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Paper for the Panel on Health Services

Report of the Subcommittee on Health Protection Scheme

Purpose

This paper reports on the deliberations of the Subcommittee on Health Protection Scheme ("the Subcommittee").

Background

2. The Health and Medical Development Advisory Committee, chaired by the Secretary for Food and Health and tasked to develop service models for healthcare services and to propose long-term healthcare financing options, 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 healthcare service reforms and six possible supplementary healthcare financing options in the First Stage Healthcare Reform Consultation Document entitled "Your Health Your Life". Based on the outcome of the first stage consultation which revealed strong public resistance to any supplementary healthcare financing options of a mandatory nature, the Government developed possible policy options along the principle of voluntary participation.

3. 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 Health Protection Scheme ("HPS"), aiming at enhancing the long-term sustainability of the healthcare system, was proposed for public consultation. The Healthcare Reform Second Stage Public Consultation Report was released on 11 July 2011. According to the Administration, members of the public have expressed support for regulating

the private health insurance ("PHI") and healthcare services through introducing HPS to improve market transparency, promote healthy competition, and enhance consumer protection. A three-pronged action plan is adopted to take forward HPS, which includes establishing a high level Steering Committee on Strategic Review on Healthcare Manpower Planning and Professional Development ("the Steering Committee") to conduct a strategic review on healthcare manpower planning and professional development; setting up a Working Group on HPS 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 is to complete the preparatory work by the first half of 2013, and to proceed to draft and introduce HPS legislation, as appropriate. The implementation of HPS will take place in 2015 the earliest.

4. The Panel on Health Services held six meetings between December 2010 and February 2012 to discuss the proposed HPS and received views of deputations at two of the meetings. Members are gravely concerned about the impact of HPS on public healthcare services as well as the healthcare manpower for the sustainable development of both the public and private healthcare sectors. While noting that the proposed HPS may bring about improvements to the health insurance market and offer more choices of private healthcare services as an alternative to public healthcare services, members have expressed reservations and divergent views on many aspects of HPS such as the benefit coverage of the Standard Plans under HPS, incentives to encourage subscription, use of the $50 billion fiscal reserve earmarked to support healthcare reform, and the supervisory and institutional frameworks for health insurance and healthcare service markets.

The Subcommittee

5. At the Panel meeting on 8 August 2011, members agreed to appoint a Subcommittee under the Panel to study issues relating to HPS. The Subcommittee's terms of reference and membership list are in **Appendices I and II** respectively.

6. Under the chairmanship of Dr LEUNG Ka-lau, the Subcommittee held a total of six meetings. The Subcommittee decided not to invite views from deputations, as the Panel had received the views of 93 deputations at its two special meetings held on 11 December 2010 and 8 August 2011 respectively.

Deliberations of the Subcommittee

7. The Subcommittee has focused its deliberations on the following areas -

(a) manpower planning and supply for the sustainable development of the healthcare system;

(b) healthcare services development;

(c) supervisory framework for health insurance and healthcare service markets;

(d) design and operation of HPS;

(e) role of health insurance in financing healthcare services; and

(f) utilization of government subsidy.

Healthcare manpower planning and supply

Strategic review on manpower planning

8. Members note from the Administration that a strategic review on healthcare manpower planning and professional development in Hong Kong would be conducted by the Steering Committee, which would formulate recommendations on how to cope with the anticipated demand for healthcare manpower, strengthen professional training and facilitate professional development having regard to the findings of the strategic review. Members generally take the view that a comprehensive review on the demand and supply of healthcare manpower is necessary and urgently required for the sustainable development of the healthcare system. They consider that the scope of the review should cover the examination of the existing mechanism for setting the professional standards for non-locally trained doctors to practise in Hong Kong as well as the promotion of the development of allied health professionals, such as recognizing medical certificates issued by chiropractors. They also urge the Administration to take into account the manpower needs arising from the expansion of private healthcare services, development of new private hospitals, implementation of HPS and service demand from non-local people in the manpower review.

9. According to the Administration, the Steering Committee would conduct a comprehensive review on the long-term manpower needs for the overall healthcare development, and the professional development of and regulatory structure for 13 healthcare professions, such as medical practitioners,

dentists, nurses, pharmacists and chiropractors who are subject to statutory regulation. The review would take into account all known and potential factors and considerations, including the wastage trends of different healthcare professions, the healthcare needs of an ageing population, changes in healthcare service utilization pattern as well as changes in healthcare service delivery models and related policies such as development of primary care and private hospitals and the implementation of HPS. The Administration has assured members that the Steering Committee would consider both short-term and long-term measures, including the registration of non-local doctors, when making recommendations to the Government on how to ensure an adequate supply of healthcare professionals.

