My **Health** My **Choice**

Healthcare Reform Second Stage Public Consultation Report

Food and Health Bureau
Hong Kong Special Administrative Region Government

This page is intentionally left blank

My Health My Choice

Healthcare Reform
Second Stage Public Consultation
Consultation Report

Food and Health Bureau
Hong Kong Special Administrative Region Government
July 2011

KEY TERMS

Term	Description
Health Protection Scheme (HPS)	A standardized and regulated framework for health insurance proposed by the Government for the second stage public consultation on healthcare reform.
Core requirements and specifications under the HPS	Requirements and specifications standardized under the HPS that all health insurance plans to be offered under the HPS are required to meet.
Health insurance plans under the HPS (HPS Plans)	Health insurance plans that meet the core requirements and specifications under the HPS to be offered by insurers. These include Standard Plans and other health insurance plans that provide top-up benefits and add-on components over and above the Standard Plans.
Standard Health Insurance Plans (Standard Plans)	Standardized health insurance plans that are offered by insurers strictly in accordance with the core requirements and specifications under the HPS without any top-up benefits and add-on components.
Top-up benefits and add-on/additional components	Top-up benefits or add-on components that insurers may choose to offer beyond the core requirements and specifications under the HPS, e.g. higher benefit limits, better service class, broader service coverage such as general out-patient consultation.
Diagnosis-related groups (DRG)	A method of classifying medical conditions requiring hospital admissions or ambulatory procedures by diagnosis and complexity that can be used as a basis for costing or charging for medical services.

QUESTIONNAIRE SURVEYS AND FOCUS GROUPS

The list of questionnaire surveys and focus groups is set out at page 8 of the consultation report.

ABBREVIATIONS

DH	Department of Health
DHA	Domestic Health Accounts
DRG	Diagnosis-related groups
eHR	Electronic health record
FHB	Food and Health Bureau
HA	Hospital Authority
HMDAC	Health and Medical Development Advisory Committee
HPS	Health Protection Scheme
OCI	Office of the Commissioner of Insurance
PHI	Private health insurance
PPP	Public-private partnership

CONTENT

This page is intentionally left blank

MESSAGE FROM DR YORK Y N CHOW, GBS, JP, SECRETARY FOR FOOD AND HEALTH

Dear Citizens,

The publication of this consultation report marks another milestone in our reform of the healthcare system in Hong Kong. It is the culmination of years of consultations and discussions since early 90s involving various quarters of the community on how Hong Kong should chart forward in the provision and financing of healthcare services. It is also a crucial jigsaw piece in the comprehensive package of healthcare reform we have spearheaded since 2005, fitting in with the other pieces on enhancing primary care, sharing electronic health records, building public-private partnership and strengthening the safety net that are already being put in place since 2008.

Healthcare reform must be built on the existing strength of our healthcare system, while striving to meet the evolving aspirations of the community. Our vision for enhancing the sustainability of the healthcare system, built upon broad-based discussions in the community, received strong support in the two-stage public consultations on healthcare reform. A robust public healthcare system providing essential healthcare to those in need and serving as a safety net for the whole population must continue to be the cornerstone. No less important is a vibrant and competitive private healthcare sector that provides value-for-money choices and quality-assured services to the community, and continues to thrive and develop as a key service industry of Hong Kong.

The healthcare reform proposals are key to achieving this vision. With the broad consensus in the first stage public consultation, we have been taking forward the various healthcare service reforms since 2008. Building on the views and suggestions expressed by the community in the first stage, we have also formulated the proposals for the Health Protection Scheme (HPS), a voluntary and government-regulated scheme aiming to provide consumers with affordable and continuous health insurance protection for value-for-money and quality-assured private healthcare services. We released the consultation document "My Health My Choice" last October, and reached out to canvass the community's views and suggestions on our proposals in the second stage public consultation.

The responses were encouraging, giving us many insightful views and helpful suggestions. I would like to thank all of you for sharing with us your valuable opinions through the over 500 written submissions and various consultation channels. I am encouraged by the support expressed for the HPS as a first step to make better use of the private sector in providing relief to the public system, and to

enhance market transparency, quality assurance and consumer protection for the benefits of the public. Equally important are the concerns and doubts expressed, which reminded us to focus on the objective of reform: achieving a sustainable healthcare system that improves the state of health and quality of life of our people, and provides healthcare protection for every member of the community.

No doubt the HPS alone could not be a complete solution on its own in solving the challenges to the long-term sustainability of our healthcare system. However, as pointed out by many during the consultation, together with the series of inter-linked service reforms, HPS is a positive step forward in enhancing the sustainable development of our healthcare system as a whole. Our next challenge is to take forward the HPS through a solid and practical action plan that achieves the objectives of the HPS and delivers its benefits to the community. This is what we propose as the way forward in this report. At the same time, our commitment to healthcare will continue to increase with our expanding health budget for improving public services and implementing service reforms.

Healthcare reform certainly does not finish here. It is an on-going endeavour of the Government that requires the continuous support of the community and the professions. I look forward to joining hands with you, as we have done before, to shape and build up the future of our healthcare system that will meet the healthcare needs of our population with enhanced sustainability, transparency and competitiveness.

Dr York Y N Chow
Secretary for Food and Health
July 2011

EXECUTIVE SUMMARY

INTRODUCTION

On 6 October 2010, the Government launched the second stage public consultation on healthcare reform. A consultation document, entitled "My Health, My Choice", was published to seek views from members of the public for a period of three months on the proposals to introduce a voluntary, government-regulated Health Protection Scheme (HPS).

2. The exercise was the second part of the two-stage public consultations on healthcare reform. It was a sequel to the first stage public consultation held in 2008, which sought public views, via a consultation document entitled "Your Health, Your Life", on the principles and concepts of four service reform proposals, and the pros and cons of reforming the current healthcare financing arrangements through six possible supplementary financing options.

3. There were broad support and general consensus, as revealed by the first stage public consultation, for the Government to take forward healthcare service reforms to: (a) enhance primary care, (b) promote public-private partnership in healthcare, (c) develop electronic health record sharing, and (d) strengthen public healthcare safety net. The Government has since embarked on initiatives to implement these service reforms, making use of the increased government budget for healthcare since 2007-08.

4. There were divergent views on reforming the current healthcare financing arrangements in the first stage public consultation, with no clear consensus within the community on which supplementary financing option should be pursued. Among the six options put forward, there were general reservations against options of a mandatory nature, i.e. social health insurance, mandatory medical savings accounts, mandatory private health insurance and personal healthcare reserve.

5. The community supported the public system to continue to provide essential healthcare services for those in need and serve as a safety net for the whole population, while also indicating a relatively stronger preference for voluntary private health insurance as a supplementary financing option that could provide more choices for healthcare based on individual needs, with enhanced consumer protection over the shortcomings of the existing health insurance market and private healthcare services. The HPS proposals were thus formulated for the second stage public consultation.

HEALTH PROTECTION SCHEME: OBJECTIVES AND PROPOSALS

6. The HPS is meant to complement the public system which will remain the cornerstone of our healthcare system. While taking forward healthcare reform, the Government's commitment to the public system will only increase, and not be reduced. Healthcare recurrent expenditure, totalling $39.9 billion in 2011-12, now accounts for 16.5% of the Government's recurrent expenditure, and is set to further increase as the Government has pledged to increase the ratio to 17% in 2012. The increased health budget has better enabled the public system, primarily through the Hospital Authority (HA), to improve services for its target areas, namely, acute and emergency care, low-income and under-privileged groups,

illnesses that entail high costs, advanced technology and multi-disciplinary professional team work, and training of healthcare professionals.

7. The HPS is a standardized and regulated scheme of private health insurance based on voluntary participation incorporating various features for consumer protection and promoting packaged charging for transparency of healthcare services. It is proposed with the aim to reform the private health insurance and healthcare services market for the sake of providing consumer with value-for-money choices, and improving efficiency, transparency and competition. It is a step forward in enhancing the long-term sustainability of our healthcare system and its financing, by addressing the public-private imbalance, containing cost increase and medical inflation, and encouraging savings and risk-pooling among the population to meet their future healthcare needs.

8. The HPS aims to achieve four objectives –

(a) provide more choices with better protection to those who are able and willing to pay for private health insurance and private healthcare services;

(b) relieve public queues by enabling more people to choose private services and focus public healthcare on target service areas and population groups;

(c) better enable people with health insurance to stay insured and make premium payment at older age and meet their healthcare needs through private services; and

(d) enhance transparency, competition, value-for-money and consumer protection in private health insurance and private healthcare services.

9. The HPS is proposed as a supervisory framework for private health insurance, whereby private health insurance offered under the HPS, to be provided by individual insurers and subscribed by individual consumers on a voluntary basis, must meet certain specified requirements. Proposals for the HPS comprised (a) insurance features, (b) savings options, and (c) possible incentives (see summary of the HPS proposals at ***Appendix A***).

10. Implementation of the HPS will also require taking measures to ensure the necessary supporting infrastructure is in place, including strengthening of healthcare capacity and manpower, developing private hospital and healthcare services capacity, facilitating adoption of packaged services and charging based on Diagnosis-Related Groups (DRG) in the private healthcare market, and enhancing market infrastructure and consumer protection mechanism for health insurance.

SECOND STAGE PUBLIC CONSULTATION: SUMMARY OF VIEWS

(A) Overview of Consultation

11. The second stage public consultation was conducted between 6 October 2010 and 7 January 2011, with wide publicity on the consultation through various channels including Announcements in the Public Interest (APIs), distribution of posters, summary leaflets,

pamphlets on HPS and the consultation document itself, the healthcare reform website "MyHealthMyChoice.gov.hk", and other means of publicizing the consultation exercise and the HPS proposals.

