立法會
Legislative Council

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Panel on Health Services

Subcommittee on Health Protection Scheme

Minutes of the third meeting held on Monday, 4 March 2013, at 10:45 am in Conference Room 2A of the Legislative Council Complex

Members present	:	Dr Hon LEUNG Ka-lau (Chairman) Dr Hon Joseph LEE Kok-long, SBS, JP Hon CHAN Kin-por, BBS, JP Hon CHEUNG Kwok-che Dr Hon KWOK Ka-ki
Members absent	:	Hon Mrs Regina IP LAU Suk-yee, GBS, JP Hon CHAN Han-pan Hon Alice MAK Mei-kuen, JP
Public Officers attending	:	Mr Richard YUEN Ming-fai, JP Permanent Secretary for Food and Health (Health) Food and Health Bureau Mr Chris SUN Yuk-han, JP Head, Healthcare Planning and Development Office Food and Health Bureau Dr Amy CHIU Pui-yin, JP Assistant Director of Health (Health Administration & Planning) Department of Health

Dr W L CHEUNG
Director (Cluster Services)
Hospital Authority

Ms Eva TSUI
Chief Manager (Statistics & Workforce Planning)
Hospital Authority

Clerk in attendance : Ms Elyssa WONG
Chief Council Secretary (2)5

Staff in attendance : Ms Maisie LAM
Senior Council Secretary (2)5

Ms Michelle LEE
Legislative Assistant (2)5

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I. Matters arising
(LC Paper Nos. CB(2)689/12-13(01) to (02), CB(2)2011/11-12(01) and CB(2)2690/11-12(01))

The Subcommittee deliberated (index of proceedings attached at **Annex**).

Government intervention in the private health insurance market

2. The Chairman noted that in Australia, each insurer was required to charge all its customers regardless of age and health risks a flat premium for the same private health insurance ("PHI") product, albeit that the taking out of PHI was on a voluntary basis. Referring to the view expressed by the Administration on previous occasions that it was difficult to do so in the case of a non-mandatory PHI as this would aggravate adverse selection, he sought explanation on why the Australian government was able to impose the requirement.

3. The Administration advised that community-rated premium in Australia was a notable case. To ensure that people with high health risks could gain access to PHI protection, insurers in Australia were prohibited from selecting customers. In addition, PHI premium was community-rated by law in order to prevent insurers avoiding the guaranteed issue requirement by using prohibitive premium loading to drive away high-risk enrolees. Increases in the community-rated premium rates of PHI products had to be approved by the Commonwealth Department of Health and Ageing in advance. Because of the guaranteed issue

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requirement and community-rating of insurance premium, an insurer might have a relatively older and less healthy customer profile compared with its competitors. To enable level playing and maintain financial viability of the PHI funds, a risk equalization system administered by the Private Health Insurance Administration Council was put in place to transfer and share costs across all insurers according to their risk profiles, i.e. transferring payment from those with lower-than-average risk exposure to those with higher-than-average risk exposure. The Australian government also adopted a "carrot-and-stick" approach, which required substantial premium subsidy on the carrot part, to encourage PHI take-out particularly among the younger population. On the other hand, under its Lifetime Health Cover programme, a person starting to take out a hospital plan after age 30 would be charged a loading in addition to the base rate premium. The loading was 2% for each year a person delayed joining after age 30, subject to a ceiling of 70%. The loading would be removed after 10 years of membership.

4. Pointing out that many existing PHI policies in Hong Kong had been available in the market for quite some years, Mr CHAN Kin-por urged the Administration to take into account the local conditions and not to follow the Australian government's approach to actively intervene in the PHI market when introducing the Health Protection Scheme ("HPS") in Hong Kong.

5. The Administration advised that HPS was proposed as a standardized and regulated framework for health insurance under its aegis for consumer protection. Reference would be made to the benefit coverage of the PHI plans currently available in the market when designing the HPS plans. While insurers participating in HPS would be required to offer standardized health insurance plans that fully complied with the core requirements and specifications, they were free to design their own health insurance plans offering top-up benefits or integrating add-on components over and above the standard plans. A high-risk pool ("HRP") would be set up under HPS as a reinsurance mechanism to absorb the excess risk arising from the participation of high-risk individuals. The proposed HRP would be financed by the premium income of the policies of high-risk individuals. Subject to the findings from the consultancy study on HPS, injection from Government into HRP would be considered as necessary.