Manpower requirement

10. The subject of healthcare manpower supply has been high on the agenda of the Subcommittee. Members are generally of the view that the objectives of the overall healthcare reform including HPS can only be achieved if the issue of healthcare manpower is addressed fully. On a careful examination of the change in the manpower strength of the Hospital Authority ("HA") over the past 20 years, some members have noted that the increase in the number of doctors employed by HA was over 40% which exceeded the increase in the Hong Kong population (about 8%) and the proportion of the population aged 65 or above (about 32%) in the same period. They have also noted that the number of specialist outpatient attendance over the same period registered an increase of 20% only but both the number of patient days and the Accident and Emergency attendance recorded a respective decrease of 14% and 5%. These suggest a decline in demand for public healthcare services. Members have questioned why there is a shortage of doctors in public hospitals in meeting the service demand for public healthcare services.

11. Members have also noted that the number of nurses employed by HA during the same period of 1998-1999 to 2010-2011 decreased slightly. They have expressed grave concern about the imbalance of manpower between doctors and nurses and its adverse impact on the quality of public healthcare services.

12. According to the Administration, the increase in the number of doctors employed by HA cannot compensate for the increase in their workload. The annualized growth rate of doctors is about 3% only and is considered necessary in view of service growth (at an annualized rate of 2% to 3%) and a host of other factors which have an impact on the manpower situation in HA, such as an ageing population that results in more intense use of HA services by the elderly, the development of more advanced medical technologies that requires more specialist time, investigations and treatment, and the introduction of new services such as psychogeriatric outreach services that requires

additional manpower. All these factors have led to an increase in demand in the manpower of doctors.

13. As regards the concern about the shortage of nursing manpower, the Administration has advised that measures have been taken by HA to increase the supply and strengthen the retention of nurses, such as re-opening nursing schools in HA, encouraging tertiary institutions to increase student places and reducing non-clinical work handled by nurses. In the Administration's view, the increased supply of some 2 000 nurse graduates each year for the coming three years should be sufficient to meet HA's manpower demand of nursing staff in the short to medium term.

14. Some members including the Chairman are not convinced by the Administration's explanation. To better assess the situation of the pressure on the public healthcare system and the strength of medical and nursing manpower to meet the service demand arising from the expansion of the public and private healthcare services, members have urged the Administration to provide more detailed information and supporting statistics on its projection for the future medical and nursing staff requirement of HA and their deployment in meeting the service demand.

15. Many members of the Subcommittee are of the view that the implementation of HPS may further strain the healthcare manpower and aggravate medical inflation. They consider that having an adequate supply of healthcare manpower is instrumental in the sustainable development of the overall healthcare system. They urge the Administration to put in place effective measures to retain talents in HA so that the manpower needs of the private sector induced by the implementation of HPS would not lead to brain-drain from the public sector and affect the quality of public healthcare services.

16. According to the Administration, HA has implemented a series of measures to address the manpower issue in the public healthcare sector. HA has created additional promotion posts, strengthened professional training and relieved the workload of its frontline healthcare workers by re-engineering and streamlining the work processes and procedures. It has also enhanced the remuneration package for doctors and nurses and taken proactive efforts to allow greater flexibility for employment of non-local doctors with limited registration and part-time doctors. The Administration has reassured members that it would continue to monitor the manpower situation in the public healthcare sector and make suitable arrangements to cope with the service needs.

17. Some members including the Chairman have pointed out that measures to increase the supply of doctors may not be able to meet the medical manpower needs in the short term because of the long lead time to train doctors. The Chairman has expressed reservations about the proposal to further increase the supply of doctors. He has urged the Administration to look squarely at the problem, in particular the service demand on both the private and public sectors when conducting the long-term manpower planning. To address the shortage of public hospital doctors and relieve service demand on public hospitals, he suggests that the Administration should explore the feasibility of purchasing more services from the private sector and engaging more private sector doctors to practise in public hospitals on a part-time basis, given the spare capacity of manpower in the private healthcare sector.

18. According to the Administration, it has made use of the private sector's capacity to meet part of the service demand on the public sector. HA has implemented a number of public-private partnership programmes and engaged private sector doctors on a part-time basis to work in public hospitals to address the shortage of manpower in some specialties. The Administration would consider members' views and continue to examine possible public-private partnership initiatives with a view to making the best use of healthcare resources in the public and private sectors and addressing the existing imbalance between the public and private healthcare systems.