12. During the consultation period, the Food and Health Bureau consulted the Panel on Health Services of the Legislative Council which deliberated the HPS proposals at three meetings and received the views of 79 deputations. We also consulted the 18 District Councils, organized two open consultation forums for the general public, and attended many seminars, briefings and/or forums organized by different parties and organizations to brief them on the HPS proposals and to listen to their views. We have received a total of 564 written submissions, comprising 125 from organizations and 439 from individuals through various means.

13. The Food and Health Bureau has also commissioned independent consultants to conduct five rounds of public opinion surveys from November 2010 to April 2011 to gauge the views of the public on general issues concerning the HPS including its objectives, principles, concept and proposed features. We have also commissioned a market research consultant to conduct consumer market research on potential customers' reactions to proposed design of private health insurance under the HPS. We have also commissioned an academic institution to conduct opinion surveys and focus group discussions to collect views of the medical profession on specific issues.

(B) Reforming Private Healthcare alongside Public System

14. There was broad support for the direction of the healthcare reform to enhance the long-term sustainability of the overall healthcare system, namely, maintaining and strengthening the public healthcare system providing equitable access to essential healthcare and serving as a healthcare safety net for the whole population, complemented by reforming the private health insurance and healthcare markets with a view to providing value-for-money choices of health insurance and healthcare services with quality assurance and consumer protection.

15. Most submissions underlined the importance for the Government to remain fully committed to supporting the public healthcare system, and welcomed the pledged increase in funding for public healthcare services. Many supported continued increase in public healthcare funding to cater for the ageing population. At the same time, many noted that over one-third of our population had some form of health insurance coverage, either through their employers or purchased on their own, and private expenditure on health insurance and healthcare services especially private hospital care was growing rapidly, indicating the increasing role of the private healthcare sector.

16. A majority of views considered that our healthcare system required not only a strengthened public system as its core, but also a complementary, competitive and transparent private system providing more value-for-money choices for members of the public. Public opinion surveys showed that about 70% of the survey respondents agreed that the Government should encourage a wider use of private services by those who could afford it, so that the public sector could better focus on serving its target areas. Notwithstanding this, a

small number of submissions considered that the Government should focus its efforts and resources solely on improving the public system alone.

(C) Regulation of Private Health Insurance and Healthcare Sectors

17. There was general consensus for strengthening regulation over private health insurance and healthcare services in the process of reforming the private healthcare markets. An overwhelming majority of views received pointed out the existing shortcomings in market practices, including insufficient pricing transparency, escalating private medical expenses, itemized charging with no certainty of payment upfront, restrictive insurance policy terms such as limited access to health insurance by high-risk individuals, increase in premium or even unilateral termination of policy after claims, etc.

18. Public opinion surveys showed consistent support with around 90% of survey respondents in favour of stepping up regulation over private health insurance and healthcare services. On the other hand, while recognizing the need for supervision, there were views from private insurers and healthcare providers cautioning against excessive regulation, pointing out that the market should best be left to operate with minimal necessary intervention by the Government. They also pointed out that the feasibility and desirability of some of the proposals for regulation would need to be further examined.

(D) Health Protection Scheme (HPS): Objectives and Concepts

19. A significant number of views received considered that the proposed HPS was a positive step forward to enhance transparency, competition and efficiency of the private healthcare sector. They were cognizant of the problems confronting the private health insurance and healthcare services markets, and considered that changes were required to make better and fuller use of the private sector. They supported the Government's objectives for introducing the HPS to provide value-for-money choices to the community. They concurred that this would complement service reforms, indirectly provide relief to the public system, better enable the public system to focus on serving its target areas, and enhance the long-term sustainability of our healthcare system in the face of ageing population and rising medical costs.

20. The support for the HPS as a tool for reforming the private healthcare markets was also reflected in the outcome of the public opinion surveys. About 70% to 80% of survey respondents supported the various stated objectives of the proposed HPS, and more than 60% of the respondents were in support of the introduction of the proposed HPS, as a means to strengthen regulation over the private sector to enhance transparency, competition and efficiency. There is also considerable support for the objectives of the HPS among the medical community, as revealed by the findings of the medical stakeholders opinion survey, with about 60% of responding doctors agreeing with the objectives of the proposed HPS.

21. A small but not insignificant proportion of views received, while supporting strengthened regulation of the private healthcare sector, cast doubt on whether the proposed HPS could achieve its stated objectives, especially in relieving pressure on the public system.

This stemmed mainly from concerns over the infrastructural support of the healthcare system, including issues such as capacity constraints of private hospitals and healthcare services, supply constraints of healthcare manpower, and possible "brain drain" of the public system. They also questioned the appropriateness of using public funding to subsidize members of the public subscribing to private health insurance, as opposed to using the funding to subsidize healthcare through the public system.

(E) Proposed HPS Features: Views and Suggestions

22. A large number of views and suggestions were received on the proposed features of the HPS, including insurance features for enhancing consumer protection; options to incorporate savings in health insurance; financial incentives and use of $50 billion earmarked from fiscal reserve; and insurance benefit coverage and levels, with DRG-based packaged charging. Most expressed support to the objectives and concept of the proposed HPS, while urging the Government to look into their feasibility and desirability in greater detail in consultation with the relevant stakeholders and having regard to the wider community views, with a view to improving the design of the HPS (see summary of views on individual features of the HPS proposals at ***Appendix A***). Major views on key HPS features, especially those that attracted contentions, are highlighted in the following sections. For details of views on other HPS features largely supported during the consultation, please refer to the main consultation report.

(i) Insurance features for enhanced consumer protection: the core requirements

23. There was wide support for the proposed insurance features aiming at safeguarding consumer interests and enhancing consumer protection, including guaranteed access and renewal, plan portability, standardized policy terms and conditions, age-banded premium schedule with guidelines on premium adjustment, etc. Public opinion surveys indicated that the various consumer protection features of the HPS, which are proposed to be core requirements that all health insurance are required to meet under the HPS, received support from around 70% to 80% of the survey respondents. There are, however, greater divergences over the following features –

(a) **Guaranteed access and renewal**: most of the views received supported enabling high-risk individuals with pre-existing conditions to access health insurance under the HPS with reasonable waiting period and affordable premium loading through regulation and subsidy; but others considered inclusion of high-risk individuals, even with premium loading, might be unfair to healthy individuals subscribing the insurance and might undermine viability of insurance pools.

(b) **Premium setting and adjustment**: many views considered that there should be government control over premium setting and adjustment, and supported consideration of control measures such as cost/price control, premium/profit regulation and/or direct provision of health insurance or healthcare services; but the insurance industry considered that government direct control over premium would stifle competition and undermine viability of insurance pools.

(c) **Limit on entry age**: many views agreed that allowing individuals to start subscribing health insurance at very old age might undermine viability of insurance pools, especially if pre-existing conditions were also to be insured after a certain waiting period, and that imposing an entry age limit (say 65) might serve the purpose of risk management; but a number of submissions expressed concerns that the proposed age limit would affect the choice for those at older ages.

(d) **Offer of no-claim discount**: many views supported the proposal of offering no-claim discount as a reward for those who stayed healthy and an incentive for the healthy to stay insured; but some questioned whether it was necessary and appropriate to put in place no-claim discount under the HPS, as subscribers might avoid early treatment or fall back on the public system in order to preserve their no-claim discount, and others questioned its feasibility in practice.

(e) **Migration of existing health insurance**: many views pointed out that migration of those currently insured on existing health insurance would be essential in building up a critical mass of insurance pools and ensuring the viability of the HPS, and measures should be introduced to prevent insurers from arbitraging between HPS plans and non-HPS plans; but the insurance industry considered that insurers' participation in the HPS should remain voluntary.

(ii) Options to incorporate savings in health insurance

24. Unlike other issues, the proposed savings options for health insurance under the HPS attracted relatively fewer discussions and submissions. Among the views received, some considered it desirable to have savings incorporated into the HPS to finance future premium, while others considered that savings were too long-term and its restricted use might not be welcome. The insurance industry considered that the inclusion of a mandatory savings feature might reduce attractiveness and complicate operation of health insurance under the HPS. Some respondents considered that, instead of offering public subsidy to encourage savings, other more direct forms of incentives such as premium rebate or service subsidies should be considered.

25. Among the broader views received, there was general recognition of the need to address the long-term financing of our healthcare system. While some appreciated the rationale for proposing savings options under the HPS, many respondents suggested that other options to cater for financing future healthcare should be considered, for instance the Government setting aside funding specifically reserved for meeting healthcare needs of the ageing population. Among those respondents who expressed doubts on providing public subsidies under the HPS, some suggested setting up such a reserve fund specifically for funding future public healthcare services.

(iii) Financial incentives and use of $50 billion earmarked fiscal reserve

26. Among the various proposed features of the HPS, the proposal to provide financial incentives for those who subscribed to health insurance plans under the HPS, making use of the $50 billion earmarked in the fiscal reserve in support of healthcare reform, attracted the

most divergent views during the consultation. Not only were there views on each of the proposed financial incentives under the HPS, but there were also suggestions for other forms of financial incentives for private health insurance and healthcare services. There were also views concerning the general principle of using public funding to provide subsidies for those who subscribed to private health insurance and utilized private healthcare services, and the use of the earmarked $50 billion for other healthcare-related purposes.

27. There were views supporting provision of financial incentives under the HPS, considering that those who chose private healthcare over public healthcare should also get a fair share of public subsidies for their healthcare. Different views were received towards the three forms of financial incentives under the HPS proposed in the consultation, though most stressed that public subsidies should benefit HPS subscribers direct, as opposed to private insurers and/or healthcare providers –

(a) **Protection for the high-risk**: notwithstanding the divergent views over allowing high-risk individuals to join health insurance, many recognized that if high-risk individuals were to be included in the health insurance pool with cap in premium loading, some form of injection would be required to compensate for the increased risk they brought to the pool. Most considered public funding support for this group necessary and justified, though some questioned how this could operate in practice and whether insurers would benefit unduly from arbitrage.

