment.
- (e) developed community outreach services with a significant growth in the past decade. The outreach attendance (e.g. community nurse, geriatric assessment, psychiatric outreach team, Visiting Medical Officers etc.) per year has increased by two-fold from 570 000 to 1 800 000. HA's Community Geriatric Assessment

Service (CGAS) is now covering almost 90% of elderly homes in the territory.

- (f) improved the working conditions and work arrangements of doctors in order to ensure compliance with the statutory requirements of granting rest days, statutory/public holidays and to address work hour issues of HA doctors. It is HA's target to reduce all doctors' average weekly work hour to not exceeding 65 hours and their continuous work hours to a reasonable level in the long run. From September 2006 to December 2011, the percentage of doctors working for over 65 hours per week on average dropped from 18% to 4.8%. HA will continue to monitor the working conditions of doctors and identify ways to manage workload while ensuring the delivery of quality services to the public.

5. Please refer to **Appendix 1** for relevant figures of service growth and manpower growth from 1998-99 to 2010-11.

Item (a)(ii) -

Detailed information with examples illustrating the cost effectiveness of existing services of the Hospital Authority ("HA") and the evaluation studies of selected pilot projects by HA.

Administration's response

6. HA has always attached importance to cost management, so as to ensure that major resources are used on items directly related to patients. While there has been increase in the overall unit costs of HA's services from 2007-08 to 2010-11 (with an average annual increase of about 2.6%), the increase is similar to that of the overall Composite Consumer Price Index of Hong Kong in the same period (which is 2.7%). The increase in cost is mainly due to adjustment of staff remuneration, expansion of coverage of the Drug Formulary, procurement of medical equipment for modernising HA, as well as increase in expenditure for addressing manpower issues.

7. HA's mechanism for costing was developed with reference to the practices of global medical institutions and the cost accounting standards. The mechanism has been working effectively and is keeping pace with time. Since its inception in early 1990s, HA has set up a dedicated team internally to review and improve the mechanism on a regular basis for

further enhancement. After years of continuous research and development, the mechanism has become more well-established in providing relevant reference for resource planning and service performance management.

8. To ensure the overall efficiency of resource utilisation, HA will review regularly the performance indicators regarding its service activities, manpower, financial situation and implementation progress of its annual plan. HA will examine closely any variations from the pre-determined targets and where appropriate, take remedial actions accordingly. The Government and the HA Board will also closely monitor the overall performance of HA's services, manpower, financial situation to ensure the proper and optimal use of government funding.

9. The cost-effectiveness of HA services may be illustrated by comparing the proportion of patients it serves with the proportion of healthcare cost it consumes in relation to the community total. HA provides 88% of all inpatient services² in Hong Kong. Most of the services for high cost, complex illnesses requiring multi-disciplinary care (such as major organ transplant, complex cancer treatment, major trauma management, renal dialysis and mental illnesses) are provided by HA. HA also looks after the healthcare of most elderly patients who require greater healthcare resources than their younger counterparts. In 2010, over 60% of patients over 65 years of age patronized public hospitals.

10. Despite the more complex and costly cases treated by public hospitals, HA only consumes about 65% of the total expenditure for inpatient curative care (including day patient hospital services) of Hong Kong³.

11. The HA has also been improving its efficiency in providing hospital care. The average length of stay of in-patient treatment is reduced from 3.79 days in 2007-08 to 3.33 in 2010-11. It is accomplished by treating less complex cases on day basis and the number of day patients treated has increased by 47.9% in the same period; the proportion of in-patient complex cases nearly doubled, increased from 13.3% in 2007-08 to 25.7% in 2010-11.

² Figures for 2010-11; sources: DH and HA.

³ Figures for 2008/09 from Hong Kong's Domestic Health Accounts.

Item (c) –

A list of insurance companies in Hong Kong and their respective amounts of underwriting.

Administration's response

12. As provided by the Office of the Commissioner of Insurance, a list of authorised insurers writing medical insurance business in 2011 is at **Appendix 2**. According to the Hong Kong insurance business provisional statistics of the Office of the Commissioner of Insurance, the total amount of gross premiums for medical insurance reported in 2011 were \$13,088 million.

Item (d) -

The formula for calculating medical inflation in the public and private sectors.

Administration's response

13. “Medical inflation” generally refers to the rise in medical costs due to advances in medical technology and public expectations for healthcare to keep up with such advances. It is a common phenomenon, and in no way unique to a certain place or region. The characteristics of a healthcare system would have a bearing on its medical inflation. In Hong Kong, our healthcare system operates on a dual-track system with both the public and private healthcare sectors providing services to the public.

14. The concept of “net medical inflation” (i.e. medical inflation rate over and above per capita real Gross Domestic Product (GDP) growth) was adopted when projection was made on the future growth of health expenditure (up to the year 2033) in the First Stage Public Consultation on Healthcare Reform in 2008, having regard to international experience as well as local trend of health expenditure. The assumption is that, in the long run, the net medical inflation rate of public health expenditure would be 0.8 percentage point per year on average over and above per capita GDP growth rate while the net medical inflation rate of private health expenditure would be 1.6 percentage points over and above per capita GDP growth rate.

