# 立法會
# *Legislative Council*

LC Paper No. CB(2)66/15-16
(These minutes have been seen by the Administration)

Ref : CB2/PL/HS

**Panel on Health Services**

**Minutes of special meeting**
**held on Tuesday, 13 January 2015, at 4:30 pm**
**in Conference Room 1 of the Legislative Council Complex**

| | | |
|---|---|---|
| **Members present** | : | Prof Hon Joseph LEE Kok-long, SBS, JP, PhD, RN (Chairman)<br>Dr Hon LEUNG Ka-lau (Deputy Chairman)<br>Hon Albert HO Chun-yan<br>Hon Vincent FANG Kang, SBS, JP<br>Hon WONG Ting-kwong, SBS, JP<br>Hon CHAN Kin-por, BBS, JP<br>Hon Albert CHAN Wai-yip<br>Hon YIU Si-wing<br>Hon Charles Peter MOK, JP<br>Hon Alice MAK Mei-kuen, JP<br>Dr Hon KWOK Ka-ki<br>Dr Hon Fernando CHEUNG Chiu-hung<br>Dr Hon Helena WONG Pik-wan<br>Dr Hon Elizabeth QUAT, JP<br>Hon POON Siu-ping, BBS, MH |
| **Members attending** | : | Hon WONG Kwok-hing, BBS, MH<br>Dr Hon Priscilla LEUNG Mei-fun, SBS, JP<br>Hon WONG Kwok-kin, SBS<br>Hon Alan LEONG Kah-kit, SC<br>Hon CHAN Yuen-han, SBS, JP |
| **Members absent** | : | Hon CHEUNG Kwok-che<br>Hon CHAN Han-pan, JP<br>Hon Christopher CHUNG Shu-kun, BBS, MH, JP |

**Public Officers attending :** Item I

Dr KO Wing-man, BBS, JP
Secretary for Food and Health

Mr Richard YUEN Ming-fai, JP
Permanent Secretary for Food and Health (Health)

Mr Chris SUN Yuk-han, JP
Deputy Secretary for Food and Health (Health) Special Duties
Food and Health Bureau

Dr Amy CHIU Pui-yin, JP
Assistant Director of Health (Health Administration and Planning Division)

**Clerk in attendance :** Ms Maisie LAM
Chief Council Secretary (2) 5

**Staff in attendance :** Ms Wendy KAN
Assistant Legal Adviser 6

Ms Janet SHUM
Senior Council Secretary (2) 5

Ms Priscilla LAU
Council Secretary (2) 5

Ms Louisa YU
Clerical Assistant (2) 5

---

Action

**I. Consultation Documents on "Voluntary Health Insurance Scheme" and "Regulation of Private Healthcare Facilities"**
[File Ref.: FH CR 4/1/3822/13 Pt.4, FH CR 4/3921/14, LC Paper Nos. CB(2)598/14-15(01) to (02), and the Consultation Documents on "Voluntary Health Insurance Scheme" and "Regulation of Private Healthcare Facilities"]

Members noted the two updated background briefs on "Voluntary Health Insurance Scheme" and "Regulation of private healthcare facilities" (LC Paper Nos. CB(2)598/14-15(01) and (02)) prepared by the Legislative Council Secretariat.

Action

Consultation Document on Voluntary Health Insurance Scheme

*Objectives of the Voluntary Health Insurance Scheme*

2. Dr KWOK Ka-ki considered that in the face of an ageing population, more efforts should be made to enhance primary care to reduce hospital admission of the elderly, instead of encouraging the uptake of hospital insurance through the Voluntary Health Insurance Scheme ("VHIS"). Based on the indicative annual standard premiums for standard plan as estimated by the Consultant, using public funding to support the proposed High Risk Pool ("HRP") set up under VHIS might turn out benefiting those affluent high-risk individuals who could afford to pay an annual premium as high as around $26,000 (in 2012 constant prices) at the age of 65 years. Without the putting in place of a mechanism to regulate the medical charges and expense loading (which stood at 36% in 2013 according to the Administration) in the individual health insurance market, it was not desirable to introduce VHIS to encourage greater use of private healthcare services. Mr CHAN Kin-por clarified that according to the latest statistics of the Hong Kong Federation of Insurers, the average expense loading in 2013 was about 32%.