(b) **Premium discount for new joiners**: among those who were in support of the HPS, most supported providing incentives to encourage participation in the scheme, most notably premium discount to boost up subscription at the initial stage. They considered such incentives needed not necessarily be permanent, and the $50 billion could be used as seed money to generate return for providing such incentives on a self-sustaining basis or extend the period for providing such incentives. There were also different suggestions on the incentive design.

(c) **Subsidies for savings for future premium**: echoing the views over the proposed savings options, most respondents who supported incentives for staying in the scheme favoured premium rebate for long-staying subscribers after age 65. Many noted that these proposed incentives would require significant financial commitment, and that the $50 billion would not be able to provide the proposed rebate on a perpetual basis. They suggested that the Government should commit to provide further funding as and when needed.

28. Meanwhile, some queried if financial incentives for private healthcare should be confined to those population groups as proposed through health insurance under the HPS. Suggestions were made for other forms of financial incentives under the HPS, or more generally subscription of private health insurance and utilization of private healthcare services. These included, for instance, premium subsidies to encourage children to enrol, premium subsidies for the older age and high-risk who need to pay a higher premium, premium subsidies for the lower-income and underprivileged groups who were less able to afford health insurance, tax deduction for private health insurance premium, direct subsidies for healthcare services through public-private partnership, direct subsidies to induce primary

preventive care, and direct reimbursement for private health services.

29. On the other hand, some questioned whether it was necessary and appropriate as a matter of principle to provide public subsidies to those who subscribed to private health insurance and used private healthcare services, noting that these subscribers were usually those who could afford to pay and fearing that private insurers and healthcare providers would reap most of the benefits. Some considered that the $50 billion should be used equitably for subsidizing healthcare for the whole population. Some opposed the use of the $50 billion to provide financial incentives under the HPS, considering that public funding should more appropriately be directed to help those relying on the public system. Specifically, some suggested using the $50 billion to set up a reserve fund for financing public health services to cater for the ageing population in the future.

(iv) Insurance benefit coverage and levels, with DRG-based packaged charging

30. Many appreciated that the HPS Standard Plan, which was intended to represent the core requirements for all health insurance, must be confined to basic benefit coverage and levels. Most respondents agreed with the proposal to include hospitalization, ambulatory procedures and chemotherapy and radiotherapy for cancers in the basic coverage, to provide targeted protection for unanticipated and expensive treatments at general-ward level, with options to purchase top-up for better amenities and coverage. Many were receptive to the argument that the basic coverage should be confined to less discretionary services to contain moral hazards, whereas more predictable, discretionary and affordable healthcare needs should be covered by add-ons to allow flexibility and keep down the premium of the HPS Standard Plan.

31. Given that the proposal to design the benefit levels of the HPS Standard Plan around packaged services and charging based on DRG is a novel idea in Hong Kong, it generally took time for respondents to understand the proposal and respond with their views. Many respondents who welcomed the proposal considered that it would help address concerns over rising medical costs in the private sector, uncertainty over payment beforehand, and lack of pricing transparency. However, there were concerns on whether packaged services and charging would be feasible in the local market, especially when some private hospitals and doctors had expressed doubts on the market's readiness to offer such.

32. Some considered that the HPS could be improved by including primary care services. For those advocating the inclusion of primary care, many did not touch on how to address the issue of moral hazards, and the likely significant impact on premiums due to high utilization and administration costs. Some respondents suggested the inclusion of maternity coverage to attract young couples, though few recognized that such coverage would likely increase the premium significantly and induce serious adverse selection. A few also asked whether the HPS could be extended to cover treatments in places in the proximity to Hong Kong, in particular provinces or cities in the Mainland where many Hong Kong people resided.

(F) Supporting Infrastructure for HPS

(i) Private hospital capacity and healthcare manpower supply

33. Private hospital capacity and healthcare manpower supply were the recurring and dominant theme in a vast majority of submissions received during the consultation. Most expressed the view that no matter how carefully and meticulously the HPS was designed, its success depended on having a robust supporting infrastructure for the healthcare system, in particular an adequate supply of healthcare manpower and sufficient capacity among the private hospitals to meet the increasing demand for private healthcare services including those arising from the implementation of the HPS, apart from rising service demand in the public healthcare system as the population demographics aged.

34. Many considered that private hospitals were currently running at near full capacity, and an expansion in private hospital capacity, in particular the provision of standard beds offering packaged services and charging, would be needed to cater for increasing demand for private healthcare services including those from health insurance under the HPS. Many noted that four pieces of land had been earmarked for private hospital development with required ratio on the provision of standard beds, and that some private hospitals had proposed or were planning further development to expand healthcare capacity. Some pointed to the need to carefully assess and plan private hospital and healthcare services capacity to ensure sufficiency over the long-term, taking into consideration the impact of the HPS as well as other sources of demand including development of Hong Kong's healthcare industry. Some went further to suggest that the Government should consider providing private services in a more direct manner, such as supplementing private services offered by HA.

35. Many stressed that having a steady and adequate supply of healthcare manpower was instrumental to the sustainability and well-being of the overall healthcare system, as well as the development of healthcare services. While noting that the intake of medical students at the two medical schools had been increased to 320 per year from the 2009/10 academic year and that the Government would closely monitor the manpower situation, many urged the Government to take more proactive measures to increase supply of healthcare manpower, both in the near and long term, including expanding the training of local healthcare professionals and enabling more non-locally trained healthcare professionals to practice in Hong Kong subject to the same stringent quality and professional standards. Some submissions from the medical profession expressed different views and considered that doctors in the private sector could be made more productive to absorb increased demands if more beds were available in private hospitals, and more detailed assessment on manpower needs would be required.

(ii) Professional development, quality assurance and supervisory framework

36. In connection with healthcare capacity and manpower, a number of submissions also pointed to the need to put greater emphasis on professional development of healthcare professions and quality assurance of healthcare services, so as to maintain the edge Hong Kong's healthcare system in its high professionalism and renowned quality of medical

services. To this end, some submissions suggested that the current training and development as well as regulatory framework of the various healthcare professions be reviewed with a view to further strengthening their professional development and standards. Some submissions considered that at the very least, the Government should take a more active role in ensuring service and price transparency of private healthcare services. Other submissions referred to tools adopted in other economies for assessing quality of healthcare services, such as hospital accreditation, clinical review and service benchmarking, and proposed their consideration for adoption in Hong Kong for quality assurance.

37. Most of the views received on this front considered it important to put in place a rigorous supervisory framework for the HPS, including a robust institutional framework for the governance and operation of HPS, and administration of the dispute arbitration or mediation mechanism. They pointed out the need for the framework to safeguard consumer protection, both to address shortcomings in existing private market practices and to inspire public confidence in the HPS. Some considered that an enhanced supervisory regime backed up by a legislative framework would benefit the long-term development of the healthcare system by improving transparency and efficiency as well as promoting healthy competition in the system. Some pointed out that an effective institutional structure for the supervision and governance of HPS would be essential.

38. Noting that HPS would encompass both Standard Plans and those with top-ups or add-ons over and above the Standard Plan requirements (HPS-plus plans), some expressed concerns that regulation of HPS-plus plans might not be as stringent as that over Standard Plans, thus giving rise to potential complaints by consumers with HPS-plus coverage. Some respondents including those from the insurance industry pointed out that some of the proposed HPS features would require more thorough examination and deliberation on their desirability and feasibility from a technical perspective, before workable legislative proposals could be formulated for the HPS supervisory framework. There were also views cautioning against over-regulation, and that HPS should more appropriately be subject to the existing regulatory regime as far as possible, rather than the supervisory framework as proposed in the consultation document.

(iii) Provision of DRG-based packaged services and HPS health insurance

39. A number of submissions expressed concerns over the HPS which stemmed from doubts about future availability of packaged private healthcare services and charging based on DRG, and private health insurance plans based on the HPS specifications. This was especially so when some private hospitals and doctors suggested that the current private healthcare market might not be entirely ready to adopt DRG-based packaged services and charging, citing reasons, among others, such as the fact that the majority of hospital admissions were handled by visiting doctors at patients' choice, and technical difficulties in arriving at one single packaged charge catering for different possibilities of complication for the same diagnosis. Constraints in private hospital capacity and healthcare manpower supply were also cited as major obstacles.

40. Participants from medical professions in focus group discussions held mixed views on the potential of DRG in improving competitiveness and cost control and the technical

feasibility of applying DRG in healthcare settings. Some noted that the application of DRG was quite popular in other countries and had positive effects on transparency and competition in healthcare services quality and pricing. Others were more cautious as to applicability of overseas experience to Hong Kong. A number of participants suggested that medical stakeholders should be closely involved in designing and implementing the DRG-based charging system in future. There were also suggestions that the Government should provide the necessary infrastructure and administrative support required for adopting DRG-based packaged services and charging.

41. Meanwhile, some submissions from the public supported more direct measures to be taken by the Government to encourage and ensure supply of DRG-based packaged services and charging, apart from the proposal for the provision of standard beds in the development of new private hospitals on the four pieces of land earmarked for such. These suggestions included, for instance, entering into partnership with private healthcare providers to provide DRG-based packaged services and charging. Some went further to suggest that the Government should consider providing DRG-based packaged services in a more direct manner, including direct provision through HA, to supplement the private sector capacity. Public opinion survey showed that 75% of the respondents considered that direct government provision of private services should be pursued, in the event of insufficient supply of services with packaged services and charging from private healthcare providers.