Public healthcare services

Efficiency and effectiveness of HA

19. According to the Administration, HA has employed over 60 000 staff, manages 41 public hospitals and institutions, 49 specialist outpatient clinics and 74 general outpatient clinics. Around 90% of inpatient services (in terms of the number of bed days) are provided by public hospitals. There is general recognition by members of the Subcommittee that the efficiency and effectiveness of HA are essential to the success of the overall healthcare reform including HPS. Some members hold a strong view that HA has not utilized its resources efficiently and effectively. They have cautioned that even HPS may help divert to the private healthcare sector some of the healthcare needs that would otherwise have to be met by the public healthcare system, public hospitals may perform additional services to maintain their service throughput in order to maintain their present level of resource allocation. In their view, improving the governance of HA and putting in place a system to measure the cost effectiveness of HA are instrumental in achieving a sustainable improvement in the quality of public healthcare services and relieving pressure on the public healthcare system.

20. The Administration has advised that the Government has set out HA's service targets which cover various aspects including access, delivery, quality and cost of services. HA's performance against targets is monitored by the Board of HA and the Government through regular reports. According to the Administration, the performance of HA is under close monitoring on an independent and professional basis which includes self assessment and external peer review. Measures of continuous improvement are also developed and implemented to enhance the service quality of hospitals, based on international best practices, standards and principles. HA has also in recent years introduced hospital accreditation in public hospitals as a useful measure to sustain and improve the quality of healthcare services.

21. The Administration has also stressed that HA has always attached importance to cost management so as to ensure that major resources are used on items directly related to patients. To ensure the overall efficiency of resource utilization, HA reviews regularly the performance indicators regarding its service activities, manpower, financial situation and implementation progress of its annual plans.

22. Some members including the Chairman are not satisfied with the Administration's explanation. They have urged the Administration to set out clear and relevant indicators for assessing the quality and quantity of the service throughputs of HA and provide justifications supported by detailed statistics for requiring more resources for HA to meet the service needs. They have also pointed to the need to improve the resource allocation mechanism for hospital clusters. In their view, the existing resource allocation mechanism, which is generally based on the service volume of the hospital clusters, may only encourage hospital clusters to introduce new services without catering for the needs of the local residents. They have stressed the need to have a clear and effective system for monitoring the performance of HA as well as an improved resource allocation mechanism so that resources will be targeted to prioritized areas and population groups.

Pressure on public hospitals

23. The Subcommittee has noted that over one-third of the hospital admissions of people covered by PHI still pertain to the public sector. Members are given to understand that the major reasons for people covered by PHI for choosing public healthcare services are the requirement for emergency cases and cases requiring inter-disciplinary care, avoidance of out-of-pocket payment when the insurance protection is insufficient to cover all the private hospital expenses and budget uncertainty.

24. Noting that people covered by PHI would still choose public healthcare services for various reasons, some members have expressed grave

concern that the expansion of private hospitals and the implementation of HPS may not be able to relieve pressure on public hospitals. They consider it most important to have HPS plans with sufficient benefit coverage to cover the healthcare needs of the insured in most circumstances and for the Administration to ensure that only a small fraction of more complex cases would be referred to public hospitals for treatment.

25. Referring to the experience in Australia where no reduction is seen in the public healthcare expenditure after the introduction of healthcare financing through PHI, some members have cast doubt as to whether HPS can help relieve pressure on the public healthcare system. To measure the effectiveness of HPS in easing the pressure on the public healthcare system, some members have called on the Administration to formulate a set of objective criteria to benchmark the service throughput of major public healthcare services and set a target ratio of the provision of inpatient services between the public and private healthcare sectors.

26. While stressing the Government's commitment to public healthcare to meet the increasing healthcare needs, the Administration has reiterated the need to take forward healthcare reform to enhance the long-term sustainability of the public healthcare system. HPS aims to provide more choices with better protection for those who can afford and are willing to use private healthcare services. This would in turn help relieve the demand for public healthcare services by enabling more people to choose private services and focus public healthcare on target service areas and population groups.

Private healthcare services

Demand for and capacity of private healthcare

27. Private healthcare capacity is one of the grave concerns of the Subcommittee. Many members have taken the view that the Administration's effort to promote the medical industry would result in greater service demand in the private healthcare sector, particularly from the Mainland. This would lead to greater demand for healthcare manpower, causing medical charges to spiral upwards and driving up medical inflation. This apart, the rise in medical costs may also increase premium to a level beyond the means of the middle class for using private healthcare. The whole HPS scheme may only benefit the participating insurers and private healthcare providers. Members consider that the implementation of HPS should be in tandem with an expansion in private healthcare capacity and manpower supply of healthcare professionals. They have called on the Administration to take more proactive measures to ensure an adequate supply of private hospital beds and healthcare personnel for the implementation of HPS.