3. Mr Albert CHAN said that he had reservation about the introduction of VHIS, albeit that the Administration had taken on board many views received in the course of developing the detailed proposals for VHIS. He was concerned that only those individuals with non-standard risk or even very serious health conditions would purchase VHIS plans, resulting in an escalation in the premiums. The high claims cost would also undermine the sustainability of HRP. Pointing out that the highly subsidized public hospital system provided the whole population with equitable access to healthcare services with well recognized quality at very affordable price, Dr Fernando CHEUNG considered that public money should be utilized to improve the public healthcare services and promote primary care. In his view, encouraging greater use of private healthcare services through insurance would drive up the medical cost, which ran contrary to the objective of VHIS to address the long-term sustainability of healthcare financing.

4. Mr Albert HO held the view that improving the tax-funded public healthcare system was a more equitable way to fund healthcare services for the whole population. Alternatively, public money could be used to promote public-private partnership ("PPP") so as to enable patients waiting for public hospital services to receive treatment in the private sector. Any shortcomings of the existing private health insurance market could be addressed through enhanced regulatory control without VHIS.

Action

5. Mr CHAN Kin-por held a contrary view. He considered it reasonable and justifiable for the Government to use public funds to support VHIS, as the amount of Government subsidy provided to VHIS subscribers would be considerably less than the case whereby the subscribers chose to use the public healthcare services where the subsidy rate was significantly higher (i.e. about 98%). Dr Elizabeth QUAT sought information about the role of the public healthcare system under VHIS. Referring to the projection that the introduction of VHIS would result in a significant expansion of private sector share by 36% in terms of inpatient (overnight and day cases) discharge (while the public sector share would be reduced by 6%) as set out in paragraph 45 of the Executive Summary of the Consultation Document on VHIS, Mr POON Siu-ping said that there was a concern in the community that the Government would reduce its commitment to the public sector under VHIS. Mr Vincent FANG and Mr Yiu Si-wing expressed support for the proposals put forward in the Consultation Document on VHIS with a view to adjusting the public-private balance.

6. SFH explained that VHIS was not intended as a total solution to the challenges faced by the healthcare system, but a supplement financing arrangement complementing public healthcare, and one of the control knobs in redressing the public-private balance. He stressed that the Government would continue to strengthen its commitment to the public healthcare system (including the public health infrastructure) which was the safety net for the whole population, in particular the lower-income and under-privileged groups. That said, it was necessary to identify measures to adjust the public-private balance. By providing a value-for-money choice to those who could afford and were willing to pay for private healthcare services with personalized choices and better amenities (i.e. mainly the middle class) through VHIS, the pressure on the public sector could be indirectly relieved. Patients in the public sector would therefore be able to benefit from enhanced accessibility of public healthcare services through reduction of waiting time.

7. SFH added that it was reasonable and justifiable for the Government to use part of the $50 billion earmarked for healthcare reform to support the operation of HRP, which was the key enabler of guaranteed acceptance with premium loading cap in order to improve accessibility of individual indemnity hospital insurance. It was estimated that $4.3 billion was required for supporting HRP for a 25-year period. Without HRP, many high-risk individuals would likely fall back on the highly-subsidized public system. There was, however, no cause for concern that only patients with very complex illnesses would subscribe to VHIS products, as many of them would resort to the public system for treatment given the high costs entailed by these complex illnesses in the private system. It should be noted that part of the remaining sum of the $50 billion would be used for setting up a fund

Action

for the Hospital Authority ("HA") to make use of the investment returns for PPP initiatives. Any remaining sum of the $50 billion would be reserved for general use, including provision of support for public hospital projects. Acknowledging the importance of primary care, SFH advised that a number of policy initiatives had been rolled out in recent years to strengthen primary care, promote prevention and early identification of disease. A case in point was the proposed pilot programme to subsidize colorectal cancer screening for higher-risk groups. Permanent Secretary for Food and Health (Health) ("PSFH(H)") supplemented that it was proposed that care management programmes should be introduced for HRP members. Overseas experience suggested that such types of programmes could drive better chronic disease management, thus achieving greater efficiency and better health outcomes.