**Food and Health Bureau
Hospital Authority
Office of the Commissioner of Insurance
May 2012**

Hospital Authority Service Throughput and Doctor Manpower Figures
2010-11 vs 1998-99

	1998-99 (‘000)	2010-11 (‘000)	Increase / Decrease (%)	
			Growth from 1998-99 to 2010-11	Annualized growth rate
Population	6,544	7,024	+7%	+0.6%
Number of discharges and deaths for general specialties⁽¹⁾	1,041	1,422	+37%	+2.6%
Number of specialist outpatient (clinical) Attendances	5,338	6,630	+24%	+1.8%
Number of inpatient major and ultra-major operations	77	134	+74%	+4.7%
Number of primary care attendances⁽²⁾	757	5,262	+595%	+17.5%
Number of geriatric outreach attendances	63	620	+884%	+21.0%
Number of radiology examinations	3,009	4,036	+34.1%	+2.5%
Number of pathology workload units	132,048	207,979	+57.5%	+3.9%
Doctor manpower⁽³⁾ (as at 31 March)	3.5	5.1	+45% ⁽⁴⁾	+3.1%

Notes :

- (1) It refers to (i) general specialties in inpatient services; (not include infirmary, mentally ill and mentally handicapped); and (ii) day patient services.
- (2) Primary care attendances include general outpatient and family medicine specialist clinic attendances. 1998-99 figures only cover general outpatient clinic attendances because family medicine specialist clinics had not yet been launched. HA took over the management of all general out-patient clinics (GOPCs) from the Department of Health in 2003.
- (3) Manpower figures provided above represent the full-time equivalent (FTE) strength of doctors, exclude interns and dentists.
- (4) The increase in the manpower of doctors should take into account the reduction of weekly working hours over the years. From September 2006 to December 2011, the percentage of doctors working for over 65 hours per week on average dropped from 18% to 4.8%.

**List of Authorized Insurers Writing Medical Insurance Business
in 2011**

1. ABCI Insurance Company Limited
2. ACE Insurance Limited
3. ACE Life Insurance Company Ltd.
4. Ageas Insurance Company (Asia) Limited
5. American International Assurance Company (Bermuda) Limited
6. American International Assurance Company, Limited
7. Asia Insurance Company, Limited
8. Assicurazioni Generali Società per Azioni
9. AXA (Hong Kong) Life Insurance Company Limited
10. AXA China Region Insurance Company (Bermuda) Limited
11. AXA China Region Insurance Company Limited
12. AXA General Insurance Hong Kong Limited
13. AXA Wealth Management (HK) Limited
14. Bank of China Group Insurance Company Limited
15. BEA Life Limited
16. Blue Cross (Asia-Pacific) Insurance Limited
17. BOC Group Life Assurance Company Limited
18. Bupa (Asia) Limited
19. Chartis Insurance Hong Kong Limited
20. China BOCOM Insurance Company Limited

- 21.China Life Insurance (Overseas) Company Limited
- 22.China Merchants Insurance Company Limited
- 23.China Pacific Insurance Co., (H.K.) Limited
- 24.China Taiping Insurance (HK) Company Limited
- 25.Chong Hing Insurance Company Limited
- 26.CIGNA Worldwide General Insurance Company Limited
- 27.CIGNA Worldwide Life Insurance Company Limited
- 28.Dah Sing Insurance Company (1976) Limited
- 29.Dah Sing Insurance Company Limited[△]
- 30.Dah Sing Life Assurance Company Limited
- 31.Falcon Insurance Company (Hong Kong) Limited
- 32.GAN Assurances
- 33.Hang Seng General Insurance (Hong Kong) Company Limited
- 34.Hang Seng Insurance Company Limited
- 35.Hong Kong Life Insurance Limited
- 36.Hong Leong Insurance (Asia) Limited
- 37.HSBC Insurance (Asia) Limited
- 38.HSBC Life (International) Limited
- 39.ING General Insurance Company Limited
- 40.ING Life Insurance Company (Bermuda) Limited
- 41.Liberty International Insurance Limited
- 42.Manulife (International) Limited

43. MassMutual Asia Limited
44. Metropolitan Life Insurance Company of Hong Kong Limited
45. Min Xin Insurance Company Limited
46. MSIG Insurance (Hong Kong) Limited
47. Nipponkoa Insurance Company (Asia) Limited
48. Pacific Life Assurance Company, Limited - The
49. Pafoong Insurance Company (Hong Kong) Limited
50. People's Insurance Company of China (Hong Kong), Limited - The
51. Prudential Assurance Company Limited – The
52. QBE Hongkong & Shanghai Insurance Limited
53. Royal & Sun Alliance Insurance plc
54. Sompo Japan Insurance (Hong Kong) Company Limited
55. Standard Life (Asia) Limited
56. Sun Hung Kai Properties Insurance Limited
57. Sun Life Hong Kong Limited
58. Tokio Marine and Fire Insurance Company (Hong Kong) Limited - The
59. Tugu Insurance Company, Limited
60. Wing Lung Insurance Company Limited
61. Zürich Versicherungs-Gesellschaft AG
(Zurich Insurance Company Ltd)

△The authorization of this insurer to carry on insurance business in Hong Kong was withdrawn by the Insurance Authority in December 2011.