28. According to the Administration, there are currently about 4 000 hospital beds in private hospitals. A significant number of additional private beds would come into stream from the new hospitals to be built on the four pieces of land earmarked for private hospital development, expansion of capacity of existing private hospitals, and conversion of existing service units run by non-governmental organizations into private hospitals. In the Administration's view, the expansion in the private healthcare capacity in the coming years should be able to meet the rise in demand arising from the implementation of HPS.

Development of new private hospitals

29. Members note that the new private hospitals to be developed at the four pieces of land earmarked for private hospital development would be required to comply with a set of special requirements for development of the sites. They consider the provision of reasonably priced private inpatient services for use by local residents most important, in particular for addressing the imbalance between the public and private sectors in hospital services. They have urged the Administration to specify in the conditions of the land grant of the new private hospitals the minimum percentage of beds or bed days for use by local residents. There is a suggestion that the minimum percentage of inpatient services for use by local residents should be set at 70% in order to ensure that the services would be offered primarily to local residents.

30. According to the Administration, the two reserved sites at Wong Chuk Hang and Tai Po would be first disposed of through open tender in April 2012. The land grant would stipulate a set of special requirements for the new private hospitals to be developed at the reserved sites covering, among others, land use, bed capacity, scope of service, price transparency, service targets and service standards. Operators of the new private hospitals would be required to provide at least 50% of their in-patient services for use by local residents.

Regulation of private hospitals

31. Members generally consider that the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap. 165) ("the Ordinance"), which is the legislation regulating private hospitals, outdated and lacking deterrent effect. They have called on the Administration to conduct a comprehensive review of the Ordinance with a view to strengthening the regulation of private hospitals, and implement measures to enhance the quality and price transparency of the services of the new private hospitals pending the conduct of the review.

32. The Administration has advised that a review on the Ordinance would be conducted to enhance service standards and price transparency of private

hospitals with a view to improving the protection for consumer rights. As it takes time to review and amend the Ordinance, a list of special requirements seeking to ensure the provision of high quality private hospital services and the meeting of the needs of the community would be imposed in the land grant for development of new private hospitals.

Supervisory framework for health insurance and healthcare service markets

33. The Subcommittee generally agrees on the need for the Administration to strengthen regulation over PHI and private healthcare services. Pointing out the many shortcomings in the PHI and private healthcare markets, including poor price transparency, escalating private medical expenses and restrictive insurance policy terms such as limited access to health insurance by high-risk individuals, members have stressed the need for the Administration to address these shortcomings with or without the implementation of HPS. While expressing support for stepping up regulation and supervision of PHI and private healthcare markets, some members have cautioned against excessive regulation, as it may discourage insurers or private healthcare providers from participating in HPS.

34. The Subcommittee also notes that the supervisory framework for HPS is proposed to comprise three separate but inter-related components, namely, prudential regulation, quality assurance and scheme supervision. The first two components of the HPS supervisory framework are proposed to rely on the existing regulatory regime, that is, the Office of the Commissioner of Insurance to supervise the financial soundness of insurers participating in HPS and to oversee complaint handling mechanisms applicable to insurance in general, whereas the Department of Health to assume the role of quality assurance for private hospitals. The regulation of healthcare professionals is proposed to rest with the relevant statutory boards and councils. As for the third component of the supervisory framework, the Subcommittee notes that a new dedicated HPS authority and an independent dispute and arbitration mechanism for HPS are proposed to be established to supervise the implementation and operation of HPS and handle disputes over health insurance claims respectively. While members in general do not object to such a proposal, there is a suggestion that the new dedicated HPS authority should also deal with complaints in relation to any aspect of PHI, not just relating to HPS. Some members also suggest that a clear delineation of the supervisory, regulatory and administrative roles and relationship among different components in the regulatory framework should be reflected in the legislative and institutional setup for HPS.

35. Members have also expressed concern about how the proposed regulatory framework for HPS would ensure that the services provided by private hospitals and doctors would be guided by the patients' best interests and based on the clinical need for treatment. They consider an effective

mechanism governing the conduct of doctors and handling disputes among doctors, patients and insurance companies crucial to the success of HPS. In their view, establishing public confidence in the regulatory framework for HPS would encourage the uptake of PHI.

36. Members are also concerned about the affordability of private healthcare services in particular after the implementation of HPS as some private healthcare service providers may be interested in promoting expensive drugs, tests and treatment for patients covered by PHI. They have pointed to the need to increase competition and transparency of the private healthcare market.

