立法會
Legislative Council

LC Paper No. CB(2)1915/15-16

Ref : CB2/PS/2/12

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. Further to the public consultation in 2005 on the future service delivery model of the healthcare system,[1] the Government initiated a two-stage public consultation to take forward the reform. On 13 March 2008, it put forth a package of healthcare service reforms and six possible supplementary healthcare financing options[2] 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 proceeded to develop possible policy options along the principle of voluntary participation.

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1 The Health and Medical Development Advisory Committee ("HMDAC") released a Discussion Paper entitled "Building a Health Tomorrow" on 19 July 2005 proposing the future service delivery model of the healthcare system.

2 The six options put forth for addressing the long-term sustainability of healthcare financing were (a) social health insurance (i.e. mandatory contribution by the workforce); (b) out-of-pocket payments (i.e. increase user fees for public healthcare services); (c) medical savings accounts (i.e. mandatory savings for future use); (d) voluntary private health insurance ("PHI"); (e) mandatory PHI; and (f) personal healthcare reserve (i.e. mandatory savings and insurance).

3. On 6 October 2010, the Government published the Healthcare Reform Second Stage Public Consultation Document entitled "My Health My Choice" ("the Second Stage Public Consultation") in which a voluntary and government-regulated PHI scheme, the Health Protection Scheme ("HPS")[3], was proposed for public consultation as health insurance was perceived as a relatively stable healthcare financing source which was less affected by economic cycles. It was proposed that insurers would be required to offer standardized indemnity insurance plans that would enable the insured to access general ward class of private healthcare services when needed. Key features of the proposed HPS products involved a range of requirements on operational rules, benefit structure and other consumer protection measures.

4. According to the Healthcare Reform Second Stage Public Consultation Report released on 11 July 2011, members of the public have expressed support for the introduction of HPS to enhance transparency, competition and efficiency of PHI for the provision of an alternative to those who are willing and may afford to pay for private healthcare services. A three-pronged action plan is adopted to take forward HPS, which includes establishing a Steering Committee on Strategic Review on Healthcare Manpower Planning and Professional Development ("the Steering Committee") to make recommendations on meeting the projected demand for healthcare professionals and fostering professional development; setting up a Working Group and a Consultative Group on HPS under HMDAC to make recommendations on matters concerning the implementation of HPS; and taking measures to facilitate the development of healthcare services and infrastructure. To provide professional and technical support to the Working Group and the Consultative Group, the Administration commissioned a Consultant[4] to study and advise on key issues relating to HPS, inter alia, the formulation of a viable and sustainable product design for HPS and areas where public funding could be considered to ensure the viability and sustainability of HPS.

5. Members of the Panel on Health Services ("the Panel") in the Fourth Legislative Council were gravely concerned about the impacts of the proposed HPS on the overall healthcare system. To enable more focused discussion on the proposals and impacts of HPS, a Subcommittee on Health Protection Scheme was formed under the Panel ("the former Subcommittee") on 8 August 2011 to study issues relating to HPS. The former Subcommittee submitted its report to the Panel on 4 July 2012, putting forth a number of recommendations.[5]

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[3] As HPS is intended as a supplementary financing arrangement, the Administration renames the scheme as Voluntary Health Insurance Scheme in the consultation document published on 15 December 2014 to better reflect its objectives and nature.

[4] PricewaterhouseCoopers Advisory Services Limited.

[5] Please refer to LC Paper No. CB(2)2527/11-12.

6. With reference to the deliberation by the Working Group on HPS and the Consultant's recommendations, the Government published the Consultation Document on Voluntary Health Insurance Scheme ("the 2014 Consultation Document") on 15 December 2014 putting forth the detailed proposals for implementing VHIS for public consultation. The consultation exercise lasted for four months until 16 April 2015.

The Subcommittee

7. One of the recommendations of the former Subcommittee is that the Panel should appoint a subcommittee to assist its monitoring work of the implementation progress of HPS in the Fifth Legislative Council. To follow up on the recommendations of the former Subcommittee, the Panel agreed at its meeting on 19 November 2012 to appoint the Subcommittee to study issues relating to the introduction of HPS as proposed by the Government for the Second Stage Public Consultation. The terms of reference and membership of the Subcommittee are set out in **Appendices I and II** respectively.

8. Pursuant to Rule 26(c) of the House Rules, the approval of the House Committee was obtained on 15 November 2013, 31 October 2014 and 9 October 2015 for the Subcommittee to continue its work in the 2013-2014, 2014-2015 and 2015-2016 sessions respectively.

9. Under the chairmanship of Dr LEUNG Ka-lau, the Subcommittee held a total of 15 meetings. The Subcommittee received views from 25 deputations on the 2014 Consultation Document at one of these meetings. A list of the organizations and individuals which/who have given views to the Subcommittee is in **Appendix III**.

Deliberations of the Subcommittee

<u>Policy objectives of VHIS</u>

10. According to the Administration, the health insurance market is lightly regulated in Hong Kong, subject only to prudential regulation under the Insurance Companies Ordinance (Cap. 41). In the last two decades, health insurance, in particular individually-purchased PHI, has been undergoing major growth as a healthcare financing source.[6] The proposal of the Administration

[6] According to Hong Kong's Domestic Health Accounts, the contribution of individually-purchased PHI to total health expenditure rose markedly by an average of 17% per annum from 1989-1990 to 2010-2011. In 2010-2011, private healthcare services were mainly financed by household out-of-pocket expenditure (65%) and insurance pay-out (30%).

is to regulate under VHIS the indemnity hospital insurance sold to individuals.[7] It is expected that with enhanced quality and certainty of insurance protection, consumers will have greater confidence in using health insurance and private healthcare services. As a result, health insurance can play a more significant role in supplementing the financing of health expenditure and supporting the dual-track healthcare system.

11. Some members, including Mr Vincent FANG, Mr CHAN Kin-por, Mr YIU Si-wing and Mr POON Siu-ping, have expressed support for the concept and policy objectives of VHIS to enhance the accessibility, quality and transparency of individual indemnity hospital insurance products and foster consumer confidence in using private healthcare services, so as to adjust the balance of the public-private healthcare sectors[8] and enhance the long-term sustainability of the dual-track healthcare system. Some other members, including Mr Albert HO, Mr Albert CHAN, Dr KWOK Ka-ki and Dr Fernando CHEUNG, have reservation about the introduction of VHIS. They consider that the effort of the Government should be focus on improving the public healthcare system. Any shortcomings of the existing private health insurance market could be addressed through enhanced regulatory control without VHIS.

12. The Administration has stressed that under the dual-track healthcare system by which the public and private healthcare sectors complement each other, the Government would continue to strengthen its commitment to the public healthcare system (including the public health infrastructure) which is the safety net for the whole population. It is, however, necessary to identify measures to adjust the public-private balance. By providing a value-for-money choice to those who could afford and are willing to pay for private healthcare services with personalized choices and better amenities (i.e. mainly the middle class) through VHIS, resources could be released in the public sector[9] to enhance service quality and shorten the waiting time. The Administration has drawn the attention of the Subcommittee that VHIS is not intended as a total

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[7] According to the Administration, an indemnity insurance generally refers to an insurance where the insured will be reimbursed or indemnified by the insurer for his/her actual loss. For the purpose of VHIS, individual indemnity hospital insurance means a contract of insurance falling within Class 2 (sickness) of Part 3 of the First Schedule to the Insurance Companies Ordinance which provides for benefits in the nature of indemnity against risk of loss to the insured attributable to sickness or infirmity that requires hospitalization and the policyholder or person insured is an individual.

[8] According to the Administration, the public sector is the predominant provider of secondary and tertiary healthcare services. Around 88% of inpatient services (in terms of number of bed days) are provided by public hospitals.

[9] Under the forecast scenario (i.e. the scenario with the implementation of VHIS), the proportions of public and private overnight inpatient bed days in 2040 are projected to be 85% and 15% respectively.

solution to the problems of the healthcare system, but is only one of the turning knobs that would contribute to the performance of the healthcare system.