42. The insurance industry, while cautiously welcoming the Government's proposal to introduce the HPS, stressed that offer of health insurance plans under the HPS or not should remain a voluntary business decision by individual insurers. They considered that over-demanding requirements under the HPS would likely dampen interests of insurers to participate in offering health insurance under the HPS, especially when many insurers were already having substantial and increasing share of the health insurance market. The insurance industry also expressed the view that the HPS Standard Plan was unlikely to be profitable given the likely stringent requirements and control. Some insurers had reservations on the Government involvement in the provision of health insurance under the HPS, whereas others were not opposed to the idea on the assumption that such provision would be on a competitive basis on a level-playing field vis-à-vis other market participants.

(G) HPS: Potential Risks and Possible Mitigations

43. Many respondents drew attention to the potential risks that might undermine the feasibility of HPS and its likelihood to achieve the stated objectives, and suggested that possible actions be taken to mitigate the risks –

(a) ***Lack of a large and balanced risk-pool***: the viability of the HPS depended on building such a pool. Some suggested focusing efforts to induce large employers to migrate the insurance plans for their employees to the HPS in order to build up a critical mass. Other suggested a combination of carrot and stick, providing incentives to attract individuals especially young and healthy lives to join, while putting in place measures to minimize adverse selection.

(b) ***Lack of interest from private insurers and healthcare providers***: the HPS depended

on the participation of private insurers and healthcare providers. Many suggested taking measures to guard against cream-skimming by insurers and healthcare providers vis-à-vis the public system. Some further suggested that the Government should assume a more active and direct role, including direct provision of HPS plans and DRG-based packaged services on a level-playing field with other market participants.

(c) ***Lack of control over premium escalation and medical inflation***: many pointed out the need for strong and concrete measures to provide the public with reassurance of control of future premium increase under the HPS, and that medical inflation in the private sector could be contained. Many supported considering necessary government intervention to ensure that health insurance premium and healthcare service charges remain at affordable levels.

(d) ***Read-across implications for the public system***: some were concerned that the implementation of the HPS would cause brain drain in the public system if manpower supply was in shortage, and if so, those relying on the public system would suffer, and public support for the HPS would wane. They considered that the Government would need to reassure the public of its commitment to public healthcare and ensure healthcare protection to those who relied on the public system.

(H) HPS: Implications for Long-Term Healthcare Financing

44. Views received from a number of respondents considered that the HPS represented a positive step forward in addressing the challenge to the sustainability of the healthcare system, though in itself not a complete solution to the problem of long-term financing for healthcare given its voluntary nature. It would make a start to harness the private sector to meet the increasing healthcare needs of the community, and alleviate the burden on the public system through enhancing private sector capacity. Continued government investment in the public system would still be required, but the introduction of the HPS would likely make the private sector better positioned to share part of the increasing demands alongside the public system, thereby helping to enhance the sustainability of our healthcare system and its financing. Some expected the HPS could help improve the efficiency and cost-effectiveness of the private healthcare sector which is also conducive to the sustainable development of our healthcare system.

45. However, some respondents, notably those who considered that the Government should focus solely on funding and improving the public healthcare system alone, were dismissive or at best sceptical of the potential benefits of the HPS. They expressed concerns that, without expanding the supporting infrastructure of the healthcare system including service capacity and manpower supply, the HPS might drive up medical inflation and end up compounding the financing problem rather than alleviating it. In particular, they did not see any need for the Government to devote resources to reform the private healthcare market through the proposed HPS, for the reason, among others, that the resources should better be spent solely on public healthcare services.

WAY FORWARD

46. The second stage public consultation on healthcare reform proves to be a productive exercise. There was wide dissemination and discussion of healthcare reform messages, information and proposals within the community. We are encouraged by the quantity and quality of views and submissions received during the consultation, and would like to take this opportunity to express our sincere gratitude to all those who have made a contribution in the process, including activity organizers, attendees at the various forums/seminars/meetings, and those who have made known their views to us, be it at forums, in writing or through responding to surveys and participating in focus groups.

47. The views and suggestions collated from various channels through the consultation have provided us with much food for thought. Together, they lay the foundation on which we could build momentum and move forward. Having studied and analyzed the views received, we consider that what we should do in future should be guided by the following –

(a) the consultation outcome reaffirms the broad-based community support for the Government's healthcare reform vision of developing our dual healthcare system, with a public system continued to be strengthened as its core, complemented by a competitive and transparent private sector;

(b) there is overwhelming public call for strengthening supervision and regulation over private health insurance and healthcare services, amidst rapidly increasing insured population and private healthcare expenditure, to address current shortcomings that undermine the long-term sustainability of the private sector;

(c) there is support for the Government to take forward the proposed HPS with the aims of providing value-for-money choices to members of the public, improving competition, transparency and efficiency of the private sector, and relieving the pressure on the public sector so as to better focus on serving its target areas;

(d) the success of the HPS depends very much on strengthening the supporting infrastructure for the healthcare system, most crucially healthcare manpower supply and private healthcare capacity, and putting in place the supervisory framework and institutional governance to ensure the objectives of HPS are met;

(e) the HPS features – e.g. underwriting, portability, plan migration, standardized terms and conditions, and the modus operandi of the high-risk pool – require further examination and deliberation in consultation with relevant stakeholders to thrash out details that are feasible, practicable and, where possible, desirable;

(f) efforts should be made prior to HPS implementation to facilitate development of the healthcare service market so that insurers and healthcare providers are better prepared and equipped to provide services that are in line with the principles and requirements of the HPS in preparation for its implementation; and

(g) there should be put in place engagement platforms on which stakeholders are represented and through which communication and deliberation could be made to

forge maximum consensus while respecting differences in views and stances in the course of developing concrete proposals for implementation.

48. Having regard to the above-mentioned considerations, we propose that the HPS be taken forward over the next two years (i.e. from second half of 2011 to first half 2013) for implementation through the following three-pronged action plan, viz. -

(a) **Review healthcare manpower strategy:** to conduct a strategic review on healthcare manpower planning and professional development including the regulatory structure of various healthcare professions, to be guided by a high-level steering committee comprising renowned overseas experts and local members of the professions, with the aim to formulate plans to strengthen manpower supply and professional qualities to meet future needs, both near-term and long-term;

(b) **Formulate supervisory framework for HPS:** to formulate legislative and institutional proposals to establish a feasible supervisory framework for health insurance and healthcare service markets under HPS, to be steered by a Working Group on HPS comprising relevant stakeholders to be set up under the Health and Medical Development Advisory Committee (HMDAC), with the aim to set up a statutory authority for HPS and to propose any financial incentives in support of the objectives of HPS; and

(c) **Facilitate healthcare service development:** to facilitate the development of the healthcare services industry as an integral part of our healthcare system in preparation for HPS implementation by taking measures to –

(i) develop essential infrastructure to support healthcare services (including private hospitals development and information infrastructure for health insurance and healthcare services);

(ii) enhance the transparency and competition of healthcare services in the private sector in quality and pricing (including benchmarking of services and charges); and

(iii) promote packaged services and charging through purchasing of common healthcare services from the private sector (including packaged charging for diagnosis- or procedure-based services).

Chapter 1 BACKGROUND

Healthcare Reform

1.1 In the last few decades, Hong Kong has developed a high quality and efficient healthcare system that provides accessible and affordable healthcare to its population and has achieved impressive health standards. This notwithstanding, we need to look for ways to reform the system with a view to ensuring its long-term sustainability amidst our rapidly ageing population, while improving the service and quality of the system in tandem with medical technology development.

1.2 In July 2005, the Health and Medical Development Advisory Committee (HMDAC) issued the discussion paper "Building a Healthy Tomorrow" on the future service delivery model of the healthcare system, aiming at ensuring and enhancing its sustainable development. The paper made a number of recommendations on the future service delivery models, which received broad support from the community and stakeholders and formed the basis for healthcare reform.

Two-Stage Public Consultations

1.3 Building on the discussion paper in 2005, the Government published the healthcare reform consultation document "Your Health Your Life" in March 2008 to initiate the two-stage public consultations to consult the public on an inter-linked package of healthcare reform proposals. The consultation document put forward a comprehensive package of proposals for reforming the healthcare system, and supplementary options for its financing arrangements, with a view to enhancing its sustainable development.

First Stage Public Consultation – "Your Health, Your Life"

1.4 The first stage public consultation in 2008 aimed at consulting the public on –

(a) the key principles and concepts of four service reform proposals to reform the healthcare system especially in its service delivery, namely –

  (i) enhance primary care;

  (ii) promote public-private partnership in healthcare;

  (iii) develop electronic health record sharing; and

  (iv) strengthen public healthcare safety net.

(b) the pros and cons of reforming the current healthcare financing arrangements through introducing six possible supplementary financing options –

  (i) social health insurance;

  (ii) out-of-pocket payments (user fees);

  (iii) mandatory medical savings accounts;

(iv) voluntary private health insurance;

(v) mandatory private health insurance; and

(vi) personal healthcare reserve (mandatory savings cum insurance).

1.5 Recognizing the rapidly ageing population, the increasing occurrence of lifestyle-related diseases as well as the rising medical costs, the community generally agreed that the long-term sustainability of the healthcare system could not be assured without comprehensive reform on both its service delivery and financing arrangements. There was broad consensus in the community to take forward the service reforms, and a general recognition of the need to reform the existing healthcare financing arrangements. Many also recognized the need for reform to address the current service and market imbalance, including the over-reliance on hospital services with insufficient emphasis on primary care, as well as the public-private imbalance in provision of hospital services.

1.6 However, divergent views were expressed on the supplementary financing options put forth in the first stage public consultation, and no consensus was reached on how the financing arrangements should be changed. The public expressed reservations in general about the mandatory financing options as solutions to address the long-term sustainability of healthcare financing. Relatively more people expressed a preference for voluntary private health insurance as a supplementary means of financing for healthcare, which they considered should offer them voluntary choice for personalized healthcare services in accordance with their individual needs, while the tax-funded public healthcare system continued to offer essential healthcare as a safety net for the whole population.