37. The Administration has reiterated that one major objective of HPS is to increase competition and transparency of PHI. To this end, participating insurers are required to abide by rules and requirements specified under HPS for the purposes of ensuring market competition, price transparency, quality assurance and consumer protection. The Administration also agrees that an independent and credible arbitration mechanism to handle disputes over health insurance claims and arbitrate disagreements among patients, health insurance companies and private healthcare providers over such claims is important for safeguarding consumer interests. To this end, participating insurers and private healthcare providers who are providing services to the insured under HPS are required to participate in this mechanism. To avoid unnecessary duplications with existing regulatory regimes that are well-established and have proved to work well, the function of the regulation of healthcare professionals is proposed to be continued to rest with the relevant statutory boards and councils. A consultant will be appointed shortly to study carefully these issues and to formulate a detailed design for HPS and the arbitration mechanism.

Design and operation of HPS

Cap on administrative costs, commission and profits

38. Members have discussed the need to impose a cap on the administrative costs, commission and profits on the insurance companies participating in HPS. Some members have made reference to the experience of the United States in controlling costs and profits of insurance companies. In the United States, health insurance companies are required by law to spend at least 80% or 85% of premium revenue on medical care (known as the medical loss ratio). This would prevent insurance companies from spending a substantial portion of premium revenue on administrative costs, commission and profits. These members urge the Administration to give consideration to imposing similarly a minimum medical loss ratio, say 85%, on participating insurers. Some members however hold a different view. Pointing out that there are over 130 insurance companies operating in Hong Kong and about 20

to 30 of them may be interested in offering health insurance, these members consider that the competition in the insurance market should be able to keep the prices in check. Noting that about 85% of premium goes to medical care, they also propose that consideration be given to regulating the charges of private hospitals and doctors in order to control medical costs.

39. According to the Administration, there is currently no regulation on the setting of premium level. The setting of premium level and its adjustment are left entirely to market forces. In the Administration's view, coupled with an effective mechanism to ensure market competition, market forces would be the best tool to ensure that the premium level and future adjustment would remain competitive. Notwithstanding this, the Administration is open-minded on the mechanism for setting and adjustment of premium level for HPS plans. To assist the formulation of a detailed design for the implementation of HPS, a consultant will be appointed shortly to perform a comprehensive review and analysis of the current market situation of PHI as well as conduct research on PHI markets in overseas jurisdictions.

Moral hazard and adverse selection

40. During the discussion on the design of HPS, members urge the Administration to be mindful of the pitfalls of moral hazard and adverse selection. Members note that generally speaking, moral hazard is the tendency of people engaging in undesirable behaviour when imperfectly monitored such as adopting a less healthy lifestyle, whereas in adverse selection, high risks individuals are more likely to buy insurance. Both problems may lead to higher medical claim, which in turn will drive up premium. To avoid these problems, members have expressed support for co-payments, deductibles and no claim discounts.

Packaged charging

41. Members note that in the existing private healthcare market, healthcare providers usually charge on an itemized basis based on actual utilization of the service items in individual cases and fees are charged separately by individual doctors and hospitals. Under such arrangements, patients bear the risk of cost uncertainty and may need to pay an extra amount unknown and unforeseen in advance when the actual charges due to utilization and other unpredictable circumstances exceed the benefit limits of individual items or the overall limits. According to the Administration, one possible solution to address cost uncertainty is to introduce packaged charging for specific treatments or procedures categorized by "diagnosis-related groups" ("DRG-based packaged charging").

42. While many members of the Subcommittee take the view that the introduction of DRG-based packaged charging to address the problem of cost uncertainty is in the right direction, they consider that the issue of DRG-based packaged charging warrants further study. DRG-based packaged charging aims to provide cost transparency and certainty to users, whereby patients requiring specific treatment or procedures will know in advance the medical charges involved, and whether their insurance would be able to cover the charges in full or out-of-pocket payment would be required. The Subcommittee however notes from the Administration's proposal that DRG-based packaged charging under HPS will act as a claims reference only. It aims to provide a reference for participating insurers and the insured for comparison of medical costs and charges for the specific treatment or procedures, and provide benchmarking and monitoring of healthcare costs.

43. There is a view that to safeguard consumers' interests and address the problem of cost uncertainty, DRG-based packaged charging should be adopted as a price reference rather than a claims reference. As increasing price transparency on the private healthcare market is of paramount importance, the Administration should step up efforts to persuade private hospitals and healthcare providers to set their medical charges with reference to DRG-based packaged charging. Consideration should also be given to separating the fees charged by individual doctors and hospitals from the lump-sum charges to encourage more independent private doctors to participate in HPS.