8. Pointing out that public health expenditure currently only accounted for about 50% of total health expenditure, Dr KWOK Ka-ki remained of the view that public funding should not be used to support the implementation of VHIS. Mr Albert CHAN opined that the healthcare system in Canada whereby the provincial and territorial governments were responsible for the provision of hospital care in their jurisdictions with the support of a national health insurance programme was more preferable. Mr Albert HO held a contrary view and supported a dual-track healthcare system comprising both public and private sectors. SFH responded that the public had reservations about introducing mandatory private healthcare insurance, which was one of the supplementary financing options put forth during the Healthcare Reform First Stage Consultation ("the First Stage Consultation").

Admin

9. To shed light on whether a greater use of private services would drive up the medical costs in the overall healthcare system, Dr LEUNG Ka-lau requested the Administration to provide a comparison between the average cost of the HA and the median cost of the private healthcare sector for conducting common operations or procedures, such as appendicectomy, laparoscopic cholecystectomy, endoscopy and colonoscopy procedures.

*Product design*

10. Mr CHAN Kin-por urged the Administration to consider the insurance industry's suggestion of allowing the co-existence of a regulated market segment where products were bound by Minimum Requirements, and an unregulated market segment where products were not bound by Minimum Requirements to suit the different needs of consumers. According to the latest statistics of the insurance industry, of the some 1.85 million existing individual health insurance policies, the annual premium of 27%, 13% and 11% of these policies was below $2,000, in the range of $2,000 to $2,500, and in the range of $2,500 to 3,000 respectively. These policyholders might

Action

not be able to afford the Standard Plan and would have to fall back on public healthcare services. This ran contrary to the objectives of VHIS. SFH responded that the Administration would continue to discuss with the insurance industry on the key issues of concern.

11. Dr LEUNG Ka-lau remarked that the surgical limit as set out in the illustrative outline of benefit schedule of Standard Plan in the Consultation Document on VHIS would not be able to fully cover the expenses arising from complex procedures without out-of-pocket payment. SFH advised that given the wide range of medical procedures, it was considered that the benefit limits of Standard Plan should be set at levels which could provide reasonable coverage for consumers.

12. Noting that Standard Plan was targeted at general ward level services, Miss Alice MAK expressed concern that it was not uncommon that patients had no choice but had to be admitted to semi-private rooms with higher charges due to the inadequate supply of general wards in private hospitals. SFH advised that under the revamped regulatory regime for PHFs, private hospitals would be required to provide greater budget certainty to consumers through making public a fee schedule setting out charges and historical statistics on actual bill sizes for common treatments or procedures, as well as providing patients having investigative procedures or elective, non-emergency therapeutic operations or procedures for known diseases on or before admission with the estimated total charges. It should also be noted that the number of private hospital beds would increase by at least 40% by 2020.

13. Mr Albert CHAN was concerned that the benefit limits of VHIS might not be able to cover the service charges of those private hospitals and doctors at the high end of the market.

14. SFH advised that efforts had been and would continuously be made by the current term Government to encourage non-profit-making organizations and local universities to establish private hospitals and operate them on a self-financing basis, so as to provide an alternative to the middle class who could afford and were willing to seek private services (in particular the elective and non-emergency therapeutic operations or procedures which had reached a bottleneck in the public system) through VHIS. In addition, VHIS would bring about greater budget certainty for policyholders through the "no-gap/known-gap" arrangement. Depending on the specification by the insurer, a policyholder could enjoy "no-gap" (i.e. full cover of expenses without out-of-pocket payment) or "known gap" (i.e. partial cover of expenses with pre-determined amount of out-of-pocket payment) if the procedure concerned, the hospital and doctor selected by the policyholder were on the lists specified by the insurer concerned. The policyholder would

Action

still be free to choose services provided by hospitals or doctors not on the list. The insurance benefit would be calculated based on the actual fees and charges against the benefit limits in accordance with the insurance policy, and out-of-pocket expenses might be necessary.

15. Mr WONG Kwok-hing was concerned about how VHIS could address the issue that excluded items was one of the main categories of claims disputes arising from individual health insurance policies. Mr Albert CHAN expressed a similar concern. SFH advised that one of the Minimum Requirements proposed for VHIS was the requirement of coverage of pre-existing conditions subject to a standard waiting period (viz. no coverage in the first year and a respective coverage of 25%, 50% and 100% in the second year, third year, and fourth year onwards).