The Minimum Requirements approach

13. Members note that the latest proposal of the Administration is to require all individual indemnity hospital insurance products to meet or exceed a proposed set of 12 Minimum Requirements upon the implementation of VHIS. The proposed Minimum Requirements include:

(a) guaranteed renewal without re-underwriting;

(b) no "lifetime benefit limit";

(c) coverage of pre-existing conditions subject to a standard waiting period;

(d) guaranteed acceptance with premium loading capped at 200% of standard premium for (i) all ages within the first year of implementation of VHIS; and (ii) those aged 40 or below starting from the second year of implementation of VHIS;

(e) portable insurance policy with no re-underwriting when changing insurers, provided that no claims were made in a certain period of time immediately before transfer of policy;

(f) coverage of hospitalization and prescribed ambulatory procedures;

(g) coverage of prescribed advanced diagnostic imaging tests, subject to a fixed 30% co-insurance, and non-surgical cancer treatments up to a prescribed limit;

(h) minimum benefit limits;

(i) no cost-sharing (deductible or co-insurance) by policyholders except the fixed 30% co-insurance for prescribed advanced diagnostic imaging tests; and annual cap of $30,000 on cost-sharing by policyholders (excluding excess amount payable by policyholders if actual expenses exceed benefit limits);

(j) budgetary certainty for policyholders through Informed Financial Consent and no-gap (i.e. no out-of-pocket payment is required) or known gap (i.e. a pre-determined amount of out-of-pocket payment) arrangement for at least one procedure or test;

(k) standardized policy terms and conditions; and

(l) transparent information on age-banded premiums through easily accessible platform.

14. There is a concern that the above Minimum Requirements approach would interfere with the free market, limit the diversity of PHI in the market and limit consumer choice over products that do not meet the Minimum Requirements. In addition, the proposal would lead to an increase in average annual standard premium due to enhanced benefits. There is a view that the Administration should allow co-existence of a regulated market segment under the aegis of VHIS and an unregulated market segment where products are not bound by Minimum Requirements, so that consumers could choose among different grades of products with diverse benefit limits and correspondingly different premium levels to suit their needs and affordability.

15. The Administration has advised that according to the 2011 Thematic Household Survey, among those who were covered by PHI, about 54% of their local hospital admissions still pertained to the public sector. One possible reason is that patients may feel uncertain about the out-of-pocket payment when the insurance protection is insufficient to cover all expenses, or are concerned over the possibility of an increase in premium or even termination of policy after claims. The Minimum Requirements are designed to provide simplicity, clarity and certainty to consumers and help those who do not possess insurance professional knowledge to understand easily and clearly the minimum protection they would receive when taking out a hospital indemnity insurance policy. The Minimum Requirements proposal is also in line with international experience. In the Administration's view, a two-market situation would be untenable as adverse selection would undermine the sustainability of VHIS: insurers could cherry pick customers from the healthy population by offering relatively lower premium for the unregulated products, leaving VHIS a choice mainly for the unhealthy population.

16. Some members including the Chairman take the view that the above findings revealed by the 2011 Thematic Household Survey could not serve as inferences of shortcomings of existing PHI products and hence a justification for the introduction of Minimum Requirements, as the relevant percentages are referring to the number of admissions, instead of the number of respondents. There may be cases that the respondents concerned used both public and private hospital services. Some insured who have already exhausted the benefit limits of their insurance may also resort to the public healthcare sector for follow-up treatment.

Product design requirements for the Standard Plan[10]

Coverage of pre-existing conditions

17. On the proposal of the Administration that insurers have to cover pre-existing conditions subject to a standard waiting period and no/partial reimbursement arrangement (viz. no coverage in the first year and a respective coverage of 25%, 50% and 100% in the second year, the third year, and the fourth year onwards), some members including Mr CHAN Kin-por have casted doubt about the Consultant's estimations that the price impact of coverage of pre-existing conditions on the premiums to be paid by insured persons with standard-risk under VHIS[11] would be 5%, whereas that on the average claims cost of members of the high risk pool ("HRP")[12] would be six times (or 600%) than that of an average standard-risk policyholder. The Administration has explained that the former referred to the price impact arising from the enrollment of those migrants with pre-existing conditions excluded in their existing insurance policies who opt to remove these case-based exclusions and the required increase in overall standard premium if all such migrants go for this option and the insurers choose to finance the extra claims cost through standard premium increase. It is estimated that the overall claims amount will increase on average by about 5%, leading to a broadly similar magnitude of increase in standard premium. The cost impact of covering pre-existing conditions on members of HRP referred to that arises from enrollment of high-risk people who would be transferred to HRP, a separate risk pool from the generic one of which the standard premium is estimated. Such impact will have no bearing on the standard premium and is not accounted for as part of the calculation.

18. Question has been raised about how common is the market practice that policyholders who are of higher-risk would be charged "normal" premium yet with reduced coverage due to exclusion of pre-existing medical conditions, or premium loadings over and above the "normal" premium due to their existing medical conditions. The Administration has advised that a survey conducted by the Consultant on the market practices of insurance companies in Hong Kong (which was estimated to be constituting a market share of about 70%)

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[10] An individual indemnity hospital insurance product that meets all (but not exceeding) the 12 Minimum Requirements is considered a Standard Plan.

[11] Taking into account all the enhanced features and benefits proposed under the Minimum Requirements, the average annual standard premium of Standard Plan is estimated by the Consultant to be around $3,600 (in 2012 constant prices).

[12] An HRP, which is the key enabler of guaranteed acceptance with premium loading cap, is proposed to be set up to accept policies of Standard Plan of which the premium loading is assessed to be 200% or more of the standard premium offered by the insurer. Under the proposal, the claims cost arising from the acceptance of high-risk subscribers would be met by their own premiums and Government funding for HRP.

from the latter part of 2012 to the early part of 2013 revealed that amongst the insurance companies responded to the survey, the proportion of health insurance policies in force as at end-2011 with specific pre-existing health condition(s) stated for exclusion from policy coverage mostly ranged from 7% to 15%. The proportion of health insurance policies in force with premium loading applied ranged from 5% to 8%. In other words, the majority of these health insurance policies were only charged "normal" premium.

19. Mr CHAN Kin-por has expressed the view that the insurance sector remains unconvinced of the Consultant's estimation that the price impact to be brought about by the requirement of covering pre-existing conditions on the premiums to be paid by insured persons with standard-risk would only be 5%. Noting the anticipation of the Consultant that under VHIS, insurance companies would more likely charge a premium loading on top of standard premium for new policyholders with pre-existing conditions, members has sought information about the estimated premium loading rates corresponding to different types of pre-existing health conditions to be applied by the insurers. The Administration has advised that due to the lack of data and information in the existing local market, it is difficult to estimate with acceptable degree of precision an average or a range of premium loading rates by health conditions under VHIS. The exact set of applicable premium loading rates could vary considerably across insurance companies due to difference in business strategy and claims experience of insurers, as well as inherent complexity of risk factors involved that could be highly individualized.

Guaranteed acceptance with premium loading cap

20. Members have expressed concern over the Administration's latest proposals that insurers offering Standard Plan would only be required to guarantee acceptance with premium loading capped at 200% of standard premium of all ages within the first year of implementation of VHIS; and those aged 40 or below starting from the second year of implementation of VHIS. According to the Administration, the first proposal aims to provide accessible and affordable individual indemnity hospital insurance cover to older age people who did not have a chance to do so when they were young. The second proposal aims to encourage more people to enroll in individual indemnity hospital insurance when they are young and healthy. Noting that the total cost to the Government for funding the operation of HRP over the period of 2016 to 2040 would only be increased from $4.3 billion (if the age limit is set at the proposed level of 40)[13] to $5.3 billion (if the age limit is raised to the age of 50)

[13] According to the Administration, the total cost to operate HRP for a period of 25 years will be $17.8 billion, of which $15.8 billion is the claims cost and the remaining $2 billion is the administration cost. Under the assumption that the estimated total premiums collected under HRP will be $13.5 billion, the required Government funding to finance HRP over the period is estimated to be $4.3 billion.

or $6.4 billion (if the age limit is raised to the age of 55), they consider that the entry age limit of guaranteed acceptance should be set at an older age, say, 50 or 55, to enable more time for older age people to consider to subscribe to the Standard Plan or at times when they have greater affordability to do so. They have surmised that the proposed guaranteed acceptance age limit of 40 is meant to limit the size of HRP membership and the public funding support required to ensure the sustainability of HRP.

