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Panel on Health Services

Meeting on 14 April 2025

Background brief on Public Healthcare Fees and Charges Reform

Purpose

This paper provides background information on **public healthcare fees and charges reform** and summarizes the major views and concerns expressed by Members of the Legislative Council ("LegCo") on the subject.

Background

2. Under Section 4(d) of the Hospital Authority Ordinance (Cap. 113), the Hospital Authority ("HA") shall "recommend to the Secretary for Health ("SHH"), for the purposes of Section 18, appropriate policies on fees for the use of hospital services by the public, **having regard to the principle that no person should be prevented, through lack of means, from obtaining adequate medical treatment**".

3. Section 18 of the Hospital Authority Ordinance stipulates that a Hospital Governing Committee may determine fees payable for hospital services provided by the public hospital for which it is established, subject to any directions that may be given by HA, which in turn shall comply with the directions that may be given by SHH. The level of fees and charges determined under this section should be **gazetted for public notice**.

4. HA last adjusted its fees and charges in 2017. The Administration announced in the **2024 Policy Address** that it would examine the structure and levels of the fees and charges to encourage prudent use of services, direct resources to patients who need them most and for those with serious or critical conditions, and increase support for patients with financial difficulties while strengthening the financial sustainability of the targeted subsidization of public healthcare services.

5. On 25 March 2025, the Administration announced the details of the fees and charges reform for public healthcare, which covers the following **three major areas**:

(a) **Reforming the subsidization structure**: reforming the subsidization structure from a systemic perspective by setting the levels of government subsidization and the proportion of co-payments by members of the public for various public healthcare services to rationalize the relative demands for inpatient, accident and emergency ("A&E"), as well as different tiers of outpatient services;

(b) **Reducing waste and abuse**: introducing a co-payment model for non-urgent diagnostic radiology and pathology services, adjusting the charges for and quantities of standard drugs, making use of the fees and charges to drive changes to the public's behaviour in seeking medical treatment to guide the optimal use of resources; and

(c) **Enhancing healthcare protection**: strengthening protection for "poor, serious, critical" patients on all fronts by enhancing the fee waiver mechanism, introducing an annual cap on fees and charges at $10,000, and increasing subsidies on drugs and medical devices for the critically ill, with a view to preventing "patients with serious conditions falling into poverty".

6. HA will implement the new fee structure from **1 January 2026**, and the details are set out in **Appendix 1**.

Major concerns of Members

7. The Panel on Health Services ("the Panel") discussed the fee structure and levels of public healthcare services at the policy briefing-cum-meeting on 18 October 2024. Members also raised two questions on the above issues in the Seventh LegCo. Members' views are summarized as follows:

<u>Factors considered when adjusting fees and charges</u>

8. Members expressed concern about **factors considered by HA when adjusting fees and charges**, including whether **public affordability** would be taken into account. The Administration stressed that the reform of medical fees and charges was necessary. One of the focuses of the reform was to prevent the overuse, misuse or abuse of certain services.

However, the Administration would provide targeted subsidization to people in need.

9. Subsequently, in response to a Member's question on 26 March 2025, the Administration stated that the fees and charges reform for public healthcare just announced was premised on the following **five principles**:

(a) **Commitment will not be lessened**: all the gains from the reform would be wholly utilized for public healthcare services;

(b) **"Co-payment by those who can afford and co-payment by those with mild conditions"**: the co-payment mechanism was required to be expanded and enhanced;

(c) **Enhancement and reduction**: to enhance the protection for "poor, acute, serious, critical" patients and to reduce in wastage;

(d) **High subsidization**: to maintain 90% overall public subsidization rate; and

(e) **Gradual and orderly manner**: aimed to achieve the objective in five years.

<u>General outpatient services in the evening</u>

10. Some Members asked whether the Administration **would explore strengthening the provision of general outpatient services during evening by HA**, such as providing 24-hour services, while increasing the charges for A&E services. Otherwise, members of the public who fell ill at night would still flock to A&E departments. The Administration responded that resources for A&E departments were very precious, and members of the public should consider whether it was necessary for them to go to A&E departments at night.