Manpower requirement for doctors in the Hospital Authority

6. The Chairman sought explanation on the difference between the calculation of the projected manpower requirement for doctors for the clinical oncology, accident and emergency ("A&E"), anaesthesiology and pathology specialties of the Hospital Authority ("HA") and that of other specialties as set out in LC Paper No. CB(2)698/12-13(02). HA explained that the manpower requirement

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projection exercise for doctors for 2016, 2021 and 2026 was conducted in 2010 using 2008 as the base year. The process included, among others, a detailed work profile analysis to identify the workload in different areas in a number of specialties of the medical grade and to specify parameters on the average duration and manpower required under the projection model set out in paragraph 5 of Annex A to LC Paper No. CB(2)2011/11-12(01). As regards the clinical oncology, A&E, anaesthesiology and pathology specialties, the manpower requirement was estimated based on the projected service workload using the parameters set out in paragraph 2 of Annex A to LC Paper No. CB(2)2011/11-12(01), as the doctor work profiles and the time required for each unit of work of these specialties had yet been developed at that time. It was expected that for the next manpower requirement projection exercise, the time requirement for these doctors in carrying out the workload would be available.

7. The Chairman noted with concern that while there would be an around 29% increase in the projected services workload of the A&E services in 2016 (i.e. from 2 115 600 in 2008 to 2 727 400 in 2016), it was estimated that there needed to be an around 37% increase in manpower requirement for doctors of this specialty (i.e. from 434 in 2008 to 596 in 2016). HA explained that apart from taking into account the service demand projection based on population growth and ageing after having adjusted for the age-sex-specific utilization rate per capita in the baseline year, it had also factored in other specific factors that would impact on doctor workload, such as the opening of additional Emergency Medicine Wards. At the request of the Chairman, HA agreed to provide after the meeting information on all the other factors it had taken into account, if any, when projecting the manpower requirement for doctors for the A&E specialty.

Admin/ HA

8. Dr KWOK Ka-ki considered it unacceptable that the projection parameter on the average outpatient consultation time for mental patients was set as nine to 10 minutes per attendance or visit. HA advised that a key assumption of the existing base case scenario projection model was that it would use the time used by doctors in carrying out the tasks for each type of workload in the baseline year (i.e. 2008 in this case) to project the future manpower requirement. HA would however take into account the factor of standard of quality care in the future rounds of doctor manpower requirement projection which would be updated every two to three years. While agreeing that there were rooms for improvement in the time used by doctors in carrying out the tasks for each type of workload, say, the average consultation time for mental patients, HA advised that improvement could only be made in a gradual manner given its current medical manpower constraint. Holding the view that manpower adequacy had a direct impact on the delivery of quality care, Dr KWOK Ka-ki urged HA to include the factor of standard of care into the medical manpower projection model. Mr CHEUNG Kwok-che requested HA to provide information on its

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phased target for improving the time used by doctors in carrying out the tasks for each type of workload, so as to facilitate members' consideration on measures that should be put in place to increase the future medical manpower supply in order to meet the requirement for each specialty. HA responded that it would not be able to provide the information at this stage, as the setting out of the priority improvement areas and the resources required for achieving the targets would entail thorough discussion by the respective clinical specialty committees.

9. On the outpatient consultation time for mental patients, HA clarified that while the consultation time of follow-up outpatient consultation was around nine to 10 minutes, as a general practice, there were about 45 to 60 minutes of consultation for each new case. The Chairman sought elaboration about the data used for working out the projection parameters on the average time required for doctors in carrying out the tasks for each type of workload. For instance, whether the outpatient consultation time for mental patients could be broken down by type of cases (i.e. new and follow-up cases). HA explained that it would be difficult to break down the tasks for each type of workload into a very large number of small items. Only those figures that would significantly impact on the medical manpower requirement would be factored in. On the outpatient consultation time for mental patients, the consultation time for new cases had not been separated from that for follow-up cases in the calculation as new cases only accounted for 4% of the annual attendances. The Chairman requested HA

HA

to provide the following information after the meeting -

(a) the respective breakdown, where applicable, of each individual projection parameter on the average time required for doctors in carrying out the tasks for each type of workload; and

(b) the appropriate measures of central tendency and variability together with the exact average values for each individual projection parameter in the calculation for deriving the projection results of the specialty-based manpower requirement for doctors as set out in Table 2 of Annex A to LC Paper No. CB(2)2011/11-12(01).