21. The Administration has advised that the proposed guaranteed acceptance age limit of 40 is aimed to encourage people to enroll VHIS when they are young and healthy. A lower age limit for guaranteed acceptance with premium loading cap would lead to a lower membership of HRP over the projection horizon, as well as early participation of healthy people which is conducive to the risk pooling function of PHI. Without such a limit, there will be incentive for more people to join VHIS until an older age when their health condition already deteriorated. The Administration, however, keeps an open mind on the setting of the age limit subject to the outcome of the public consultation.

22. There is a suggestion that insurers should be allowed to offer individual indemnity hospital insurance policies with exclusion of specific pre-existing conditions to provide accessible and affordable PHI coverage to those high-risk individuals aged above 40 who choose to subscribe health insurance after the first year of launch of VHIS. The Administration has undertaken to give consideration to the suggestion.

23. Dr KWOK Ka-ki has suggested that, to enable more insured persons with premium loading to be eligible for entry into HRP, the premium loading cap should be lowered from the proposed level of 200% to, say, 50% of the standard premium. The Administration has advised that it would consider whether or not the premium loading cap should be lowered having considered the views received during the public consultation exercise and the financial implications. It should be noted that the steeper the reduction in premium loading cap, the more the membership of HRP would increase. This would lead to a rise in the operation cost for HRP arising from the claims cost of the new HRP members as well as the increase in administrative work to handle a larger number of HRP members, and hence, an increase in the amount of public funding required for financing HRR.[14]

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[14] Based on the actuarial model of the Consultant for estimating the financial position of HRP, a ballpark assessment conducted by the Administration for the scenario of lowing the premium loading cap from 200% to 100% would lead to an increase in the total amount of public funding required for HRP (from 2016 to 2040) from $4.3 billion to $24.6 billion.

Coverage of hospitalization and prescribed ambulatory procedures

24. The Administration has advised the Subcommittee that some of the hospital insurance products in the market currently only provide reimbursement for procedures performed under an inpatient setting and requiring overnight hospital stay. To better utilize the capacity of the private sector in providing inpatient care for genuine cases, the Administration's proposal is that apart from hospitalization necessitated by diagnosed medical conditions, the benefit coverage of a Standard Plan has to cover a list of prescribed ambulatory procedures necessitated by diagnosed medical conditions, including endoscopies such as oesophago-gastro-duodenoscopy and colonoscopy, as well as certain relatively simple surgeries such as cataract extraction and intra-ocular lens implantation surgery. It is proposed that the ambulatory procedures to be covered will be determined and prescribed by the VHIS regulatory agency in consultation with major stakeholders.

25. Question has been raised about the Consultant's estimation that covering endoscopies or colonoscopy through packaged pricing in ambulatory settings would decrease the average standard premium of the Standard Plan by approximately 12%. The Administration has advised that the Consultant has adopted the individual PHI market's average expense loading[15] in 2011 (i.e. 43%, and hence a claim ratio of 57%) in the calculation. It is estimated that the claims cost per insured person[16] at all ages for coverage of endoscopies or colonoscopy would be about $560 for the Standard Plan, which is lower than that of $790 for comparable individual indemnity hospital insurance product in the market. This is mainly due to a higher use of more cost-effective[17] ambulatory procedures with packaged pricing to substitute for unnecessary hospital admissions.[18] Such cost savings is expected to outweigh the cost increases due to a higher claims frequency (i.e. an estimated 35% increase) as greater demand will be generated by coverage of ambulatory procedures under VHIS, and the cost increases due to a higher claims-to-bill ratio (i.e. from the current 89% to 100% as it is assumed that the full cost of ambulatory

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[15] Expense loading refers to the amount of insurer expenses as a percentage of the amount of total premium collected. Insurer expenses include commissions and broker fees, profit margins, expenses and other overhead expenses.

[16] According to the Administration, claims cost per insured person was a function of claims frequency, average billed size and claims-to-bill ratio.

[17] According to the estimate of the Consultant, the average cost of the procedure "colonoscopy with removal of tumor, polyp or lesion" performed under an ambulatory setting was around $8,600 in 2010. The average cost was around $19,100 for those who stayed overnight in a hospital (general ward level).

[18] It is assumed that the percentage of endoscopy or colonoscopy performed under an inpatient setting would decrease from the current 70% to 15% under VHIS.

procedures would be covered under VHIS). Mr CHAN Kin-por has pointed out that according to the Hong Kong Federation of Insurers ("HKFI") statistics, the up-to-date average claim ratio stood at 69% in 2013 (and hence an expense loading of 31%) for the whole PHI market.

Coverage of prescribed advanced diagnostic imaging tests and non-surgical cancer treatments

26. On the Administration's proposal of covering prescribed advanced diagnostic imaging tests under the Minimum Requirements, question has been raised as to the reason why the Administration would consider that these tests would be more easily subject to mis-use or abuse and, hence, should be subject to a fixed 30% co-insurance arrangement. The Administration has advised that in the course of discussing with the insurance and healthcare sectors on the requirement, there are concerns that covering advanced diagnostic imaging tests under VHIS might lead to moral hazard and a rapid increase in utilization of these tests. The imposition of a fixed 30% co-insurance for claims on these tests would be conducive to managing the risk of utilization growth arising from moral hazard, which would in turn help keep premium levels in better check in the longer term. Noting the Consultant's finding that the average out-of-pocket payment by policyholders of existing individual indemnity hospital insurance products (ward level) is about one-third of the total costs, the Administration considers the 30% co-insurance ratio (subject to an annual ceiling) proposed by the Consultant reasonable, as it would balance between the need to combat moral hazard and premium affordability of the Standard Plan.

27. The Chairman is of the view that the proposal is a step backward in consumer protection, as advanced imaging tests for surgical purpose are covered under some existing individual indemnity hospital insurance policies in the market and are likely to be fully claimable under the benefit item of miscellaneous hospital expenses. He has suggested that the co-insurance arrangement should only be imposed on those tests conducted for diagnostic purpose. The Administration has advised that the existing arrangements would entail unnecessary hospitalization and the reimbursement may not be sufficient for covering the full cost of these tests.

Budget certainty

28. In the Second Stage Public Consultation, it was proposed that HPS plans should offer coverage for common procedures using diagnosis-related groups[19] ("DRG")-based packaged pricing. On the Administration's latest

[19] Diagnosis-related groups is a sophisticated coding system for classifying medical conditions requiring treatments or procedures by diagnosis and complexity.

stance that it would take a relatively longer time for Hong Kong to develop an operable system of DRG suitable for local use in the private sector that a "no-gap/known-gap" arrangement and an "Informed Financial Consent" would instead be introduced under VHIS to promote budget certainty, some members have expressed concern that there would be a lack of mechanism to govern the healthcare costs. Concern is also raised as to whether private healthcare providers would be interested in contracting with the insurers and providing the estimated service charges required to map out the lists of "no-gap" or "known-gap" procedures to be covered in the insurance policies regulated under VHIS, given the present overwhelming demand for private hospital services.

29. The Administration has explained that the original proposal to develop a DRG-based charging system is only a means to meeting the end of enhancing payment certainty. Patients would enjoy greater payment transparency and certainty under the "no-gap/known-gap" and "Informed Financial Consent" arrangements. The Administration has advised the Subcommittee that the major technical challenges for formulating packaged pricing are the complexity of diseases and the fact that a majority of private hospitals' admissions are handled by visiting doctors. Nevertheless, the Administration would continue to discuss with the existing private hospitals the introduction of packaged charging for common treatments or procedures. In addition, new private hospital developments are required to offer at least 30% of in-patient bed days each year for packaged priced services.