16. Noting that the requirement of guaranteed acceptance with premium loading capped at 200% of the standard premium would apply to all within the first year of implementation of VHIS and those aged 40 or below starting from the second year onwards, Mr POON Siu-ping considered that more time (say, two or three years) should be allowed for those aged 40 or above to decide whether to purchase VHIS plans. Dr LEUNG Ka-lau suggested that a higher age limit, say 55 years old, should be imposed.

17. Taking note of the suggestions, SFH advised that the proposal was meant to encourage early subscription to VHIS products. After the first year of implementation of VHIS, subscribers above the age of 40 would still be able to enjoy the benefits of all other Minimum Requirements proposed for Standard Plan except for guaranteed acceptance and the premium loading cap proposed for Standard Plan. Dr LEUNG Ka-lau further suggested that an arrangement should be put in place to allow those high-risk individuals above the age of 40 who might otherwise be excluded or priced out under VHIS after its first year of implementation to purchase products with case-based exclusion clauses. SFH undertook to consider the suggestion.

*Average annual standard premium of Standard Plan*

18. Mr POON Siu-ping sought information about the updated estimation for the average annual standard premiums of Standard Plan, which was estimated by the Consultant to be $3,600 in 2012 constant prices. In particular, he was concerned about the level of premium of Standard Plan for those aged 40 and above, which was estimated to be around $6,400 on average in 2012 constant prices. SFH advised that the indicative schedule of annual standard premiums for Standard Plan estimated by the Consultant was for illustration purposes only.

Action

19. Mr CHAN Kin-por remarked that while the insurance sector welcomed the proposals to standardize the policy terms and conditions and enhance the benefit coverage to safeguard consumer interest, it should be noted that consumers would need to pay a higher premium for the enhanced benefits offered by Standard Plan. With reference to the indicative schedule of annual standard premiums for Standard Plan estimated by the Consultant as set out in Table 3.3 of the Consultation Document on VHIS and taking into account the increase in premium at an average annual rate of 6% in the past few years, the average standard premium for those aged 45 to 49, who would most likely purchase health insurance, would be around $6,350 (or as high as about $9,200 as Consultant's estimation was subject to a potential range of variation between -8% and +45%) if VHIS was to be implemented in 2017.

20. PSFH(H) explained that the key driver for estimated premium variation was how well VHIS was able to contain moral hazard on the use of advanced diagnostic imaging tests, such as Magnetic Resonance Imaging examination. In the scenario with a premium variation of +45%, it was assumed that per-person usage of these tests would be on the high side, as in the United States, which illustrated a scenario with ineffective control of abuse in usage. It was for this reason that a fixed 30% co-insurance was proposed for the use of prescribed advanced diagnostic imaging tests in order to keep the cost under check.

*Financial incentives*

21. Mr WONG Kwok-hing considered that the tax deduction proposal was not attractive enough to incentivize the taking out of health insurance. In his view, the whole amount of annual premium payable should be eligible for tax deduction so as to provide greater financial incentives for VHIS. Dr Elizabeth QUAT expressed concern about whether VHIS would be able to attract the young and healthy to join to ensure its sustainability.

22. Mr CHAN Kin-por remarked that the sustainability of VHIS hinged on whether there were enough young and healthy subscribers to balance the risk. Holding the view that the tax deduction proposal would not provide a great incentive for the young and healthy population to purchase VHIS plans, he urged the Administration to re-consider using the $50 billion earmarked for healthcare reform to provide no-claim discount for all new joiners as proposed during the Healthcare Reform Second Stage Consultation ("the Second Stage Consultation") so as to incentivize the young and healthy to join VHIS.

Action

23. SFH stressed that the provision of financial incentives was not the only measure that could promote hospital insurance uptake. The Minimum Requirements proposed were a kind of regulatory incentive that could boost consumer confidence in taking out VHIS, as they would enhance the accessibility, continuity, quality and transparency of insurance protection for consumers. Currently, it was not uncommon for insurers to decline health insurance applications from not only individuals with very serious health conditions, but also the relatively healthy individuals who had developed certain health conditions. It was considered that the proposed tax deduction would be attractive to the relatively younger working population as well as the middle class. SFH added that the outcomes of the Second Stage Consultation revealed that there were considerable views in the community against direct premium subsidy or discount. In addition, the proposed no-claim discount might have the unintended effect of discouraging policyholders from seeking necessary treatments.