1.7 At the same time, many respondents pointed out various shortcomings they perceived of voluntary private health insurance currently offered in the market, e.g. excluding pre-existing conditions, no guarantee on renewal of policies, inadequate benefits coverage, disputes over insurance claims, lack of portability and continuity of policies, and risk of premium escalations due to ageing and rising medical fees. On private healthcare services, some recognized that there were significant uncertainties and financial risks for using private healthcare services due to inadequate transparency and predictability in the charging of private healthcare services, which caused many of those who could afford private healthcare services to resort to the public healthcare system.

Second Stage Public Consultation – "My Health, My Choice"

1.8 Building on the first stage public consultation, the Government has promptly taken forward the four service reforms making use of the substantially increasing government budget for healthcare since 2007-08. While the service reforms are being implemented, we also need to consider the next step in healthcare reform to complement the service reforms, and to further our goal to help enhance the long-term sustainability of our healthcare system. Taking into considerations the views expressed by the community during the first stage public consultation, we consider that there is a need to carry out further reform of the healthcare market structure in order to –

(a) improve public-private market balance;

(b) provide more choices for the public;

(c) increase healthcare service capacity; and

(d) improve quality of care in general.

1.9 In reforming the healthcare market structure, the Government's commitment to healthcare will continue to increase and not be reduced. In particular, the Government will continue to maintain the public healthcare system as the essential safety net for the whole population, focusing on its target service areas, namely services for low-income families and under-privileged groups, acute and emergency care, and catastrophic and complex illnesses requiring high cost, advanced technology and multi-disciplinary professional team work which may not be readily available or may entail very high cost in the private sector.

1.10 We have put forward in October 2010, for the second stage public consultation on healthcare reform, proposals for a voluntary supplementary financing scheme that aims to reform the private health insurance and healthcare services market, and take a first step in enhancing the long-term sustainability of the healthcare system including its financing by finding ways to –

(a) enhancing efficiency of healthcare services;

(b) creating and promoting healthy competition;

(c) containing cost increase and medical inflation; and

(d) encouraging savings among the population to meet future healthcare needs.

1.11 Based on these principles, we have outlined the proposals for a voluntary Health Protection Scheme (HPS), which is a standardized and regulated private health insurance scheme based on voluntary participation, comprising both insurance and savings components, standardized and regulated by the Government, that can provide the public with affordable, value-for-money and quality-assured choice of private health insurance and private healthcare services. The HPS has been proposed with the following objectives –

(a) Provide more choices with better protection to those who are able and willing to pay for private health insurance and private healthcare services.

(b) Relieve public queues by enabling more people to choose private services and focus public healthcare on target service areas and population groups.

(c) Better enable people with health insurance to stay insured and make premium payment at older age and meet their healthcare needs through private services.

(d) Enhance transparency, competition, value-for-money and consumer protection in private health insurance and private healthcare services.

1.12 By providing a quality and affordable alternative to public healthcare, the HPS aims to expand the capacity of the healthcare system as a whole and enable more people to use private healthcare on a sustained basis, thereby relieving demand pressure for public healthcare services and benefiting those who need to rely on the public healthcare system.

1.13 The HPS is proposed as a standardized and regulated framework for health insurance under its aegis. Health insurance plans to be offered under the HPS (HPS Plans) are required to

meet the core requirements and specifications for health insurance standardized under the HPS. These requirements and specifications are proposed for the purpose of consumer protection and offer advantages over existing private health insurance products available in the market. Specifically, it is proposed to require insurers participating in the HPS to offer standardized health insurance plans in accordance with the core requirements and specifications (Standard Plans), and to comply with scheme rules and requirements specified under the HPS.

1.14 The HPS is also aimed at promoting transparency and predictability in medical fees by proposing the adoption of Diagnosis-Related Groups (DRG) as the basis for charging for medical services, or commonly known as packaged charging for common procedures. The Government would encourage the private healthcare market to offer quality-assured, all-inclusive and condition-specific packaged services and pricing. HPS Plans would be required to set reimbursement levels based on packaged charging where available, thereby enhancing transparency and certainty of medical charges to the insured. This enhances market transparency and competition in private healthcare services and helps safeguard consumer interests in making use of such services.

1.15 We proposed to introduce government regulations that are aimed at enhancing price transparency, increasing competitiveness and ensuring adequate consumer protection. We also put forward consultations on various issues concerning the supporting infrastructure for the healthcare system required to support the implementation of the HPS. These include healthcare capacity and manpower, provision of DRG-based health insurance and healthcare service, standardized health insurance policy terms and conditions and associated definitions, health insurance claims arbitration mechanism, and supervisory structure for private health insurance and private healthcare services under the HPS. We also highlighted the need to monitor the impact on healthcare system sustainability and long-term healthcare financing, as well as the potential risks of the proposed HPS.

Chapter 2 THE SECOND STAGE PUBLIC CONSULTATION

2.1 In the second stage public consultation on healthcare reform, titled "My Health, My Choice", we consulted the public on –

(a) the proposed introduction of the standardized and regulated voluntary HPS including the regulatory framework for regulating private insurance and healthcare sector under the HPS and the supporting infrastructural measures required to support the implementation of the HPS –

(i) the supervisory structure and regulatory framework for private health insurance and private healthcare services in Hong Kong, comprising existing prudential regulation, quality assurance regulation to be strengthened, health insurance claims arbitration mechanism, and new agency to be established to supervise the implementation of the HPS;

(ii) the necessary measures to expand healthcare capacity and the planning of professional development and manpower of the various healthcare professionals, to support the long-term development of the healthcare system as a whole, including both the public and private sector, and the implementation of the HPS; and

(iii) other infrastructural support required for the implementation of the HPS, including the provision of DRG-based medical services and packaged charging, provision of health insurance based on HPS requirements, and the mechanisms for monitoring the impact of private health insurance and private healthcare services on the long-term sustainability and financing of the healthcare system.

(b) the proposed features and design of the HPS, including the combination of key features required of HPS Plans are aimed at consumer protection and quality-assurance, as well as ensuring the transparency and competition in the private health insurance market –

(i) No turn-away of subscribers and guaranteed renewal for life

(ii) Published age-banded premiums subject to adjustment guidelines

(iii) Cover pre-existing medical conditions subject to waiting period and time-limited reimbursement limits

(iv) Cap premium plus high-risk loading at 3x published premium

(v) Make higher risk groups insurable with High-Risk Pool reinsurance

(vi) Offer no-claim discount up to 30% of published premiums

(vii) Insurance plans portable between insurers and on leaving employment

(viii) Transparent insurance costs including claims and expenses

(ix) Standardized health insurance policy terms and definitions

(x) Government regulated health insurance claims arbitration mechanism

(c) the proposal to consider making use of $50 billion, that the Government has pledged to draw from the fiscal reserve to support healthcare reform after the supplementary healthcare financing arrangement is finalized for implementation, to provide financial incentives to encourage the public to participate in the HPS on a sustained basis, thereby relieving the long-term demand for public healthcare services. The proposed options for providing financial incentives include –

(i) **Protection for high-risk individuals:** to allow high-risk individuals to join HPS Plans without requiring other healthy insured to pay excessive premium, we propose to consider government injection into High Risk Pool (HRP) where necessary, an industry-operated reinsurance mechanism for taking on high-risk individuals and sharing out their risks, to buffer the excess risk arising from the participation of high-risk individuals.

(ii) **Premium discount for new subscribers**: to attract individuals especially the young to join HPS Plans, we propose to consider government incentives for all new joiners of HPS Plans to enjoy maximum no-claim discount i.e. up to 30% discount on the Standard Plan premium immediately on joining. We propose to make this available for a limited period after the introduction of HPS.

(iii) **Savings for future premium**: to enable the insured to continue to afford health protection under the HPS at older age, we propose to consider government incentives for savings by individuals for paying future premium at older age (say 65 or above). We propose that the government incentives should be proportional to their length of continuously staying insured under the HPS and may be up to a certain percentage of their Standard Plan premium.

2.2 The three months' consultation period of the second stage public consultation on healthcare reform ended on 7 January 2011. During the consultation period, we have publicised the consultation document and proposed HPS through a publicity campaign. We engaged different sectors and various stakeholders in the community through a series of briefings and public forums to explain the proposed HPS and to listen to their views. We also received the views of members of the public including various stakeholders through their written submissions. Besides, we canvassed the views of the public through various means as part of the consultation. The sections below summarised activities that had taken place in connection with the consultation.

2.3 We would like to take this opportunity to thank members of the community and various organizations for their active participation and the valuable opinions provided during the consultation period. They have expressed constructive views on both healthcare reform in general and more specifically on the proposed voluntary HPS including its detailed proposals and design features, which have helped us better understand public expectations on healthcare reform and facilitated our deliberation and fine-tuning of the proposals for the HPS.

General Publicity

2.4 We launched a publicity campaign on the healthcare reform public consultation with the theme "My Health, My Choice", to invite public participation in the exercise by giving their views on the proposed HPS. We aired three Announcements in the Public Interests on both television and radio, and posted over 2 100 posters at District Offices, public libraries, public hospitals and

clinics, government offices and etc. A total of 170 000 copies of leaflet, 460 000 copies of brochure and 53 000 copies of the consultation document were distributed to the public. We also gave out a total of over 84 000 token souvenirs to draw public attention to the healthcare reform public consultation. The Secretary for Food and Health had published two newspaper articles to share our vision and direction on healthcare reform and encourage public discussion on the subject.