<u>Setting up healthcare accounts and premium fee-charging inpatient and day care services</u>

11. Members asked whether the Administration had **considered setting up personal or family healthcare accounts for the public to settle co-payments, and establishing premium fee-charging inpatient and day care services in public healthcare institutions that were linked to the compensation under the Voluntary Health Insurance Scheme** ("VHIS"), so as to give the public an additional choice.

12. The Administration advised that VHIS's reimbursement policy had already covered all facilities which offered inpatient services, including those in the public healthcare system. As for the suggestions of setting up personal or family healthcare accounts to settle the co-payments for public healthcare, and establishing premium fee-charging services linked to the VHIS compensation in the public healthcare system, the Government was willing to listen to comments from various sectors in the community and relevant stakeholders, consider the practical needs for the relevant arrangements and study the feasibility.

Persons emigrated overseas returning to Hong Kong for subsidized public healthcare services

13. Some Members **expressed concern about the situation of persons emigrated overseas returning to Hong Kong to use subsidized public healthcare services ("emigrants returning for medical treatment")**, and asked whether the Administration would commence a study on the situation, so as to conduct a systematic analysis of and formulate response plans for the relevant phenomenon, e.g. restricting their use of the relevant services.

14. The Administration replied that any holder of a valid Hong Kong Identity Card and any child under 11 years of age who was a Hong Kong resident was regarded as an Eligible Person for subsidized public healthcare services. At present, there was no requirement for the users to reside in Hong Kong for a specified number of days. Therefore, HA did not require patients who sought services at HA to provide information on the number of days they had resided in or left Hong Kong when attending each consultation, hence could not compile statistics relating to the relevant situation. In view of the sporadicity and urgency of healthcare services that made it impossible for approval of applications annually, HA currently had no intention to require all holders of valid Hong Kong Identity Card to provide information on the number of days they had resided in Hong Kong for each medical consultation, and identify them as "emigrants returning for medical treatment" in a bid to restrict their use of the services.

Latest situation

15. On 16 January 2024, Prof Hon Priscilla LEUNG Mei-fun, Revd Canon Hon Peter Douglas KOON Ho-ming and Hon Elizabeth QUAT proposed discussion on the review of fees and charges for public healthcare services. They were concerned about Hong Kong people who had settled overseas returning to Hong Kong to receive public healthcare services, the abuse of A&E departments, and ways to solve the problem of fees and charges in the future, such as whether there would be tiered fees.

16. The Administration will brief the Panel on the **public healthcare fees and charges reform** at the meeting on 14 April 2025.

Relevant papers

17. A list of relevant papers is in **Appendix 2**.

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Appendix 1

Public healthcare fees and charges reform

Service		Current fee	Fees effective from January 1, 2026
Inpatient (Acute bed)	Admission fee	$75	To cancel
	Maintenance fee (per day)	$120	$300
Inpatient (convalescent / rehabilitation, infirmary and psychiatric beds) Maintenance fee (per day)		$100	$200
Day procedure and treatment	Admission fee	$75	To cancel
	Maintenance fee (per day)	$120	$250
Day hospital (Geriatric, rehabilitation)		$60 / $55	$100
Community nursing service, Community allied health service		$80	$100
Community psychiatric nursing service		Free	Free
Psychiatric day hospital		$60	Free
Accident and emergency		$180	$400 (Fee exempted for Category I, II)
Specialist outpatient clinic (SOPC) (Include allied health clinic)	1st attendance	$135	$250
	Subsequent	$80	
	Drug	$15 per unit, 16 weeks maximum	$20 per unit, up to 4 weeks
Pathology testing service (applicable for SOPC)	Basic	No additional charges	Free
	Intermediate		$50
	Advanced		$200
Non-emergency radiology imaging service	Basic	No additional charges	Free
	Intermediate		$250
	Advanced		$500
Family medicine outpatient service	Consultation	Family medicine outpatient service $135 for the 1st attendance $80 per subsequent attendance	$150
		$50 for general outpatient	
	Drug	Family medicine outpatient service $15 per unit, 16 weeks maximum	$5 per unit, up to 4 weeks
		No additional charge for general outpatient	