24. Noting that the use of savings only for paying future premium was one of the various concerns raised by the public during the Second Stage Consultation over the proposal of building a savings component in the Health Protection Scheme (subsequently renamed as VHIS) plans, Mr YIU Si-wing asked whether the Administration would consider revising the proposal to allow the policyholders to use the savings for other purposes. SFH advised that the proposal had not been taken forward under VHIS given the considerable concerns raised by the public over the proposal.

*Employees currently covered by group hospital insurance policies*

25. Mr YIU Si-wing pointed out that many of the working population who were covered by group hospital insurance policies would not take out an individual policy. They might, however, become unable to afford private health insurance protection upon retirement. Dr KWOK Ka-ki asked whether the Administration had assessed the affordability of the retirees to purchase Standard Plan. According to the Consultant, the respective average annual standard premium of Standard Plan for average standard-risk and high-risk policyholders in the age group of 65 to 69 was $8,600 and as high as $25,800 (in 2012 constant prices).

26. PSFH(H) advised that it was proposed that insurers had to provide an Conversion Option as an optional component in the group hospital insurance products that they offered to employers. The Conversion Option would allow an employee to transfer to an individual Standard Plan at the same underwriting class when leaving employment if he or she had been employed for a full year immediately before the transfer. It should also be

Action

noted that the public healthcare system would continue to be the safety net for the whole population.

*Regulatory agency*

27. Mr YIU Si-wing sought elaboration about the new dedicated agency proposed to be set up to ensure the smooth implementation and operation of VHIS. PSFH(H) advised that it was proposed that the regulatory agency would be set up as an administrative unit under the Food and Health Bureau. It was expected that the number of staff of the regulatory agency should be relatively modest as it was only responsible for regulating the product design of one line of insurance products. The Administration would liaise closely with existing regulatory bodies, such as the Office of the Commissioner of Insurance, on matters related to their respective responsibilities to ensure compatibility with existing and future legislative regime for regulation of the insurance industry and effective coordination of duties.

*Supply of healthcare manpower*

28. Pointing out that the implementation of VHIS was expected to lead to an increase in private sector activities, Dr Helena WONG asked how the Administration could ensure that the implementation of VHIS would not aggravate the healthcare manpower constraint problem of HA. Mr Albert HO raised a similar question.

29. SFH advised that to his understanding, the manpower capacity of the private healthcare sector still had room to meet an increasing service demand. That said, to ensure an adequate supply of healthcare manpower in the longer term, the Administration had been conducting a strategic review on healthcare manpower planning and professional development in conjunction with developing detailed proposals for VHIS.

*Way forward*

30. Dr Elizabeth QUAT was concerned that the insurance industry had reservations about certain detailed proposals of VHIS. She asked about the way forward in case the Administration failed to gain the support of the insurance industry in implementing VHIS.

31. SFH responded that the way forward for the implementation of VHIS would depend on the majority views expressed by the relevant stakeholders and the community at large in this public consultation exercise. PSFH(H) supplemented that according to the 2011 Thematic Household Survey, among those who were covered by private health insurance, about 54% of

Action

their local hospital admissions still pertained to the public sector. One possible reason was that patients might feel uncertain about the out-of-pocket payment when the insurance protection was insufficient to cover all expenses. Statistics showed that the average expense loading of the individual health insurance market in Hong Kong was the highest among the overseas jurisdictions studied by the Consultant. The standardization, quality assurance and better flow of market information under VHIS would facilitate easy comparison by consumers, foster market competition, and hence bring the expense loading to a level more in line with international experience. This might partly explain why the insurance industry had concerns over the implementation of VHIS. That said, the Administration would continue to discuss with the insurance industry with a view to building a consensus. It was also worthy to note that in the course of formulating the detailed proposals of VHIS, individual hospital insurance products with features similar to the Minimum Requirements had started to emerge in the market.