Legislative Council

2.5 The Secretary for Food and Health briefed the Panel on Health Services of the Legislative Council and launched the healthcare reform second stage public consultation at its special meeting on 6 October 2010. The Panel held another special meeting on 11 December 2010 and regular meeting on 13 December 2010 to discuss the HPS and to listen to the views of a total of 79 deputations on healthcare reform. The Under Secretary for Food and Health attended these two meetings to explain the HPS, to answer questions and to listen to the views of Members and the deputations. Please see ***Appendix B*** for links to the notes of the meetings and the submissions of the deputations.

District Councils

2.6 The Under Secretary for Food and Health attended all 18 District Councils (DCs) to brief them on healthcare reform and the proposed HPS and to listen to Members' views on the proposal. Members expressed actively their views on the reform and reflected the views of local communities. Most DCs agreed in general to the direction of introducing a regulated voluntary health insurance scheme with two DCs passed motion expressing support to the proposed voluntary and government-regulated HPS. Please see ***Appendix C*** for links to the notes of the relevant DC meetings and excerpts of the concluding statement of the Chairmen and the motions passed at those meetings.

Briefings/Seminars/Forums in the Community

2.7 The Secretary for Food and Health and/or representatives of the FHB attended during the consultation period 80 briefing sessions, including the aforementioned Legislative Council and District Council meetings, community forums organized by FHB and briefings and seminars organized by various political parties, professional bodies, labour unions, chambers of commerce, trade associations, social welfare organizations, district organizations and community groups. These occasions provided the opportunity for the Government to present the future blueprint for healthcare reform and details of the proposed HPS, as well as for the Government to listen to the views expressed and exchanged by various interested parties and members of the public. Please see ***Appendix D*** for a list of the briefing sessions, forums and seminars held.

Written Submissions and Opinions Expressed

2.8 The Government received a total of 564 submissions on healthcare reform from individuals and organizations by hand, email, post, facsimile and online feedback form, etc. These included 439 submissions from individuals and 125 submissions from organizations. Please see ***Appendix E*** for a list of all written submissions received and the originators (except where the originator requested to remain anonymous). Copies of the submissions are available

on the healthcare reform second stage website (http://www.MyHealthMyChoice.gov.hk), except where the originator requested not to make public the submission. In addition, we have also monitored commentaries and opinions expressed through other channels, including the media (both electronic and printed) and online forums such as the Public Affairs Forum run by the Home Affairs Bureau. We have taken all these into account when analyzing the public responses.

Questionnaire Surveys and Focus Groups

2.9 To facilitate collation and assessment of views on the proposals and issues related to healthcare reform, we commissioned independent consultants to conduct questionnaire surveys and focus groups discussions on various subjects from different target groups -

No.	Project Title	Consultants	Purpose	Study Period
1	Public Opinion Survey on Supplementary Healthcare Financing	Consumer Search Hong Kong Limited	To gauge the general public's views on supplementary healthcare financing, in particular the HPS, via telephone interviews.	November 2010 to April 2011
2A	Medical Stakeholders' Opinion Research on Health Protection Scheme – Postal Survey	School of Public Health and Primary Care, The Chinese University of Hong Kong	To gauge the views of western medical doctors on the HPS, via postal survey.	December 2010 to May 2011
2B	Medical Stakeholders' Opinion Research on Health Protection Scheme – Focus Group Study	Same as above	To solicit more in-depth qualitative views of western medical doctors and private hospital administrators on the HPS, via focus group discussions.	December 2010 to May 2011
3A	Consumer Market Research on the Health Protection Scheme – Telephone Survey	Consumer Search Hong Kong Limited	To gauge the consumers' views on the design of the HPS, via telephone interviews.	January to May 2011
3B	Consumer Market Research on the Health Protection Scheme – Focus Group Study	Same as above	To gain a deeper understanding of consumers' views on the design of the HPS, via focus group discussions.	January to May 2011

2.10 Please see summary of the results of the three questionnaire surveys at ***Appendices F-H***. The detailed reports of the questionnaire surveys and focus groups are available on the healthcare reform second stage website (http://www.MyHealthMyChoice.gov.hk). Meanwhile, we also have received and taken note of a number of questionnaire surveys conducted by third-parties, and made reference to these surveys when analyzing public responses to the healthcare reform.

2.11 The ensuing chapters set out our analysis of the public views reflected in the consultation exercise.

Chapter 3 PUBLIC VIEWS ON HEALTHCARE REFORM AND HPS OBJECTIVES

Overview

3.1 While the second stage public consultation on healthcare reform focuses mainly on the HPS proposals, the views received in the consultation touched upon a wide range of issues concerning the healthcare reform in general, in addition to those directly related to the proposed features of the HPS and healthcare infrastructure in support. This Chapter sets out views pertaining to the broader topics of healthcare reform and the objectives of HPS. More detailed analysis of the specific views received (including opinion survey results and focus groups findings) on the proposals for HPS including its concept and design, as well as supporting infrastructure of the healthcare system are set out in Chapters 4 and 5.

Support for Healthcare Reform

3.2 There are a number of views expressed strong support for the comprehensive package of structural reform of healthcare services that are being implemented by the Government. These views covered the importance of enhancing primary care and disease prevention to improve population health and reduce reliance on hospital care, the role of health adviser and gatekeeper in ensuring effective use of healthcare, the need for a patient-centred electronic health record system to empower individuals to take responsibility for their healthcare and lifestyle, and need for reform to bring about a more tightly integrated and collaborative healthcare system.

3.3 These general views reaffirmed the approach being taken by the Government in taking forward the healthcare reform in a comprehensive manner to enhance the long-term sustainability of the overall healthcare system, including enhancing primary care, developing electronic health record systems and improving healthcare services delivery, while reinforcing the public system as safety net for the population. Some respondents also emphasized the need to further develop the role of various healthcare professions apart from doctors and nurses in the healthcare system, e.g. Chinese medicine practitioners, not only in primary care but also in other more specialized services.

Role of Public Healthcare System

3.4 The Government's affirmation of the continued role of the public healthcare system, in providing equitable and universally accessible healthcare and serving as an essential safety net for the population as a whole, was widely echoed by views received in the consultation. All welcomed the Government's increased health budget[1] for improving public healthcare services while implementing healthcare reform. Some further considered that the Government should continue to increase its commitment to healthcare beyond the pledged 17% of recurrent government budget. Some advocated for an immediate budget increase to meet demand for public healthcare.

3.5 While supporting taking forward the healthcare reform, many respondents considered

[1] Recurrent government expenditure on health increased from $31.6 billion (15.9% of recurrent government expenditure in overall) in 2007-08 to $39.9 billion (16.5% of overall expenditure) in 2011-12.

that the Government must not diminish its commitment to public healthcare. They emphasized that public healthcare services should not be adversely affected by the reform, and in no circumstances should the Government undermine the public healthcare system. Some considered that the public healthcare services provided by the Hospital Authority (HA) should be prioritized to better serve the grass-roots and the under-privileged in particular. More specifically, many respondents held the view that public healthcare service should continue to be improved to provide better services especially for those in need, for instance, by shortening waiting queue and further strengthening the safety net.

3.6 At the same time, some respondents pointed out that effort should be made to get people to take responsibility for their own health and healthcare, so as to contain the burden on the public healthcare system in the long run. Many of them considered that healthcare resources could not be increased unlimitedly to cope with the increase demand, and eventually continued increase in Government's healthcare expenditure would undermine the low tax environment that was crucial to Hong Kong's continued prosperity. Some of them emphasized that public healthcare should focus on targeted service areas and provide targeted support and protection mainly to those in need especially the low-income and under-privileged groups.

Reforming Private Healthcare System

3.7 Alongside support for maintaining and strengthening the public healthcare system, the majority of views obtained during the consultation supported reforming the private healthcare system, including both the private health insurance and private healthcare sectors, to provide additional quality-assured, value-for-money choices and enhance regulation for consumer protection. A majority of views considered that a sustainable healthcare system required not only a strengthened public system as its core, but also a complementary, competitive and transparent private system providing more value-for-money choices for members of the public. These views were echoed by the findings of Public Opinion Survey on Supplementary Healthcare Financing targeting general public (Survey 1), in which 70% of the survey respondents agreed that the Government should encourage more people to use private healthcare service so that the resources of public healthcare system could be focused on serving the low-income families, disadvantaged groups and people with severe illness.

3.8 There was strong public support for the Government to reform the private health insurance and private healthcare service markets to address the existing shortcomings in the private healthcare system, while maintaining the public healthcare system as the core safety net. Many respondents noted that a substantial and increasing proportion of the population (over one-third) had some form of health insurance coverage, either through their employers or purchased on their own, and private expenditure on health insurance and healthcare services especially private hospital care was growing rapidly. They considered that these trends indicated the increasing role of the private healthcare sector, and that on its own spelt the need for reforming the private system to provide affordable health insurance with consumer protection, and quality-assured, value-for-money choices of healthcare services to the public.

3.9 Notwithstanding the broad support for reforming the private healthcare system alongside the public one, there were a small number of submissions which took a different view. These submissions considered that the Government should invest solely in the public healthcare system, and should not bother about reforming the private system at all or should leave the private sectors alone to develop on their own. They pointed out that the experience of some

overseas economies suggested that it might be more cost-effective for the population as a whole for healthcare service to be delivered through a predominantly public system and for healthcare resources to be concentrated in provision of public healthcare. Some opined that, instead of reforming the private healthcare system, the Government should focus its efforts on reforming the public healthcare system and improving its efficiency.