Strengthening Healthcare Protection

(A) Enhanced Medical Fee Waiving Mechanism

1. Relax the income and asset limit

Income Limit	Relax income limit from the current 75% of Median Monthly Domestic Household Income (**MMDHI**)[1] to: 2-person household or larger: MMDHI 1-person household: 150% of MMDHI *(to better assist 1-person household with lack of social support)*
Asset Limit	Relax to asset limit for Public Rental Housing application

[1] MMDHI based on the General Household Survey conducted by the Census and Statistics Department. Upon enhancement, MMDHI (excluding foreign domestic helpers) will be adopted.

2. Extend the scope of coverage and validity period of waiver
   - Extend the scope of coverage for period waiver for those below 65 of age, to include general outpatient clinic (GOPC) services for episodic appointments[2]
   - The longest validity period of medical fee waiver will be extended from 12 months to 18 months
   - Within a maximum of 18 months, there is no need to submit financial documents for financial assessment for applying medical fee waiver

[2] Currently, if patient below 65 of age with period waiver needs to attend GOPC services for episodic appointments, s/he is required to approach (medical) social worker to apply for one-off medical fee waiver. For those patients age 65 or above, there is no need for them to apply for waiver additionally.

3. Refine the definition of "household"
   - Relax the definition of "household" to that for applying assistance from safety net* for self-financed drugs or medical devices

Patient type	"Household" and Core Family Member Definition
Dependent patient[3]	The patient, his/her parents/legal guardians, and dependent siblings living together
Non-dependent patient	<u>If married</u> – the patient, his/her spouse, and dependent children (but not parents/legal guardians or siblings) living together <u>If unmarried</u> – the patient would be treated as a single person household (irrespective of whether parents/legal guardians or siblings are living together)

[3] A dependent is defined as a person who is unmarried AND either (i) under 18 years old; or (ii) 18-25 years old receiving full-time education. A patient who does not fulfill the above requirements is classified as a non-dependent patient.

*Including Samaritan Fund

(B) Introduction of Inpatient and Outpatient Cap of Annual Spending

1. Cap of annual spending of HK$10,000 per patient for all fee items (excluding self-financed drugs and medical devices)
2. Eligible for all Hong Kong residents

(C) Enhanced Safety Net* for Self-financed drugs and medical devices

Accelerated introduction of innovative drugs and devices to (1) HA Drug Formulary; (2) Safety Net; and (3) Special Drug Categories. Relaxed eligibility criteria:

1. Relax the calculation of income for "annual disposable financial resources"
   (applicable to applications for drugs and non-one-off non-drug items)
   - Only 80% and 60% of the income will be used for assessment of new applicants and recurrent applicants respectively

2. Widen the sliding scale for calculating the amount of patient contribution
   (applicable to applications for drugs and non-one-off non-drug items)
   - By making reference to the sliding scale of Legal Aid Schemes, to widen the sliding scale for calculating the amount of patient contribution, reducing the amount of patient contribution for existing patients and providing a higher amount of subsidy, and support patients who are currently NOT eligible for subsidy due to relatively higher annual disposable financial resources

3. Relax the income limit
   (applicable to applications for one-off non-drug items)
   - Relax the income limit for 1-person household to 1.5 times of the current income limit for consistency of the enhancement measures on medical fee waiver

*Including Samaritan Fund

Source of information: Press release issued by the Government of the Hong Kong Special Administrative Region on 25 March 2025

Appendix 2

Public Healthcare Fees and Charges Reform

List of relevant papers

Committee	Date of meeting	Paper
Panel on Health Services	16 January 2017	Agenda Item V: Review of the fees and charges for public hospital services Minutes Follow-up paper
	25 April 2017	Agenda Item V: Review of the fees and charges for public hospital services Minutes
	18 October 2024	Agenda Item III: Briefing by the Secretary for Health on the Chief Executive's 2024 Policy Address Minutes

Council meeting	Paper
8 January 2025	Question 2: Persons emigrated overseas returning to Hong Kong for welfare benefits and services
26 March 2025	Question 4: Public healthcare services and their fees and charges

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