10. Referring to HA's concern about the shortage of medical manpower in the public healthcare sector, the Chairman pointed out that many servicing doctors of HA were willing to work longer hours given the provision of due compensation of overtime hours. He cited the relatively shorter annual average working hours per doctor (net of lunch hours) of the psychiatric specialty (i.e. 1 650 to 1 900 hours for the psychiatric specialty versus 2 330 to 2 540 hours for a majority of other specialties) as an example to illustrate that inviting servicing doctors to undertake overtime work with the grant of overtime

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allowance could immediately relieve the problem of medical manpower shortage. The Administration responded that from the policy perspective, the terms of employment had to take into account, among others, the factor of employees' quality of life. Hence, the proposed arrangement could only be a short term measure for providing greater labour flexibility. At present, measures such as employment of part-time doctors and non-local doctors under limited registration had been put in place by HA to strengthen its workforce. HA supplemented that a special honorarium scheme had been introduced to incentivize A&E doctors to work extra sessions for the A&E Departments. Pointing out that there was a surplus medical manpower in the private sector but a medial manpower shortfall in the public sector, the Chairman opined that HA should regularize the employment of part-time doctors to cater for fluctuations in its full-time medical workforce strength. This could also serve as an indicator on medical manpower needs. When the proportion of part-time doctors required accounted for a prescribed percentage, say, 10%, of HA's medical manpower requirement, there was a need to increase supply of doctors in the long term.

II. Healthcare manpower planning

(LC Paper No. CB(2)689/12-13(03))

11. Members expressed disappointment about the lack of concrete details of the respective studies conducted by the University of Hong Kong ("HKU") and the Chinese University of Hong Kong ("CUHK") on the manpower demand for healthcare professionals from the 13 disciplines that were subject to statutory regulation, and the local and overseas regulatory frameworks governing healthcare professionals. On the assessment of healthcare manpower needs, the Chairman remarked that the assessment should take into account the potential decrease in demand for public healthcare services after the implementation of HPS. Dr KWOK Ka-ki said that it was worthy to note that some healthcare professionals, in particular occupational therapists, physiotherapists and nurses, would work in hospital as well as other settings (such as residential care homes for the elderly or people with disabilities). There might also be a change in the model of care, and hence the demand for these professionals, in the face of an ageing population. In addition, the increase in the number of registered Chinese medicine practitioners who were degree holders, as well as the increasing role of Chinese medicine in primary care, should be factors that had to be taken into account in projecting the demand for medical practitioners. He urged the Administration to give due consideration to these factors when formulating the projection on healthcare manpower demand.

12. The Administration responded that the strategic review on healthcare manpower planning and professional development in Hong Kong was now

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progressing in full swing. In respect of the HKU study, it should be noted that healthcare workforce planning was an extremely complex mission and there was no universal model for estimating healthcare manpower whether in the literature or among the jurisdictions surveyed. Bearing in mind the challenges of healthcare manpower projection, HKU was in the process of developing a generic forecasting model that suited the local circumstances and was adaptable to changing parameters as far as possible. The model sought to capture the relevant factors and parameters and estimate the demand and supply of healthcare professionals for the relevant disciplines with an initial planning horizon of 15 to 20 years. The Chairman suggested and members agreed that the Administration should revert to the Subcommittee on the generic forecasting model to be developed by HKU, as well as the comparative review conducted by CUHK, in about two months' time. To facilitate members' discussion on the model to be developed by HKU, the Chairman requested the Administration to provide after the meeting details of the major available models for estimating healthcare manpower. The Administration agreed.

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III. Date of next meeting

13. Noting that the Administration needed more time to draw up the details of the proposed institutional framework for the governance and operation of HPS, which was originally scheduled for discussion on 22 April 2013, the Chairman advised that the Clerk would liaise with the Administration on the appropriate timing for the discussion of the subject.