Regulation of Private Health Insurance and Healthcare Services

3.10 Views received in the consultation reflected a broad consensus for strengthening regulation over private health insurance and private healthcare services in the process of reforming the private healthcare system. An overwhelming majority of views received pointed to the existing shortcomings in market practices, including insufficient pricing transparency, escalating private medical expenses, itemized charging with no certainty of payment upfront, restrictive insurance policy terms such as limited access to health insurance by high-risk individuals, increase in premium or even unilateral termination of policy after claims, etc. The consultation reflected strong public support for regulating private health insurance and private healthcare services to address these shortcomings. A significant number of respondents specifically welcomed stepping up regulation and supervision of voluntary private health insurance.

3.11 On the other hand, the insurance industry and healthcare providers were positive towards supervisory measures that can enhance consumer confidence, but cautioned against excessive regulation, pointing out that the market should best be left to operate with minimal necessary intervention by the Government. They also pointed out that the feasibility and desirability of some of the proposals for regulation and supervision would need to be further examined. For instance, while generally acknowledging the benefits of standardized policy terms and definitions, the industry considered that the difficulties of doing so should not be under-estimated. They also considered that the proposed claims arbitration/mediation mechanism would require detailed examination.

Objectives of Health Protection Scheme

3.12 A significant number of views received considered that the proposed HPS was a positive step forward to enhance transparency, competition and efficiency of the private healthcare system. They were cognizant of the existing shortcomings in the private healthcare sectors, and agreed that changes were required to make a better and fuller use of the private sector. Respondents in general considered that the objectives and general framework of the HPS would benefit the public by improving their healthcare protection, though some individuals and organizations raised concerns on specific proposals and initiatives of the scheme. Some organizations believed that the HPS could lead to efficient use of private healthcare resources, which would be in line with the direction of healthcare reform in promoting public-private-partnership, with a view to addressing the public-private imbalance in the provision of in-patient care.

3.13 This echoed with the result of Survey 1 which showed that some 70% to 80% of survey respondents supported the various stated objectives of the HPS (results of specific questions are set out in the following paragraphs), and some 63% of the respondents supported the Government to introduce the voluntary HPS, as a means to strengthen regulation over the private system to enhance transparency, competition and efficiency. Similar view was reflected in the Medical

Stakeholders Survey conducted by the Chinese University of Hong Kong (Survey 2A) in which about 60% of the responding medical professionals agreed or strongly agreed with the objectives of HPS as stated in the consultation document.

3.14 The submissions received during the consultation supported the objective of strengthening of government supervision of the private health insurance and healthcare service markets, in particular through introducing various consumer protection features as proposed under HPS. The community in general demanded enhancing regulation in order to -

(a) Protect consumers and safeguard their interests in the use of private health insurance and private healthcare services;

(b) Enhance transparency and competition in the private health insurance and private healthcare service markets; and

(c) Provide a quality-assured and value-for-money alternative to public healthcare, while focusing public system on its target areas.

General views received on these specific objectives of the HPS are set out in the following sub-sections.

(a) Protect Consumers and Safeguard Their Interests

3.15 Majority of submissions received supported the objective of HPS in enhancing consumer protection and safeguard in private healthcare sector. A number of submissions supported the Government to use HPS to address the unwelcome market practices of private health insurance and private healthcare services. Some submissions supported the Government to strengthen the existing control over market practice, premium, cost and profit margin of private health insurance sector. Some submissions pointed out the need to enhance the existing supervisory regime on private healthcare sector to safeguard consumer interests, in view of the increasing role of the private healthcare sector. The views received from the submissions echoed the results of findings in Survey 1 which 89% and 91% of respondents agreed that the Government should regulate private health insurance and private healthcare services respectively, to provide better protection to the consumers.

3.16 A number of respondents considered that the HPS should be conceptualized from the perspective of formulating a consumer and patient protection policy in private healthcare sector. In the course of formulating proposals to enhance consumer protections, a few submissions urged the Government to work with existing regulatory or professional bodies such as the Medical Council and the Hong Kong Academy of Medicine to strengthen quality assurance on private healthcare services.

(b) Enhance Market Transparency and Competition

3.17 There was a general consensus on the objective of HPS in enhancing transparency and competition in private health insurance and private healthcare sector. Many submissions supported the Government to take forward measures through HPS to achieve this objective. As reflected in Survey 1, 84% and 85% of respondents agreed that the Government should enhance competition and transparency of private health insurance and private healthcare service markets

respectively.

3.18 Many submissions, in particular supported the requirements and features of HPS on standardizing the terms and conditions of health insurance plans to enhance transparency and facilitate consumer to make easy comparison over health insurance policies. A number of submissions also considered that the Government should step up efforts to enhance transparency and certainty of charging, and promote quality assurance of private healthcare services. Some of them in particular welcomed the introduction of packaged pricing in healthcare sector, with a view to promote transparency and upfront certainty.

(c) Provide a Quality-Assured and Value-for-Money Alternative

3.19 Many submissions, both from individuals and organisations, welcomed the objective of HPS in providing additional choices with better protection to those who would be able and willing to pay for private health insurance and private healthcare services. They considered that the implementation of the HPS would provide additional choice of sustainable healthcare protection, as an alternative to the public healthcare services, to the community. According to Survey 2A, 57% of the responding medical professionals agreed that the introduction of the HPS would provide more choices with better protection to patients.

3.20 A majority of submissions agreed the objective of HPS to enable health insurance subscribers to use value-for-money private healthcare on a sustained basis, so as to enable the public healthcare system to better focus on its target groups and service areas. A number of submissions specifically pointed out that the HPS would make it easier for high-risk individuals as well as those who, for various reasons, had been facing tremendous hurdles in the purchase of health insurance to have genuine access to health insurance at affordable prices, and thus a wider opportunity to seek private healthcare services as an alternative to public services.

Concerns over Implications of HPS

3.21 Notwithstanding the broad support received to the HPS as a tool for reforming the private healthcare system, a small but not insignificant proportion of views expressed doubts during the consultation on the necessity and rationale for introducing HPS. These views in general welcomed strengthening the supervision of the private health insurance and private healthcare service sectors for consumer protection and market transparency per se. Rather, they largely reflected their concerns over the potential risks of introducing HPS under circumstances with infrastructural constraints, and argued against providing government subsidy under HPS as opposed to further increasing funding for public healthcare -

(a) **Funding and quality of public healthcare services**: Some submissions expressed concerns on whether the funding and quality of public healthcare would suffer as a result of introducing HPS. Apart from concerns on HPS draining manpower and capacity of the public healthcare system (see also sub-paragraph (b) below), they would like to know whether the Government would remain as committed to public healthcare by continuing to increase funding and improve quality, if resources were being diverted to HPS.

(b) **Capacity and manpower of the healthcare system**: Many submissions stressed that the success of the HPS and indeed healthcare reform hinged on whether our healthcare

system as a whole had adequate capacity and manpower, including supply of manpower in various healthcare professions most notably doctors and nurses, and availability of healthcare infrastructure. Lukewarm reaction of the current private healthcare sector to offer packaged services and pricing, especially in view of continued influx of demand from outside Hong Kong, were cited as factors potentially undermining the feasibility of HPS.

(c) **Affordability of health insurance premium and healthcare service charges**: Many submissions considered future affordability of private health insurance and private healthcare services crucial. Many expressed doubts on the ability of the Government to contain increase in insurance premium and medical charges merely through transparency and competition under HPS. There was strong public support for introducing more stringent control over premium and price increase. Some submissions went further to suggest that the Government should consider playing a more direct and active role in the provision of health insurance and/or private health services to inspire public confidence.

(d) **Subsidization for subscribing to private health insurance and using private healthcare services**: Rather divergent views were expressed towards the proposals to use $50 billion fiscal reserve to provide financial incentives under HPS. Some submissions supported public subsidy for specific groups (the high-risk, elderly or young age) to get health insurance coverage; some supported direct subsidy for private healthcare services; and some demanded immediate tax relief for private health insurance and/or private healthcare services. On the other hand, some considered it inequitable and inefficient to subsidize those who could afford to subscribe to private health insurance and use private healthcare services, and suggested setting up a $50 billion designated fund for public healthcare services to meet healthcare needs arising from ageing population. A number of submissions considered that public subsidy should be provided in line with the HPS objectives.

Impact on Healthcare System Sustainability and Financing

HPS as a Positive First Step in Financing

3.22 Many responding individuals and organizations agreed that the introduction of a voluntary HPS was a positive step forward in enhancing the sustainability of the healthcare system including its financing. Many submissions welcomed the proposed HPS as the first step of introducing supplementary financing. Some considered that it would make a start to harness the private sector (including private health insurance and private healthcare service sectors) to meet the increasing healthcare needs of the community. They acknowledged that it would make regulated health insurance a more viable funding source for meeting part of the future healthcare needs of the community. In this regard, they recognized that, as pointed out in the consultation document, the HPS could not be a complete solution to the long-term healthcare financing problem in view of its voluntary nature. Nonetheless, many considered that a voluntary and regulated health insurance scheme would be a positive step and more acceptable to the public.

3.23 A number of submissions expected that HPS could help improve the efficiency and cost-effectiveness of the private healthcare sectors which was also conducive to the sustainable

development of the healthcare system. About 53% of the responding medical professionals in Survey 2A were positive about the long-term impact of the HPS on the development of Hong Kong's healthcare system. A number of submissions considered that the HPS would likely to make the private sector better positioned to share part of the increasing healthcare service demand alongside the public system and alleviate the burden on the public system through enhancing private sector capacity. They expected that the reform could enable the public healthcare sector to better focus its resources on those in need. In Survey 2A, 56% of the responding medical professionals agreed that the HPS would relieve demand on the public healthcare system. Some submissions expected that with the implementation of the HPS, those patients who needed to rely on the public sector would enjoy lower waiting time and better resources while those who were not satisfied with the current private health insurance would have improved affordability, service choices and quality assurance.