30. Some members have expressed concern that private hospitals may form a price cartel to maintain the packaged charges for common procedures at a high level. They have asked the Administration whether private hospital services would be subject to the regulatory regime of the Competition Ordinance (Cap. 619). The Administration has advised that most private hospitals fall within the definition of "undertakings" and would therefore be subject to the regulation of the Competition Ordinance. In addition, the Steering Committee on Review of the Regulation of Private Healthcare Facilities has conducted a root-and-branch review of the regulatory regime for private healthcare facilities, which include, among others, private hospitals, with a view to strengthening the regulatory standards to meet the public aspiration and better safeguard public health. The Administration has put forth various measures to enhance price transparency of private healthcare facilities in the Consultation Document on Regulation of Private Healthcare Facilities for public consultation.[20] There is

[20] The Government has published the Consultation Document on Regulation of Private Healthcare Facilities on 15 December 2014, in which price transparency is put forward as one of the proposed regulatory aspects, for a three-month public consultation. The proposed requirements include (a) provision of fee schedule; (b) provision of quotation; (c) provision of recognized service packages; and (d) disclosure of historical bill size statistics. The Government released the consultation report on 11 April 2016.

board support for regulating private healthcare facilities from the perspective of enhancing price transparency to enable consumers to be better informed, which would in turn strengthen their confidence in utilizing private healthcare services.

Impact of VHIS on existing PHI subscribers

Average annual standard premium of Standard Plan

31. The Consultant's estimation is that the average annual standard premium of the Standard Plan would be around $3,600 in 2012 constant prices (viz. 9% or $300 higher as compared to the average premium of existing individual indemnity hospital insurance products (ward level) of $3,300 in 2012), subject to a potential range of variation between -8% and +45%. Mr CHAN Kin-por has remarked that as the actual premiums offered by different insurers would vary by factors such as pricing strategy and risk profile of individual insurers, it would be difficult for the insurance industry to come up with their figures concerning the average annual standard premium of Standard Plan. Members are concerned that those existing PHI subscribers who are at the lower end of the range of premium and/or in the older age group may be priced out as they would be unable to afford a 30% to 40% higher premium under the Standard Plan. According to the insurance sector, the annual premium of about 50% of the existing individually-purchased PHI policies is below $3,000.

32. The Administration has explained that since some premium impacts may vary considerably depending on market reaction, the estimated figure of $3,600 is subject to a range of variation from -8% to +45%. Among the 12 proposed Minimum Requirements, the Consultant considers that the coverage of pre-existing conditions, coverage of hospitalization and ambulatory procedures, coverage of advance diagnostic imaging tests and non-surgical cancer treatments, and minimum benefit limits would carry significant and quantifiable impacts on the standard premium of the Standard Plan, while the impacts of the remaining requirements are considered non-quantifiable and/or insignificant.[21] A key driver for the variation is how well VHIS is able to contain moral hazards on the use of advanced diagnostic imaging tests. In the scenario with a premium variation of +45%, it is assumed that per-person usage of these tests would be on the high side, as in the United States, which

[21] In particular, the Consultant considers that guaranteed acceptance with premium loading cap would not carry significant impact on the standard premium as the price impact primarily translated into premium loading. As regards guaranteed renewal, the Consultant considers it acceptable not to include this requirement in the scope of quantification since the price impact will occur only gradually and incrementally in the long term and offset through improved market dynamics.

illustrates a scenario with ineffective control over abuse in usage. The Administration has further advised that the increase in the estimated average annual standard premium under VHIS could be partly offset if tax incentives are to be introduced.

33. Mr CHAN Kin-por has pointed out that at present, about 80% of the amount of premium paid by the insured for individual indemnity hospital insurance policies is used to cover the medical costs. Some members have expressed concern that the Minimum Requirements could not help containing medical inflation arising from, among others, advances in medical technology and medications. They consider that the proposed regulatory measure to enhance price transparency of private hospitals could not contain increase in hospital charges. With higher medical cost as a result, the reimbursement levels would get less unless there is corresponding upward adjustment in the level of premium.

34. The Administration has advised that while there would be no direct regulation of price setting for hospital services, just as there would be no direct interference with premium setting for the Standard Plan, the increase in the supply of private hospital beds by about 40% in the next few years, the extensive use of packaged charges by the newly developed private hospitals, and the inclusion of prescribed ambulatory procedures in the benefit coverage of VHIS products to discourage unnecessary overnight hospital stay would help keep medical costs under better control.

35. The Administration has further advised that while there is no official medical inflation index available in Hong Kong, the Consultant assumes that the excess medical inflation (i.e. the excess of medical inflation over general inflation) would be lower during the projection horizon of 2016 to 2040 with the implementation of VHIS. This is due to greater budget and cost certainty for consumers and insurers through the "no-gap/known-gap" and "Informed Financial Consent" arrangements on the one hand, and more efficient use of private healthcare resources on the other hand through facilitating delivery of healthcare in ambulatory setting. The Consultant has adopted the working assumptions that the excess medical inflation per annum is 3.6% under the baseline scenario (i.e. without VHIS), and ranged from 2.1% to 4.1% under the forecast scenario (i.e. with VHIS) for projecting the long-term impact of VHIS.

36. Some members, including Mr CHAN Kin-por, have casted doubt about the accuracy of the estimated premium growth rate of individual indemnity hospital insurance products (ward level) under the VHIS regime from 2016 to 2040. According to the Consultant, the projected premium growth rate concerned is 3.5% per annum (in excess of the general inflation rate). The

Administration has advised that according to the Census and Statistics Department, the general inflation rate has hovered at around 2% to 4% in recent years. The estimate by HKFI in September 2015 was that the growth rate of average premium of health insurance had been around 5% per annum in recent years. Against the above backdrop, the Administration considers that the estimation of the Consultant is broadly consistent with the current market situation.

37. Mr CHAN Kin-por is of the view that the average annual standard premium would not be affordable to many members of the public. Assuming that the premium would grow at a rate of 6% per annum, the average standard premium for those aged 45 to 49, who would most likely purchase health insurance, would be around $6,356 (or as high as about $9,216 as the Consultant's estimation is subject to a potential range of variation between -8% and +45%) if VHIS is to be implemented in 2017. The average annual standard premium for people aged 15 to 19 would be in the range of $2,000 to $2,900.

38. Concern has been raised about the high expense loading of local individual health insurance market, which stood at 36% in 2013 according to the Office of the Commissioner of Insurance[22] and is the highest among the jurisdictions studied by the Consultant.[23] The Administration has advised that it is expected that under VHIS, standardization, quality assurance and better flow of market information would facilitate easy comparison by consumers, foster market competition, and hence lead to a more moderate expense loading. Mr CHAN Kin-por has remarked that according to the statistics of HKFI, the up-to-date expense loading is 31% for individual health insurance market, and around 25% if group indemnity hospital insurance policies are included.

Premium of high-risk individuals

39. While it is proposed that only those applicants whose premium loading is assessed to equal or exceed 200% of standard premium would be admissible to HRP, Dr KWOK Ka-ki and Mr CHEUNG Kwok-che have expressed concern that insurers may mark up the premium loading rate in order to pass on all higher-risk subscribers to HRP.

40. The Administration has advised that by transferring the policies of those applicants whose premium loading is assessed to equal or exceed 200% of

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[22] According to the Office of the Commissioner of Insurance, the corresponding figure for the group health insurance market in Hong Kong was 19% in 2013.

[23] According to the Consultant, in 2012, the average expense loading of the whole health insurance market was 13% in Australia, 13% in Ireland, 7% in the Netherlands and 9% in Switzerland.

standard premium to HRP, the insurer would surrender the premium collected for these policies after deducting a nominal handling fee to be prescribed by the VHIS agency. While the insurer would continue to be responsible for the administration of the policies, the premium income (net of expense), claim liabilities and profit/loss of these policies would be accrued to HRP instead of the insurer concerned. Hence, as long as the insurers could charge a premium loading on higher-risk applicants to commensurate with the extra risks that they take on, they could still expect to have an underwriting profit by keeping the higher-risk subscribers under their own portfolio. In addition, given that all insurers would be required to provide the Standard Plan as an option to the consumer, it would not be in the interest of an insurer to mark up the premium loading rate due to price competition, given that the consumer could compare offers from other insurers for coverage of the Standard Plan.

41. Members have sought clarification as to whether insurers could introduce premium loading at next policy renewal, so as to pass on unfavourable risks to HRP, in case the low-risk policyholders have made a claim. The Administration has advised that insurers would only be allowed to underwrite a prospective insured person, taking into account the latter's health status, pre-existing medical conditions and other relevant risk factors, before effecting a health insurance policy. No re-underwriting would be allowed for policy renewal.