44. The Administration has stressed that DRG-based packaged charging can provide greater transparency on medical charges and insurance claims. It can also help create and promote healthy competition in private healthcare services. As the concept of DRG-based packaged charging is still new to Hong Kong and people need time to understand the concept and benefits of DRG-based packaged charging, it is hoped that with time, private hospitals and healthcare providers would be more willing to set their charges with reference to DRG-based packaged charging.

45. Noting that the coverage of DRG-based packaged charging may only apply to about 30% of hospital admissions or ambulatory procedures, some members have expressed grave concern about the arrangements for payment of claims under HPS for those treatment and procedures where no DRG-based packaged charging is available. In order to avoid confusion among the insured, participating insurers and private hospitals, members have urged the Administration to set out clearly the reimbursement arrangements under HPS, irrespective of whether DRG-based packaged charging is available.

46. According to the Administration, HPS plans would set reimbursement levels for common treatment or procedures based on DRG so as to promote packaged charging for common procedures or treatment in the private

healthcare sector. If the packaged price offered by private healthcare providers is above the packaged benefit limit under the HPS plans, co-payment by the insured for the excess would be necessary. Where the insured chooses a provider that charges on an itemized basis for a treatment/procedure covered by packaged benefit limit under the HPS plans, the insurer would reimburse the insured up to the packaged benefit limit. HPS plans would still need to offer itemized benefit schedules to cater for medical conditions where no private healthcare provider offers packaged charging. In such cases, the HPS plans will provide reimbursement in the same way as with existing health insurance products.

47. Members have also discussed the scope of services to be covered by the packaged charging under HPS plans. In their view, the package should set out clearly items and services to be included and excluded based on a normal low-risk condition. Any extra services provided for the high-risk patients should be charged on a need basis to avoid driving up the premium.

Premium setting

48. The setting of premium level is of grave concern to members. In particular, members have expressed concern about the affordability of premium for the low risk and high risk individuals. They consider the illustrative premium levels neither reasonable nor attractive for people to join HPS. Since HPS is a voluntary scheme, many members have expressed worry on the financial viability of HPS if it cannot achieve a sizeable take-up. Some members are also worried that high risk individuals including the elderly may be priced out of HPS. To better assess the financial viability and sustainability of HPS, members urge the Administration to include in the comprehensive review a detailed projection on the number of people joining HPS with breakdowns by age and risk level.

49. Members have also expressed grave concern about the control over future adjustment of premium. They are skeptical of the continued affordability of premium for high risk individuals, if the setting and adjustment of the premium are left entirely to market forces.

50. According to the Administration, the insurance market is competitive with over 100 insurance companies operating in it. The barriers to entry in the insurance market are considered low, too. Since HPS will be designed to increase transparency in the insurance market such as requiring participating insurers to be transparent in insurance costs including claims, administrative expenses and commission, this will help secure public confidence in HPS and in turn attract more people to join HPS and stay insured. If the market is profitable, new firms may enter, thus pushing down the premium.

Risk pooling

51. Members note that one of the objectives of HPS is to better protect the high-risk groups by enabling them to gain access to health insurance coverage. As a higher risk would also translate into a higher premium, in order to ensure the financial viability of HPS, a high-risk pool will be introduced to share out the risk. Many members have cast doubt on the financial viability of this risk pooling for it may only aggravate adverse selection, undermine the risk pooling effect and make HPS unsustainable. In their view, the proposed high-risk pool may not be sufficient to deal with the excess risk of high-risk individuals, and require long-term financial commitment by the Government to support the operation of the high-risk pool. They suggest that the consultant to be appointed to conduct the comprehensive review should examine carefully the financial viability of the high-risk pool.

52. According to the Administration, if the high-risk pool is not separated from the normal risk pool in operation, the number of claims will increase, triggering further increases in the premium. The rising claims and escalating premium may also discourage the young and healthy from joining HPS and undermine the financial viability of HPS. Nevertheless, the Administration has noted members' concerns and will ask the consultant to examine carefully the implications of the key features of HPS such as coverage of pre-existing conditions and access of high-risk groups to the premium level of the standard HPS plans.

Incentives for joining HPS

53. Many members of the Subcommittee consider that the provision of a tax deduction for HPS premium would be an effective incentive to encourage the uptake of HPS plans. They have urged the Administration to consider providing a tax deduction for HPS premium. In the Administration's view, different financial incentives may bring about different effects. No-claims discount and premium discount for new joiners may also be direct and attractive incentives for joining HPS. This notwithstanding, the Administration is open-minded on the offering of a tax deduction for HPS premium.