Regulation of private healthcare facilities

*Types of private healthcare facilities to be regulated*

32. Mr Vincent FANG sought elaboration about which types of facilities providing medical procedures in ambulatory setting, and whether facilities providing medical services under the management of incorporated companies (e.g. beauty companies) in which non-medical investors or managers might take part in their operation, would be subject to regulation under the revamped regulatory regime for private healthcare facilities ("PHFs"). SFH advised that given that high-risk medical procedures or practices once confined to hospitals were increasingly performed in ambulatory setting due to rapid advancement in healthcare technology, it was proposed that facilities providing high-risk medical procedures in ambulatory setting should be regulated. Whether a medical procedure would be classified as high-risk depended on (a) risk of the procedure, (b) risk of anaesthesia involved, and (c) patient's condition. This apart, facilities providing medical services under the management of incorporated bodies would be regulated in the new piece of legislation. To avoid duplicate regulation, ambulatory facilities which were part of private hospitals would be exempt from obtaining separate licences as they would be regulated as "hospitals".

*Organizational structure of regulated PHFs*

33. Dr Helena WONG sought elaboration about the qualifications and experience required of the person-in-charge to be appointed for the regulated PHFs to manage the establishment, and the composition of the board of

Action

directors of private hospitals. For the latter, she was particularly concerned about how patients would be represented. SFH advised that subject to the outcomes of the public consultation, the new piece of legislation on the regulation of PHFs would provide for, among others, the detailed requirements in respect of the appointment of the person-in-charge of a regulated PHF, as well as the establishment of Medical Advisory Committee, etc.

*Complaints management system*

34. Expressing support for the proposal of establishing a two-tier complaints handling system for private hospitals, Miss Alice MAK sought elaboration about the scope of powers to be conferred on the proposed Independent Committee on Complaints against Private Hospitals ("the Independent Committee") in handling complaints against private hospitals at the second-tier. Holding the view that there would be an increase in the number of ambulatory medical centres upon the implementation of VHIS as certain ambulatory procedures necessitated by diagnosed medical conditions would be covered under Standard Plan, she considered that the Independent Committee should be empowered to handle also complaints against all ambulatory medical centres.

35. SFH advised that under the two-tier complaints handling system for private hospitals, hospitals were required to manage complaints at source according to a standardized complaints handling mechanism prescribed by the regulatory authority. The Independent Committee would be empowered to investigate and review all unresolved cases and make recommendations to the regulatory authority for consideration and follow-up. Taking into account that the two-tier complaints handling would incur considerable amount of administrative workload and compliance costs for non-hospital PHFs (including ambulatory medical centres) which had a much smaller scale of operation and lower complexity in the organizational structure, it was proposed that a simplified mechanism should be adopted for non-hospital PHFs by requiring them to set up a designated complaints handling channel.

*Regulatory authority*

36. Expressing support for the revamped regulatory regime for PHFs, Mr YIU Si-wing sought elaboration about the regulatory authority for the new regime. SFH advised that it was proposed that the Director of Health should be empowered to enforce the regulatory requirements under the new regime, as the Director had all long been the regulatory authority under the

Action

existing Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap. 165) and the Medical Clinics Ordinance (Cap. 343).

*Way forward*

37. The Chairman asked whether the Administration would, subject to the outcomes of the public consultation, proceed to take forward the enhanced regulation of PHFs regardless of whether VHIS was to be implemented. SFH replied in the affirmative.

Invitation of public views

38. Dr KWOK Ka-ki suggested that a special meeting should be arranged to receive public views on the two Consultation Documents on VHIS and PHFs. The Chairman proposed and members agreed that the Panel should hold a special meeting to receive views from deputations on the Consultation Document on PHFs, whereas further discussion on the Consultation Document on VHIS would be held by the Subcommittee on Health Protection Scheme set up under the Panel. The Chairman said that the Clerk would follow up on the meeting arrangements for the special meeting of the Panel. Members would be informed of the meeting date in due course.

[*Post-meeting note:* With the concurrence of the Chairman, a special meeting has subsequently been scheduled for 17 February 2015 from 9:30 am to 12:30 am to receive public views on the Consultation Document on PHFs.]

## II. Any other business

39. There being no other business, the meeting ended at 6:21 pm.

Council Business Division 2
Legislative Council Secretariat
16 October 2015