Migration of existing individual hospital insurance policies

42. According to the Administration's proposal, where the expiry of the existing individual indemnity hospital insurance policies falls within the first year of implementation of VHIS, insurers are required to, upon such expiry, offer an option to policyholders concerned to migrate to an individual hospital insurance policy that meets or exceeds the Minimum Requirements. Policyholders will have the option of migrating to compliant policies or renewing their existing policies. For the latter, such policies will be grandfathered and are exempted from the Minimum Requirements as long as the insurers concerned continue to administer such policies. After the one-year migration window period, a policyholder who has not yet migrated and wishes to be covered by a compliant policy would need to purchase a separate policy as a new customer, and may be subject to full underwriting if deemed necessary by the insurer concerned.

43. There is a view that the migration window period for policyholders of existing individual hospital insurance policies to migrate to compliant policies under VHIS should be longer. There is a suggestion that both compliant and

non-compliant products should be made available for prospective customers to choose during the migration window period.

Employees covered by existing group hospital insurance policies

44. Pointing out that most of the existing employer-provided indemnity hospital insurance policies are of limited protection in terms of benefit coverage and limits, the Chairman has requested the Administration to estimate the impact on premiums if employer-provided group indemnity hospital insurance policies would be subject to Minimum Requirements. Concern is also raised that existing group indemnity hospital insurance in the market is not limited to policies held by employers for the benefit of employees. Mr CHAN Kin-por, however, is of another view. He considers that the introduction of the Minimum Requirements would discourage employers, in particular the small to medium sized enterprises, from providing group indemnity hospital insurance for their employees. Concern is raised as to whether employees could enjoy continuity of health insurance after retirement and whether those covered by group indemnity hospital insurance products taken up by their employers would be given the choice to take up products with lower premium but fewer benefits, such as those with case-based exclusions of pre-existing conditions.

45. The Administration has advised that insurers would be required to offer employers a Conversion Option in the group indemnity hospital insurance products so that employees covered by the group policy could, upon leaving their employment, choose to switch to an individual Standard Plan at standard premium without re-underwriting, provided that the employees concerned have been employed for a full year before transferring to the individual Standard Plan. It is also proposed that insurers may, on a group policy basis, offer Voluntary Supplement to individual members covered by a group policy who wish to procure at their own costs additional protection on top of their group policy at a level tantamount to that of the Standard Plan. Subject to the outcome of the consultation, the Administration would consider changing the proposed Voluntary Supplement into a mandatory nature (in parallel with the required provision of Conversion Option).

<u>Public funding for VHIS</u>

Financing of HRP

46. Some members have expressed strong reservations against the use of public funds to subsidize the uptake of PHI. Some members consider it not cost effective to use public funds to subsidize the middle-income group for

taking out VHIS plans as the insured may continue to utilize the public system, in particular for the more expensive healthcare services. Hence, whether VHIS could achieve, among others, its objective of relieving pressure on the public healthcare system and in turn, benefiting the lower-income group is in doubt. There is also a view that given the high administrative fees charged by the private insurers, any such subsidies may benefit the insurers more than the insured themselves. Some members consider that it would be more cost effective to use the $50 billion fiscal reserve earmarked to support healthcare reform to improve public healthcare services, particularly in promoting primary care and prevention and early identification of disease in order to reduce the need of the population for the more expensive hospital services. Another suggestion is that in face of an ageing population, the $50 billion fiscal reserve should be used to provide direct subsidy to elderly persons aged 65 or above in using private healthcare services, as they may not be able to afford continuous health insurance protection after retirement when they need it most.

47. According to the Administration, Hong Kong is unique in that both the public and private hospital systems are well developed to provide a comprehensive range of quality services. However, there is a significant public-private imbalance that the highly subsidized public system provides around 88% of inpatient services (in terms of number of bed days), resulting in longer waiting lists and waiting time for services. To provide better choice of individualized healthcare for the public under the dual-track healthcare system, an objective of VHIS is to enable more middle-income persons who could afford and are willing to purchase PHI to use the readily available private services on a sustained basis. In so doing, the public system could focus on serving its target areas and population groups, including, among others, illnesses that entail high cost and advanced technology, and the low-income and under-privileged population groups. The Administration has stressed time and again that VHIS is not intended to be a total solution to the challenges faced by the healthcare system, but a supplementary financing arrangement complementing public healthcare, and one of the turning knobs in reducing the long waiting time for public healthcare services (in particular that for the elective surgeries which has reached a bottleneck).

48. The Administration has stressed the need to use public funds to support HRP, which is the key enabler of guaranteed acceptance with premium loading cap and without which insurers may have to assimilate the excessive risks among their policyholders by charging higher premium across the board causing those high-risk individuals who could not afford to pay the premium to fall back on the public system, which is heavily subsidized by the Government. In the Administration's view, it is equitable to provide public funding support

to enable those high-risk individuals who are willing to contribute to their own healthcare costs through paying premium to obtain health insurance coverage.[24] Given that it is estimated that only about $4.3 billion from the $50 billion fiscal reserve earmarked to support healthcare reform would be required to support HRP for a period of 25 years (i.e. 2016 to 2040), part of the remaining sum of the $50 billion has been used for setting up an endowment fund for the Hospital Authority ("HA") to make use of the investment returns for public-private partnership initiatives. Any remaining sum of the $50 billion would be reserved for general use, including provision of support for public hospital projects.

Tax deduction vs. other forms of financial incentives

49. The proposal of the Administration is to introduce tax reduction for premium paid for individual hospital insurance policies owned by taxpayers covering themselves and/or their dependants that comply with the Minimum Requirements so as to encourage the taking out of hospital insurance. Some members, including Mr CHAN Kin-por, Miss Alice MAK and Mr POON Siu-ping, are concerned that the proposal may not provide a strong incentive for the young and healthy to take out VHIS, as the average tax benefit per eligible taxpayer is estimated to be only about $450.[25] This calls into question the sustainability of VHIS as only individuals of higher risk would join. There is a view that an annual ceiling on claimable premiums, which is proposed to be $3,600 per person insured, should not be imposed. Mr CHAN Kin-por considers that the proposal would not be as attractive as the previously proposed options of premium discount and premium rebate for long stay under the savings options put forward in the Second Stage Public Consultation as an incentive for new joiners to the Standard Plan and the insured to stay on.

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[24] The Administration has provided the Subcommittee with an example on the procedure of tonsillectomy for illustration, details of which are set out in paragraphs 13 to 18 of LC Paper No. CB(2)855/13-14(01). Assuming that a patient would need to pay about one-third of the total costs for receiving private healthcare services, a patient would need to pay $11,300 (one-third of $34,000) out-of-pocket if he or she chooses to undergo the tonsillectomy procedure in a private hospital. The remaining amount would be payable by HRP, i.e. $22,700 ($34,000 - $11,300). Since HRP would be partly financed by the premium collected from the patient (three times standard premium of the corresponding age-band), the amount of Government subsidy provided to the patient in this case, even taking into account the operation costs of HRP, would be significantly less (i.e. a portion of $22,700) compared with the case where the patient chooses to undergo the procedure in a public hospital (i.e. $33,700).

[25] Assuming that the annual level of claimable premiums was capped at $3,600 per person insured, and based on an estimate of about 570 000 taxpayers and 360 000 dependants eligible for tax deduction, the tax revenue forgone is estimated to be $256 million (in 2012 constant prices) in 2016 (assuming that both VHIS and tax deduction would be implemented in 2016).

50. The Administration has clarified that the exact amount eligible for tax deduction would be determined by the Government upon implementation of VHIS. However, it is likely that a cap would be imposed given that VHIS is aimed at enabling policyholders to access general ward class of private healthcare services. According to the Administration, the provision of direct premium subsidy or discount might provide an incentive for some insurers to mark up the premiums of the VHIS plans, thus effectively pocketing a significant portion of the premium subsidy or discount. Some form of premium control would therefore be necessary. There are considerable reservations within the community over the inclusion of compulsory savings component as an essential part of VHIS, as it would result in a higher premium at the younger age and discourage people from enrolling in VHIS plans. It is considered more appropriate for the savings component to be an optional feature under VHIS.