(*Post-meeting note:* At the request of the Administration and with the concurrence of the Chairman, the next meeting was scheduled for 4 June 2013 at 2:30 pm to discuss the design of private health insurance policies regulated under HPS and the institutional framework for the governance and operation of HPS.)

14. There being no other business, the meeting ended at 12:33 pm.

Council Business Division 2
Legislative Council Secretariat
3 June 2013

Annex

Proceedings of the third meeting of the Subcommittee on Health Protection Scheme on Monday, 4 March 2013, at 10:45 am in Conference Room 2A of the Legislative Council Complex

Time marker	Speaker	Subject	Action Required
000846 - 000952	Chairman Admin	Opening remarks	
Agenda item I: Matters arising *Agenda item II: Healthcare manpower planning*			
000953 - 001450	Chairman Admin	Briefing by the Administration on the progress of the strategic review on healthcare manpower planning and professional development [LC Paper No. CB(2)698/12-13(03)]	
001451 - 001942	Chairman Admin Mr CHEUNG Kwok-che	The Administration's undertaking to - (a) revert to the Subcommittee on the generic forecasting model to be developed by the University of Hong Kong on the manpower needs of the 13 healthcare disciplines, and the review conducted by the Chinese University of Hong Kong on the regulatory frameworks of the healthcare professions in about two months' time; and (b) provide details of the major available models for estimating healthcare manpower.	**Admin**
001943 - 002533	Chairman Admin	Briefing by the Administration on the synopsis on private health insurance ("PHI") in Australia [LC Paper No. CB(2)698/12-13(01)]	
002534 - 003236	Mr CHAN Kin-por Admin	Mr CHAN Kin-por's view that the Administration should take into account the local conditions and not to follow the Australian government's approach to actively intervene in the PHI market when introducing the Health Protection Scheme ("HPS") in Hong Kong. The Administration's elaboration of the community rating requirement and the risk equalization system adopted in Australia; and its advice that it would make reference to the benefit coverage of the PHI plans currently available in the market when formulating the detailed design and arrangements for HPS. Injection from Government into the high-risk pool ("HRP") to be set up under HPS would be considered as necessary. In response to Mr CHAN Kin-por's enquiry about the absence of information on the amount of	

Time marker	Speaker	Subject	Action Required
		commission expenses in Table 2 of LC Paper No. CB(2)698/12-13(01), the Administration's advice that commission expenses had been included in the category of management expenses.	
003237 - 003610	Chairman Mr CHAN Kin-por Admin	In response to Mr CHAN Kin-por's enquiry about the timetable for finalizing the proposed design of PHI policies to be regulated under HPS, the Administration's advice that it would be able to brief the Subcommittee on the subject in May or June 2013. On issues that consensus with the insurance industry had yet been reached by then, the respective views of the Administration and the industry would be provided for members' consideration. The clerk to liaise with the Administration on the appropriate timing for discussion of the proposed institutional framework for the governance and operation of HPS, which was originally scheduled for discussion on 22 April 2013.	**Admin/ Clerk**
003611 - 003904	Chairman Admin	The Chairman's enquiry on the reasons why the Australian government was able to impose the requirement of community rating of insurance premium, albeit that the taking out of PHI was on a voluntary basis. The Administration's elaboration on the financial and regulatory measures introduced by the Australian government to ensure affordability and value of a PHI as a product, and enhance access of the insured population to private healthcare. These included, among others, the community rating requirement, the risk equalization system, and the "carrot-and-stick" approach to encourage PHI take-out.	
003905 - 005230	Chairman Admin	In response to the Chairman, the explanation of the Hospital Authority ("HA") on the different approach it adopted in calculating the projected manpower requirement for doctors for the clinical oncology, accident and emergency, anaesthesiology and pathology specialties and that of other specialties. HA's undertaking to provide after the meeting information on all the other factors it had taken into account, if any, when projecting the manpower requirement for doctors for the A&E specialty.	**Admin/ HA**
005231 - 010304	Chairman Dr KWOK Ka-ki Admin	Dr KWOK Ka-ki's view that it was unacceptable that the projection parameter on the average outpatient consultation time for mental patients was set as nine to 10 minutes per attendance or	