<u>Health insurance in financing healthcare services</u>

54. The Subcommittee has noted that the overall share of PHI in healthcare financing is around one eighth only and more than one-third of people covered by PHI still choose public healthcare services. In this regard, members have expressed grave concern about the heavy reliance on public healthcare services and the disproportionate share of PHI in healthcare financing. Some members have urged the Administration to set a target ratio for the share of PHI in healthcare financing after the implementation of HPS.

55. Some members have cautioned that income protection insurance plans such as critical illness cover and hospital cash may provide the insured with an incentive to choose public healthcare services. They urge the Administration to carry out more detailed studies on the utilization of healthcare services by people covered by PHI as well as the coverage of the health insurance plans provided to these people in order to better assess the impact of different types of insurance on public and private healthcare services.

Utilization of government subsidy

56. Members have discussed in depth the Administration's proposal of utilizing the $50 billion fiscal reserve earmarked to support the implementation of HPS. Many members have expressed a very strong view that it would be more cost effective to use the $50 billion fiscal reserve on the public healthcare system, instead of using it to support the uptake of PHI. In their view, the total cost of implementing HPS is more than the $50 billion fiscal reserve if premiums paid by individuals for subscription to HPS are also included. In this regard, they are skeptical of the cost-effectiveness of investing such a large sum of money on PHI. They have also cast doubt on whether HPS can relieve pressure on the public healthcare system, as the insured may continue to utilize the public system, in particular for the more expensive medical services.

57. Some members have also expressed grave concern about using public money to subsidize the uptake of PHI, as any such subsidies may benefit the private insurers and healthcare providers more than the insured themselves. They have urged the Administration to provide more information for substantiating its claim that the use of the $50 billion fiscal reserve would benefit the insured, in particular the high-risk people.

58. Some members have pointed out that the provision of government subsidy for PHI and private healthcare may only spiral medical costs and aggravate medical inflation. They have also questioned the financial viability of the high-risk pool which may require a continued injection from the Government after the $50 billion fiscal reserve has been exhausted. They have asked the Administration to provide information to demonstrate the cost effectiveness of utilizing government subsidy to support the implementation of HPS.

59. The Administration has stressed that the Government would not reduce its commitment to public healthcare services. It would continue to uphold the public healthcare system as an equitable and accessible safety net for the population as a whole. In considering the option of utilizing public funding for HPS, the Administration has taken into consideration whether the use of public funding could facilitate the achievement of the policy objectives of HPS, be conducive to the long-term sustainability of HPS, enhance the

protection of consumers' rights, and benefit the insured and the community at large. Taking into account members' views, the Administration will direct the consultant to be appointed to analyse and examine the necessity, feasibility and effect of various options of utilizing public funding to facilitate the implementation of HPS.

60. Pointing out that one of the objectives of HPS is to address the shortcomings of the current PHI and private healthcare markets, the Chairman considers that using legislative means to address the shortcomings of the markets may be more effective. For example, insurance companies may be required by law to introduce features such as no turn-away of subscribers, guaranteed renewal for life and covering pre-existing conditions. He has sought the view of the Administration on the feasibility of using legislative means to achieve the objectives of HPS.

61. According to the Administration, without government subsidy to support the implementation of HPS, the premium set by the insurance companies may be excessively high and may not be affordable to most people. A health insurance scheme providing additional coverage and protection will incur a higher level of risk. If all the risks are fully reflected in the scheme, the higher premium will discourage the young and healthy from joining it, which will further reduce the risk pool and push up the premium level. The Administration has stressed that the utilization of the $50 billion fiscal reserve is to address the risk pool issue, maintain the premium at an affordable level and provide incentives for the young and healthy to join early so as to ensure the long-term sustainability of the scheme.

Implementation of HPS

62. Some members have expressed grave concern about whether the next term Government would continue with the implementation of HPS, having regard to the differences in policy inclination between the incumbent Administration and the Chief Executive-elect on issues such as development of private hospitals and the provision of local obstetric services to Mainland pregnant women. They have expressed worry that the next term Government may not accord the same priority to the implementation of HPS as the incumbent Administration.

63. The Administration has stressed that the first stage public consultation has reflected a broad community consensus to take forward the healthcare service reform to meet the challenges of the ageing population and rising medical costs. While there is still room for improving and refining the next stage of the healthcare reform by the next term Government, the incumbent Administration considers the current preparatory work for the introduction of HPS, such as the comprehensive review on the current market situation of PHI,

manpower planning and options of utilizing public funding to support the healthcare reform, necessary and important for the next term Government to map out the way forward for the healthcare reform.