51. The Administration has further advised that tax deduction is not the only measure that could promote the uptake of individual indemnity hospital insurance. Under VHIS, the young and healthy would have greater incentive to join the scheme early given that the premium would be age-banded and that the amount of premium loading would be calculated on the basis of the health conditions of the insured at the time he or she joined the health insurance. The requirement of guaranteed renewal for life would also enable the early entrants to enjoy life-long protection without having to undergo re-underwriting even if they suffer from catastrophic illnesses after purchasing their VHIS plans. According to the market survey conducted by the Consultant to gauge the willingness of middle-income individuals to purchase or migrate to the Standard Plan focusing on the main scenario of $3,600, about 70% of the respondents, with or without cover of indemnity hospital insurance, indicated that they are willing to consider to do so.

52. Some members have expressed concern about the high annual premium level under VHIS of which subscribers may become unable to continue to afford when they aged or retired. Mr CHAN Kin-por estimates that the average annual premium for a high-risk individual in the age group of 60 to 64 could be in the range of $27,696 to $40,158 if VHIS is implemented in 2017. Taking into consideration that some policyholders may, for various reasons, become unable to afford the premium after continuing staying insured under VHIS for years, Prof Joseph LEE, Mr YIU Si-wing and Dr KWOK Ka-ki have suggested that Government subsidy should be provided to enable the insured to enjoy an extended period of protection, say, three years for a thirty-year subscription, after expiry of the payment term. The Administration has advised that the proposal is complex and may entail high administration cost, and warrants

careful consideration. The market could, in any way, decide whether to provide an option for the insured to pay higher premium at a younger age to offset the premium at older age from the business perspective.

Institutional framework for the governance and operation of VHIS

53. According to the Administration, the Office of the Commissioner of Insurance or the independent Insurance Authority to be set up in place of the former, should continue to serve the function of regulating the insurers when VHIS is in place. Regulation of insurance intermediaries should continue to rest with existing self-regulatory bodies. As regards scheme supervision, it is proposed that a new regulatory agency should be set up to perform the function of ensuring a smooth implementation and operation of VHIS, and to ensure the policy objectives of VHIS are achieved. An advisory committee comprising major stakeholders is to be established to provide professional advice to the regulatory agency. The Administration further proposes that a claims dispute resolution mechanism is to be put in place for resolving financial disputes concerning claims settlement of health insurance as an alternative to litigation.

54. There is a view that the proposed regulatory agency for VHIS should not end up becoming a "white elephant". Given that the existing Insurance Claims Complaints Bureau, the self-regulatory body sponsored by the insurance industry which provides adjudication services for free has all along been effective in dealing with claims disputes arising from individual insurance policies, the proposed claims dispute resolution mechanism for VHIS would be suitable for resolving disputes involving a larger amount of money.

55. According to the Administration, the setting up of the proposed regulatory agency is to ensure that individual indemnity hospital insurance plans being offered in the market would comply with the prescribed Minimum Requirements, and handles complaints about insurance claims arising from the VHIS plans. The proposal is consistent with the common practice in overseas jurisdictions where PHI is an important policy tool in healthcare financing, such as Australia, Ireland, the Netherlands, Switzerland and the United States. The Administration has advised that claims disputes between insurers and healthcare service providers under direct billing arrangement would not be covered under the proposed claims dispute resolution mechanism during the initial phase of implementation of VHIS.

The way forward for the proposed VHIS

56. The Subcommittee notes that the Government has received a total of 600 written submissions from the public on the 2014 Consultation Document.

According to the Administration, there is broad support for the concept and policy objectives of VHIS. Noting that the Administration's original plan as set out in the 2014 Consultation Document was to introduce the bill and its subsidiary legislation required for VHIS into the Legislative Council in the 2015-2016 legislative session, members have raised concern about the Administration's latest timetable for taking forward the proposed VHIS.

57. The Administration has advised that it is in discussion with the insurance sector through HKFI on refining the details of the VHIS proposals. The insurance industry, while in general supported the policy objectives of the VHIS to provide enhanced health insurance protection for consumers, expresses concerns over some of the specific proposals put forth in the 2014 Consultation Document, including the two Minimum Requirements of guaranteed acceptance and portable insurance policy, as well as the sustainability of HRP. This apart, the insurance industry has suggested implementing VHIS through means other than the legislative route, including the option of allowing insurers to enter into a self-regulating industry agreement or inviting the Office of the Commissioner of Insurance or the future independent Insurance Authority, a new insurance regulator independent of the Government, to promulgate relevant guidance notes. The Administration is exploring the feasibility of these options in consultation with the relevant bureau or departments, and has been maintaining a regular dialogue with HKFI, with a view to working out a sensible, practicable and viable proposal to implement VHIS. The Administration's plan is to iron out the way forward and release the consultation report in around mid-2016.

58. The Chairman is of the view that given that the Administration has already worked out the expected costs of operating HRP and the required injection from the Government for financing HRP in order to enable those high-risk individuals who are willing to contribute to their own healthcare costs through paying premium to obtain health insurance coverage, there is no need for the Administration to further study the issue. If the Administration considers that it needs more time to work out the details of HRP with the insurance industry, an option is to commission an independent consultant to verify the respective estimation made by the Administration and the insurance industry.

59. Mr CHAN Kin-por is of the view that implementing VHIS through means other than the legislative route could save time and immediately bring about enhanced quality and certainty of hospital insurance protection for the benefit of consumers, and could reduce the regulatory cost and the compliance burden on insurers. Some members including Dr KWOK Ka-ki consider that the Administration should establish the proposed regulatory agency to monitor the implementation of the Minimum Requirements, irrespective of whether the Minimum Requirements concerned would be implemented through legislation

or not. Mr CHAN Kin-por, however, considers that the establishment of the independent Insurance Authority to exercise statutory regulation over the insurers and the insurance intermediaries would not only promote the stable development of the industry, but also provide better protection for existing and potential policy holders. The insurance industry prefers to put the regulation over the Minimum Requirements under the purview of the independent Insurance Authority to obviate the need of subjecting the industry under two regulatory authorities.

60. The Administration has advised that if the Minimum Requirements are to be implemented first through means other than the legislative route, it would put in place a mechanism to closely monitor the compliance of the insurers with the requirements and handle the disputes that may arise. In the event that a separate regulatory agency is to be established for VHIS through legislation, it would be far less complicated than the original proposal if its functions do not cover the monitoring of the operation of a HRP.

Supporting infrastructure

61. The implementation of the proposed VHIS is expected to lead to an increase in private healthcare sector activities. Hence, the success of VHIS hinges on having in place the necessary supporting infrastructure, including, among others, an adequate supply of healthcare manpower. Members note that as part of its efforts to take forward VHIS, the Administration has established the Steering Committee, which is chaired by the Secretary for Food and Health, to formulate recommendations on how to cope with anticipated demand for healthcare manpower, strengthen professional training and facilitate professional development so as to ensure the healthy and sustainable development of the overall healthcare system. The review of the Steering Committee covers the 13 healthcare disciplines that are subject to statutory regulation, viz. medical practitioners, dentists, dental hygienists, nurses, midwives, Chinese medicine practitioners, pharmacists, chiropractors, medical laboratory technologists, occupational therapists, optometrists, radiographers and physiotherapists.

62. According to the Administration, the review of the Steering Committee will be completed in around mid-2016. The Government will publish the report and take forward the recommendations in consultation with relevant stakeholders as appropriate upon completion of the review.

The healthcare manpower projection model

63. Members note that to assist the Steering Committee in making informed recommendations, the University of Hong Kong ("HKU") has been

commissioned to conduct a comprehensive manpower projection for the healthcare professions under study. In this connection, HKU has developed a generic forecasting model, which comprises a demand model and a supply model, for projecting the healthcare manpower up to 2041 ("the generic model"). Concern is raised as to whether the generic model would take into account local circumstances such as the challenges arising from an ageing population, and could be adopted to adjust for the impact of externalities such as an increase in inpatient beds arising from known and planned private hospital developments in the next few years.