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		visit, which was far less than that of other places such as Australia and the United States where the average consultation time for new cases and follow-up cases was about 60 minutes and no less than 30 minutes respectively. HA's clarification that there were about 45 to 60 minutes of consultation for each new outpatient cases of the psychiatric specialty; and its advice on the key assumption of the existing base case scenario model, which included, among others, the adoption of the time used by doctors in carrying out the tasks for each type of workload in the baseline year to project the future manpower requirement, without factoring in the standard of quality care. On Dr KWOK Ka-ki's call that the factor of standard of care should be incorporated into the medical manpower projection model, HA's advice that subject to manpower availability and its discussion outcomes with the respective clinical specialty committees, improvement in the time used by doctors in carrying out the tasks for each type of workload could be made in a gradual manner. In response to Dr KWOK Ka-ki's enquiry about the average consultation time of the Family Medicine Specialty's general outpatient clinics, HA's advice that the average consultation time was seven minutes.	
010305 - 011546	Chairman Mr CHEUNG Kwok-che Admin	Mr CHEUNG Kwok-che's enquiry about HA's phased target for improving the time used by doctors in carrying out the tasks for each type of workload, which was necessary in order to map out the medical manpower needs for each specialty; and the calculation of the projection manpower requirement for doctors in HA as set out in LC Paper No. CB(2)698/12-13(02). HA's advice that the setting out of the priority improvement areas and the resources required for achieving the targets would entail thorough discussion by the respective clinical specialty committees; and citing the psychiatric specialty as an example, its explanation of how the projection results set out in Table 6 of LC Paper No. CB(2)698/12-13(02) were derived.	
011547 - 012259	Chairman Admin	The Chairman requested HA to provide the following information after the meeting - (a) the respective breakdown, where applicable,	**Admin/ HA**

Time marker	Speaker	Subject	Action Required
		of each individual projection parameter on the average time required for doctors in carrying out the tasks for each type of workload; and (b) the appropriate measures of central tendency and variability together with the exact average values for each individual projection parameter in the calculation for deriving the projection results of the specialty-based manpower requirement for doctors as set out in Table 2 of Annex A to LC Paper No. CB(2)2011/11-12(01).	
012300 - 014045	Chairman Admin	The Chairman's suggestion that the problem of medical manpower shortage in public healthcare sector could be immediately relieved by inviting the servicing doctors of HA to undertake overtime work with the grant of overtime allowance; and his remark that there was a potential decrease in demand for public healthcare services after the implementation of HPS. The Administration's response that the proposed arrangement could be a short term measure for providing greater labour flexibility; and its advice on the existing measures taken by HA to strengthen its workforce. In the longer term, it was necessary to devise a healthcare manpower projection model to assess, among others, the medical manpower needs with a view to ensuring the healthy and sustainable development of the healthcare system. The Chairman's view that for medical manpower projection, it was of paramount importance that a mechanism would be put in place to ensure that the time required for making adjustments to meet any deviation from the projected needs could be as short as practicable; and his suggestion that HA should regularize the employment of part-time doctors to cater for fluctuations in its full-time medical workforce strength and serve as an indicator on the need to trigger an increase in the supply of doctors in the long term.	
014046 - 014845	Chairman Dr KWOK Ka-ki Admin	Dr KWOK Ka-ki's view that the Administration should give due consideration to the following factors when formulating the projection on healthcare manpower demand - (a) some healthcare professionals would work in hospital as well as other settings. There might also be a change in the model of care, and hence the demand for these professionals, in the face of an ageing population; and	

Time marker	Speaker	Subject	Action Required
		(b) the increase in the number of registered Chinese medicine practitioners who were degree holders, as well as the increasing role of Chinese medicine in primary care. The Administration's elaboration of the challenges and constraints of healthcare manpower projection and the factors that the commissioned study on the manpower demand for healthcare professionals from the 13 disciplines would be taken into account in developing the generic forecasting model.	
Agenda item III: Any other business			
014846 - 014925	Chairman	Closing remarks	

Council Business Division 2
Legislative Council Secretariat
3 June 2013