Recommendations

64. The Subcommittee recommends that the Administration should -

in respect of the strategic review on manpower planning

(a) examine the existing mechanism for setting the professional standards for non-locally trained doctors to practise in Hong Kong as well as the promotion of the development of allied health professionals;

(b) take into account the manpower needs arising from the expansion of private healthcare services, development of new private hospitals, implementation of HPS and service demand from non-local people;

(c) put in place effective measures to retain medical and nursing staff of HA;

(d) explore the feasibility of purchasing more services from the private sector and engage private sector doctors to practise in public hospitals on a part-time basis;

in respect of public healthcare services

(e) put in place an effective mechanism for monitoring the cost effectiveness of services provided by HA, including setting out clear and relevant indicators for assessing the quality and quantity of the service throughput of HA;

(f) improve the resource allocation mechanism for hospital clusters of HA so that resources will be targeted to prioritized areas and population groups;

(g) set a target ratio between the provision of inpatient services by the public and private healthcare sectors to measure the effectiveness of HPS in easing pressure on the public healthcare system;

in respect of private healthcare services

(h) take proactive measures to ensure an adequate supply of private hospital beds and healthcare personnel for the implementation of HPS;

(i) specify in the land grant for development of new private hospitals the provision of reasonably priced private inpatient services for use by local residents;

(j) conduct a comprehensive review of the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance with a view to strengthening the regulation of private hospitals;

(k) implement measures to enhance the quality and price transparency of the services of the new private hospitals pending the conduct of the review of the Ordinance;

in respect of the supervisory framework for HPS

(l) take proactive measures to address the shortcomings of the PHI market;

(m) extend the function of the new independent and credible dispute mechanism to deal with complaints in relation to any aspect of PHI, not just HPS;

(n) delineate clearly the supervisory, regulatory and administrative roles and relationship among different components in the regulatory framework for HPS;

in respect of the design of HPS

(o) give consideration to imposing a cap, say 15%, on the administrative costs, commission and profits on the insurance companies participating in HPS;

(p) give consideration to separating the fees charged by individual doctors and hospitals from the lump-sum charges to encourage more independent private doctors to participate in HPS;

(q) set out clearly in the packaged charging items and services to be included and excluded based on a normal low-risk condition;

(r) set out clearly the reimbursement arrangements under HPS irrespective of whether DRG-based packaged charging is available;

(s) provide a sufficient benefit coverage to cover the healthcare needs of the insured in most circumstances;

(t) examine carefully the financial viability of the high-risk pool;

(u) consider providing a tax deduction for HPS premium;

<u>in respect of PHI</u>

(v) carry out more detailed studies on the utilization of healthcare services by people covered by PHI, the coverage of the health insurance plans provided to these people and the projection on the number of people joining HPS with breakdowns by age and risk level in order to facilitate the development of detailed proposals for HPS;

(w) set a target ratio for the share of PHI in healthcare financing after the implementation of HPS;

<u>in respect of the utilization of government subsidy</u>

(x) provide more information and justifications for supporting the utilization of government subsidy for the implementation of HPS; and

<u>in respect of the implementation of HPS</u>

(y) report to the Panel on the outcomes of the reviews and the consultancy studies as well as the implementation progress of HPS at regular intervals after the conclusion of the Subcommittee's work.

65. The Subcommittee also recommends that the Panel should follow up the above issues with the Administration in the next legislative term and appoint a subcommittee to assist its monitoring work in this regard if necessary. In addition, stakeholders and members of the public should be invited to give views on the subject to the Panel or the subcommittee if so appointed in the Fifth Legislative Council.

Advice sought

66. Members are invited to note the deliberations of the Subcommittee and support its recommendations.

Council Business Division 2
Legislative Council Secretariat
4 July 2012

Appendix I

Panel on Health Services

Subcommittee on Health Protection Scheme

Terms of reference

To study issues relating to the introduction of the Health Protection Scheme as proposed by the Government for the second stage public consultation on healthcare reform and make recommendations where necessary.

Appendix II

Panel on Health Services

Subcommittee on Health Protection Scheme

Membership list

Chairman	Dr Hon LEUNG Ka-lau
Members	Hon CHEUNG Man-kwong Hon LI Fung-ying, SBS, JP Hon Audrey EU Yuet-mee, SC, JP Dr Hon Joseph LEE Kok-long, SBS, JP Hon Cyd HO Sau-lan Hon CHAN Hak-kan Hon CHAN Kin-por, JP Dr Hon PAN Pey-chyou Hon Alan LEONG Kah-kit, SC Total : 10 Members
Clerk	Ms Elyssa WONG
Legal Adviser	Miss Evelyn LEE