64. According to the Administration and HKU, there is no universal model for estimating healthcare manpower whether in the literature or among the jurisdictions surveyed. The more common approaches adopted include workforce-population ratios, demand/utilization-based or need-based models and supply models. Developed to suit the local circumstances and adopting the methodology of curve-fitting of historical sample, the generic model would use historical inpatient and outpatient utilization data from the public and private healthcare sectors and the population projections of the Census and Statistics Department to project the healthcare service utilization of age-, sex-specific population groups. Support vector machine would then be used to project the required number of doctors, which would be sector-specific (i.e. for the public and private sectors) and separated by clinical settings (i.e. inpatient and outpatient services). The projected demand would be compared with the projected supply and the difference so derived would be quantified in the gap analysis to see if any surplus or shortage of medical manpower existed. The generic model is so designed such that it could be adopted to adjust for the impact of externalities, such as an increase in public and/or private inpatient beds over and above endogenous historical growth and an increase in demand for private services in view of the impending implementation of VHIS.

65. Given that a key assumption of the generic model is that the manpower projection follows the historical trend in the data, question has been raised as to the reason why historical utilization volume of a relatively short span of time (i.e. from 2005 to 2011) is used for projecting service utilization in the public healthcare sector. Concern is also raised as to whether the generic model would take into account the fluctuation in healthcare service utilization.

66. The Administration has advised that using more recent service utilization data in the modeling would help to project more accurately the demand for doctors in the coming years brought about by an increase in public healthcare service utilization due to an ageing population. In addition, data of earlier years could not reflect changes in the service delivery models of HA (e.g. the introduction of the grade of Health Care Assistant to relieve nurses of simple

care duties). The reason why data from 2005 but not 2004 onwards is used for the projection was that the data of 2004 might be unduly influenced by the outbreak of Severe Acute Respiratory Syndrome in 2003. Given that the commissioned study commenced in 2012, data up to 2011 is used for making the initial projections. The projections could be updated when more up-to-date data became available. According to HKU, sensitivity analysis is used to compute the projection by omitting a portion of historical data where the omitted data is regarded as unreliable. All projection trials converge to a locus when historical data is reliable.

67. Question has been raised as to whether using historical service utilization data of HA with adjustments for population growth and demographic changes as the parameter to forecast HA's healthcare manpower demand would fail to take into account the problem of HA of having inadequate healthcare manpower to support its services in the past years. According to HA, when translating the time requirement (man-hours) of the healthcare professionals of HA in carrying out each unit of the projected service workloads, there would be an +5% to +10% adjustment with a view to improving the services provided. There is a view that given the rising public expectations for longer consultation time for public outpatient services, the factor of consultation time per patient should be included as a parameter for the medical manpower demand model for converting the healthcare demand/utilization to public sector doctor full time equivalent. HKU has advised that under the generic model, an increase in outpatient consultation time per patient would represent a decrease in manpower supply of doctors in the planning horizon.

68. Members are concerned that the impact brought about by the retirement of an experienced doctor could not be offset by the addition of a fresh medical graduate to the total doctor pool under the medical manpower supply model. According to the Administration, the estimated number of local medical graduates in each of the coming academic years up to 2018 would be based on the actual number of students currently in different years of study in University Grants Committee ("UGC") funded medical undergraduate programmes. The supply model assumes that there would be an addition of 420 local medical graduates per year from 2019 to 2041, and a constant annual inflow of 60 non-local graduates to the registration pool.

69. As regards whether the generic model would take into consideration the distribution of medical manpower resource between the public and private healthcare sector, as well as the elasticity of medical manpower supply in the private market, HKU has advised that these factors would be taken into account in the medical manpower projection if needed be.

70. Members note that the generic model would be suitably adapted to cater for utilization parameters peculiar to individual professions in forecasting the manpower demand and supply situation of the other healthcare disciplines under study. There is a suggestion that the parameters for projecting the demand for nurses and allied healthcare professionals should include the utilization of care services provided in the welfare setting, such as those provided at the residential care homes for the elderly and people with disabilities and day care centres for the elderly, and those under the home care services schemes for frail elders and programmes for autistic persons. According to the Administration, the Social Welfare Department would be invited to provide profession-specific service utilization data in the welfare setting for the purpose of making projections for nurses, occupational therapists and physiotherapists.

71. On the question of whether the common international standard on nursing manpower ratio (i.e. one nurse to six patients) would be adopted for projecting the manpower requirements for nurses, the Administration has advised that there is no universally applicable set of international standard on nurse to patient ratios. Given that healthcare systems of different countries vary, adjustments for differences in care setting are important for such models to be relevant. According to HA, a higher nurse-to-patient ratio could only be introduced after the current manpower shortage problem has been resolved.

72. The Subcommittee has requested the Administration to provide the neural network architecture (with the elements of inputs, weights, biases and transfer function) for forecasting the long-term manpower requirements of the 13 healthcare professions subject to statutory regulation; and explain in writing how future actual adjustments of the variables, say, there is an oversupply of medical graduates in a certain year, would feed back into the generic model for a corresponding adjustment in the projection of the relevant healthcare manpower requirements. The Administration has also been requested to arrange a demonstration to illustrate the running of the generic model. At the time of submission of this report to the Panel, the Administration has not yet provided the requisite information for reference of the Subcommittee. The demonstration has not been arranged.

Healthcare manpower planning

73. Members note that the initial and rough indications under the manpower projection models for doctors, dentists and nurses are that there would likely be a general shortage of healthcare manpower in the run-up to 2041. Given that healthcare manpower supply could not be increased overnight, members are concerned about the interim measures to increase the

supply of healthcare manpower pending the outcome of the commissioned study being conducted by HKU.

74. The Administration has advised that it has, based on the current forecast of healthcare manpower shortage of HA that there would be a shortfall of 330 doctors in 2020, discussed with the Education Bureau and UGC an interim arrangement to increase the number of intake of doctors, dentists and other healthcare professionals starting from the 2016-2017 academic year in order to meet the triennial planning cycle for the UGC-funded institutions. It is noted that there is a substantial increase in the training capacity for nurses in the self-financing sector. Based on the preliminary findings of the strategic review, the Government has increased the number of publicly-funded degree places in medicine, dentistry and other healthcare disciplines by 50, 20 and 68[26] respectively in the 2016-2017 to 2018-2019 triennium. To complement local supply, the Medical Council of Hong Kong has increased the frequency of the licensing examination from once to twice a year starting from 2014 and would introduce more flexibility into the internship arrangement with a view to facilitating more overseas-trained doctors to register for practice in Hong Kong. The Dental Council of Hong Kong and the Nursing Council of Hong Kong has also respectively increased the frequency of the licensing examinations for overseas-trained dentists and nurses from once to twice a year starting from 2016.

75. Noting that the manpower projections for the healthcare professions under the study would be up to 2041, there is a suggestion that the projection period should be extended for 25 more years to take into account the likely factor that the proportion of elderly people in the population and their healthcare demands might decline after the peak period. An adjustment mechanism should also be put in place to address the deviation between the projected and the actual demand for individual healthcare professionals, if any, in the planning horizon. The Administration has advised that while the commissioned study seeks to estimate the demand and supply of healthcare professionals for the disciplines under study with an initial planning horizon of up to 2041, it would assess the accuracy of the projected healthcare manpower demand from time to time, say, every one to two year(s). Where necessary, adjustments would be made to address the differences between the projected and the actual demand.

76. Question has been raised as to how the manpower projection for doctors could help to avoid the situation which occurred in early 2000s whereby medical graduates could not undergo training in HA due to a downward adjustment in the Government subvention to HA during economic downturn, and hence, a decrease

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[26] The number of UGC-funded degree places in pharmacy, medical laboratory science, occupational therapy, optometry, physiotherapy and radiography has been increased by 10, 10, 10, 6, 20 and 12 respectively in the 2016-2017 to 2018-2019 triennium.

in HA's budget for the recruitment of new resident trainees. The Administration has advised that while an economic downturn might affect healthcare demand and manpower needs during a certain period of time, the medium to long-term manpower requirements brought about by factors such as an ageing population and changes in the delivery models of healthcare would remain unchanged. Hence, the generic model would shed light on the need to maintain a stable supply of medical graduates to HA notwithstanding economic cycles. This would avoid over-reaction during economic downturn which might prove short-sighted at a later day.

Regulatory framework for healthcare professionals

77. Members note that to assist the Steering Committee in making informed recommendations, the Chinese University of Hong Kong ("CUHK") has been commissioned to conduct a comprehensive review of the regulatory frameworks in local and overseas contexts of the healthcare professions concerned, as well as mechanisms for setting standards and maintaining competence. An initial finding of the study conducted by CUHK is that healthcare professional regulation is increasingly moving from the premise of self-regulation of the profession to protect its own interests to one of co-regulation in partnership with the public to better protect the public's health. There is a global trend for more openness and accountability, including greater involvement of lay persons in regulatory bodies and relevant panels for review and inquiries. In comparison with overseas jurisdictions, healthcare regulation in Hong Kong is characterized by a high degree of professional autonomy.

78. The Subcommittee notes that the Steering Committee agrees that the prevalent legislation which governs the relevant healthcare professions should keep pace with the times and should be reviewed comprehensively. There is a concern about the room for changing the existing regulatory frameworks for healthcare professionals under Article 142 of the Basic Law.[27] The

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[27] Article 142 of the Basic Law reads as follows:

"The Government of the Hong Kong Special Administrative Region shall, on the basis of maintaining the previous systems concerning the professions, formulate provisions on its own for assessing the qualifications for practice in the various professions.

Persons with professional qualifications or qualifications for professional practice obtained prior to the establishment of the Hong Kong Special Administrative Region may retain their previous qualifications in accordance with the relevant regulations and codes of practice.

The Government of the Hong Kong Special Administrative Region shall continue to recognize the professions and the professional organizations recognized prior to the establishment of the Region, and these organizations may, on their own, assess and confer professional qualifications.

The Government of the Hong Kong Special Administrative Region may, as required by developments in society and in consultation with the parties concerned, recognize new professions and professional organizations."

Administration has assured members that any legislative proposals seeking to change the local regulatory framework for healthcare professionals would be in conformity with the Basic Law.

79. Question has been raised as to whether the initial findings of the study had pointed to the need to subject the 15 healthcare professions not statutorily regulated at the moment under some form of regulatory control, say, be regulated under the Supplementary Medical Professions Ordinance (Cap. 359). There is a view that allied healthcare professionals, in particular clinical psychologists and dietitians, should be subject to statutory control at a level comparable to the control over medical practitioners to ensure patient safety.

80. The Administration has advised that given that excessive regulation might pose unnecessary barriers to market entry, discourage competition and cause resource implications to the society, statutory regulation of healthcare professions should be called for only when the practice of a profession involved considerable health risks to the public. The Government has accepted and, is following up on, the recommendations set out in The Ombudsman's direct investigation report on "Control of Healthcare Professions Not Subject to Statutory Regulation", which was published in October 2013. As announced by the Chief Executive in his 2016 Policy Address, based on the preliminary results of the strategic review, the Government would launch a voluntary accredited registers scheme for non-statutorily regulated healthcare professions.

81. The Subcommittee notes that in response to public concerns over the efficiency of the Medical Council in complaint investigation and disciplinary inquiries as well as its lack of flexibility for the admission of non-locally trained doctors, pending the completion of the strategic review and in advance of the implementation of the full recommendations of the strategic review, the Government has introduced the Medical Registration (Amendment) Bill 2016, which seeks to amend the Medical Registration Ordinance (Cap. 161) and its two subsidiary legislation in order to address the above issues, into the Legislative Council on 2 March 2016. The Bills Committee formed to study the Bill has completed its work and the Council's scrutiny of the Bill is underway.

Recommendations

82. The Subcommittee recommends that the Administration should:

<u>Design of the proposed VHIS</u>

(a) ensure that the Government will continue to strengthen its commitment to the development of the public healthcare system

as the safety net for the whole population. The role of VHIS should only be a supplementary financing arrangement to complement public healthcare, so as to relieve pressure on the public system;

(b) ensure that the introduction of VHIS would not result in limiting the choice of consumers with different needs and making the average standard premium of compliant products unaffordable to many members of the public, particularly the younger and healthier consumers as well as those existing PHI subscribers who are at the lower end of the range of premium;

(c) give consideration to the suggestion of allowing insurers to offer case-based exclusions so that consumers with higher health risks may choose to take out a policy with a lower premium;

(d) consider extending the one-year window period or setting the entry age limit of guaranteed acceptance with premium loading cap at an older age, instead of at 40 as currently proposed, so as to enable more time for people to consider joining VHIS;

(e) give consideration to the suggestion of extending the proposed one-year migration window period for policyholders of existing individual indemnity hospital insurance policies to migrate to VHIS compliant policies;

Use of public funds

(f) examine carefully the details of HRP in view of the concern of the insurance industry, including considering the suggestion of appointing an independent consultant to verify the respective estimation made by the Administration and the insurance industry in this regard;

(g) in respect of the proposal of introducing tax deduction for premium paid for VHIS compliant policies owned by taxpayers covering themselves and/or their dependents, consider not imposing an annual ceiling on claimable premiums to provide a stronger incentive;

(h) give consideration to the suggestion of providing Government subsidy to enable the insured to enjoy an extended period of protection after expiry of the payment term if the policyholders,

for various reasons, become unable to afford the premium after continuing staying insured under VHIS for years;

Private healthcare services

(i) encourage existing and new private hospitals to adopt a transparent fee-charging system and offer packaged charge for common operations or procedures on known diagnosis, as medical cost is one of the key factors in ensuring the long-term sustainability of VHIS;

(j) ensure sufficient private healthcare capacity to cope with the increasing service demand arising from the implementation of VHIS;

(k) strengthen private primary care services to reduce the need of the population for the more expensive hospital and specialist services;

Healthcare manpower planning

(l) ensure that the generic model, which uses, among others, HA's historical service utilization data to forecast the healthcare manpower demand of HA, would take into account the existing problem of HA of having inadequate healthcare manpower to support its services;

(m) put in place an adjustment mechanism to address the deviation between the projected and the actual demand for individual healthcare professionals, if any; and

(n) ensure that healthcare manpower planning would cover the period beyond 2041 to take into account the likely factor that the proportion of elderly people in the population and their healthcare demands may decline after the peak period.

Advice sought

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

Council Business Division 2
Legislative Council Secretariat
15 July 2016

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 Albert HO Chun-yan (from 17 October 2013 to 27 October 2014) Hon Vincent FANG Kang, GBS, JP (since 11 November 2013) Prof Hon Joseph LEE Kok-long, SBS, JP, PhD, RN Hon CHAN Kin-por, BBS, JP Hon CHEUNG Kwok-che Hon Mrs Regina IP LAU Suk-yee, GBS, JP (up to 18 September 2014) Hon YIU Si-wing, BBS (since 27 October 2014) Hon Charles Peter MOK, JP (from 11 November 2013 to 9 October 2015) Hon CHAN Han-pan, JP Hon Alice MAK Mei-kuen, BBS, JP (up to 19 October 2015) Dr Hon KWOK Ka-ki Hon POON Siu-ping, BBS, MH (since 27 October 2014) (Total : 9 members)
Clerk	Ms Maisie LAM
Legal adviser	Ms Wendy KAN

Appendix III

Panel on Health Services

Subcommittee on Health Protection Scheme

A. Organizations and individuals which have/who have made oral representation to the Subcommittee

1. Civic Party
2. Democratic Alliance for the Betterment and Progress of Hong Kong
3. Democratic Party
4. Employers' Federation of Hong Kong
5. Federation of Hong Kong Industries
6. Hong Kong Private Hospitals Association
7. Hong Kong Public Doctors' Association
8. Insurance Claims Complaints Bureau
9. Liberal Party Youth Committee
10. Medical Insurance Association of The Hong Kong Federation of Insurers
11. New People's Party
12. Oi Man Estate Residents Union
13. Patients and Medical Professionals Rights Association
14. Provisional Hong Kong Academy of Nursing Limited
15. The Association of Hong Kong Professionals
16. The Chinese General Chamber of Commerce
17. The Federation of Hong Kong and Kowloon Labour Unions

18. The Hong Kong Federation of Insurers

19. The Hong Kong Medical Association

20. The Lion Rock Institute

21. The Society of Hospital Pharmacists of Hong Kong

22. Mr Paul LAW Siu-hung

23. Professor Raymond LIANG, Emeritus Professor of The University of Hong Kong

24. Mr NG Chung-tat

25. Mr NGAN Man-yu, Kwun Tong District Council member

B. Organization and individual which has/who has provided written submissions to the Subcommittee only

1. Hong Kong Doctors Union

2. Mr YEUNG Wai-sing, Eastern District Council member