3.24 Some submissions considered that the voluntary HPS could be the first step on supplementary financing, and the HPS would require continued monitoring and adjustment to ensure that its objectives could be achieved, not least in relieving the pressure on the public system. Some commented that healthcare financing would ultimately require some form of mandatory supplementary financing option, and considered a mandatory option more effective in funding healthcare and pooling health risks. Some respondents suggested that the voluntary HPS could form the basis for taking further steps on supplementary financing, for instance, if the HPS eventually proved to be attractive and achieved high penetration rate, consideration could then be given to make the HPS into a more rigorous supplementary financing scheme or even to contemplate making it a mandatory option. Taking forward the HPS at this juncture could help build the necessary support and promote its acceptance.

HPS as an Incomplete Solution on Financing

3.25 Some submission received in the consultation opposed the HPS on the ground that it was not a complete solution on its own to resolve the challenges to the long-term sustainability and financing of the healthcare system. Some cast doubts on whether the HPS could even achieve its stated objectives of enhancing market efficiency and cost-effectiveness, and relieving the pressure on the public healthcare system, citing those concerns on HPS as set out in paragraph 3.21 above as reasons. Some submissions were worried that the implementation of the HPS would aggravate medical inflation. With higher medical cost as a result, some of them were concerned that the quality of public services would get worse if there was no corresponding investment in improving public healthcare services. Some also questioned to what extent a voluntary HPS could address the long-term financing needs of Hong Kong.

3.26 A number of submissions, on the other hand, considered that if we do not take steps to enhance the quality assurance and value-for-money of private healthcare, private funding for private health insurance and private healthcare services are unlikely to sustain, in which case healthcare needs of our ageing population would increasingly fall on the public system. Some submissions were of the view that, HPS as part of the healthcare reform, to the extent that it enhances the transparency and competitiveness of the private healthcare sector, should help sustain private resources for healthcare and relieve the pressure on public healthcare system over the long-run.

3.27 A few submissions suggested that a tax-funded public healthcare system was a more equitable way to fund healthcare services for the population. Some went further to suggest that

the salaries tax and profits tax should be made more progressive to generate more tax revenue to finance future healthcare. In this connection, we note that tax increase is not a financing option favoured by the majority of the community. According to Survey 1, only 35% of the survey respondents agreed that the Government should increase tax to meet the increasing healthcare expenditure in order to maintain the sustainability of the public system. At the same time, more than 40% the survey respondents stated their opposition to tax increase for funding healthcare expenditure. These finding echoed the finding of the first stage healthcare reform public consultation which tax increase as an supplementary financing option was found to be least favoured by the public.

Chapter 4 PUBLIC VIEWS ON HPS CONCEPT AND DESIGN

Overview

4.1 There were active discussions among the community and stakeholders on the concept and design of the proposed HPS. Apart from expressing support to the objectives and concept of the proposed HPS, many submissions expressed views on the specific design features of HPS, especially the introduction of standardized core requirements and specifications for health insurance under HPS, i.e. to specify the basic benefit coverage and limits that all health insurance must provide, and to require all health insurance to comply with a number of standardized rules and requirements.

4.2 In general most considered that the standardized core requirements and specifications of HPS could help ensure basic and essential healthcare protection for the insured under HPS and address the shortcoming of existing private health insurance products, and that the rules and requirements under HPS could help enhance consumer protection, market transparency and competition in private healthcare sector. Survey 1 reflected that the various consumer protection features of the HPS, which are proposed to be core requirements that all health insurance are required to meet under the HPS, received strong support from around 70% to 80% of the survey respondent.

4.3 The proposal of considering financial incentives under the HPS making use of the $50 billion earmarked fiscal reserve attracted the most discussion. Apart from divergent views on whether public subsidies should be given, many commented on the three proposals for financial incentives put forward, and suggested other ways of providing financial incentives and making use of the $50 billion. Many submissions that supported considering financial incentives expressed concerns on future affordability of private health insurance and healthcare services, if insurance premium and medical fees continue to escalate and are bound to increase as the insured becomes older.

4.4 Many submissions also expressed views on the desirability and feasibility of individual features under the HPS, e.g. savings component, acceptance of high-risk individuals and HRP, DRGs-based services and charging, portability and migration, etc., especially whether and how they would be implemented in practice. Many called for more detailed examination of these issues together with the stakeholders in developing the details of the proposed HPS, with a view to ensuring their feasibility and, as far as possible, desirability in terms of achieving the objectives of the HPS, as well as to meeting the expectations of consumers.

Scheme Concept

4.5 Majority of views supported the concept of the proposed HPS as a standardized and regulated statutory framework that specify the **core requirements and specifications** that private health insurance must meet as a basic standard. Many of them agreed that health insurance plans offered under HPS are required to meet the core requirements and specifications under HPS. These views considered that the standardized core requirements and specifications of HPS could help ensure basic and essential healthcare protection for the insured, and enable genuine access to and choice of private healthcare services for the insured when in need. Some submissions specifically pointed out that the standardized features could provide an objective benchmark for

the community to compare between various health insurance products available in the market.

4.6 The concept of formulating a **"Standard Plan"** under the HPS, i.e. insurers participating in the HPS are required to offer health insurance plans in accordance with the core requirements and specifications, was supported in views received. A number of submissions also expressed specific support to the modular approach of the HPS (i.e. core requirements and basic coverage plus optional top-up benefits, i.e. benefit levels over and above the minimum standard specified in the core requirements, or add-on components, i.e. additional benefit coverage for medical services beyond those covered by the core benefit coverage) which allow consumers to choose, based on their preference, higher benefit limits or additional coverage beyond the core requirements and specifications to suit their needs.

4.7 Majority of views also supported that all private health insurance under HPS must comply with the **standardized scheme rules and requirements** set by the Government as ground rules for health insurance under the HPS. Most agreed that private insurers offering private health insurance should be required to comply with these standardized rules and requirements with a view to safeguarding consumer interests and enhancing consumer protection, market transparency and competition in private health insurance. Referring to the existing practice, many submissions considered that requiring participating insurers to follow standard rules and requirements for private health insurance under HPS would help address the shortcomings of existing private health insurance products available in the market, and enhance consumer confidence in private health insurance.

4.8 Survey 1 showed that 81% of the respondents agreed that the health insurance plans to be offered under the HPS should have standardized policy clauses including definitions and terms with a view to safeguarding consumer interests and minimizing unnecessary disputes in making claims. The views received from Consumer Market Research conducted by Consumer Search HK Limited (Survey 3A) also reflected that 43% of the survey respondents found the standardization of policy terms and conditions attractive/very attractive, while 19% of them considered this feature unattractive/very unattractive.

4.9 Some submissions went further to suggest that consideration could be given to design HPS plan on family, rather than individual, basis. This, in their view, could better achieve risk sharing between different generations and enhance healthcare protection on a family basis for future healthcare needs.

Preference among Scheme Features

4.10 A large number of views and suggestions were received on the proposed features of the HPS. Many submissions welcomed the features of HPS with the aim to facilitate HPS subscribers to have access to affordable and value-for-money private healthcare services. There was a wide support for the proposed insurance features aiming at safeguarding consumer interests and enhancing consumer protection, including, for instance, guaranteed access and renewal, insurance plan portability, standardized policy terms and conditions, age-banded premium schedule with guidelines on premium adjustment, with DRG-based packaged pricing as benefit limits, etc.

4.11 Survey 3A attempted to ascertain consumer responses to the 10 key proposed features of the HPS apart from benefit coverage and limit design. The results showed that the respondents in general considered these proposed features attractive/very attractive, with those saying in

favour ranging from 40% to 64%, with five out of the 10 features considered attractive/very attractive by more than half of the respondents. This was much higher than the percentage of respondents, ranging from 14% to 26%, who considered them unattractive/very unattractive.

4.12 Survey 3A also reflected the relative preferences among the 10 key proposed features of HPS. The top five features and the proportion of respondents who considered them very attractive/attractive are listed below. The top four most appealing features of the HPS were all related to certainty in acceptance of enrolment, followed by the adoption of DRG-based benefit structure which was related to certainty in medical charges and co-payment. Key findings of consumer research on the proposed features of HPS are summarized in ***Appendix H***.

(a) guaranteed acceptance and renewal for life (64%);

(b) health insurance policy fully portable (61%);

(c) allow coverage of pre-existing conditions (56%);

(d) pooling of high-risk subscribers (53%); and

(e) adoption of DRG-based benefit structure (53%).

Benefit Coverage and Levels

Core Benefit Coverage and Levels

4.13 Many submissions supported the view that the core benefit coverage of the Standard Plan under HPS should focus on basic and unanticipated medical needs requiring essential but costly treatment, which could be better served through a pre-paid, risk-pooled insurance scheme. Most considered that medical treatments requiring hospital admissions (in-patient treatments) and specific medical procedures that may be carried out in an ambulatory setting (ambulatory procedures) must be covered as part of the core benefit coverage. Many considered that it was appropriate to focus the core benefit coverage on in-patient services and ambulatory procedures.

4.14 A number of submissions considered that the setting of benefit level and limit under the Standard Plan should facilitate patients receiving optimal treatment from private healthcare sector. Some submissions pointed out that the benefit limits of existing health insurance were inadequate to provide sufficient protection to the insured when they need healthcare service in private sector, and some of them expected the benefit levels of the core coverage of HPS Plan should enable them to have sufficient protection for access to private healthcare services.

4.15 The findings of Survey 2A showed that about 53% of the responding medical professionals did not think that health insurance in the current market had been offering enough coverage for common treatments in private hospitals. 72% of the responding medical professionals ranked hospital admission as the most important insurance benefit, followed by ambulatory care (12% and 42% ranked ambulatory care as the most important and the second most important benefit respectively). This echoed with views collected in other channels which suggested that the emphasis of current health insurance on hospital admissions and the absence of specific coverage of ambulatory procedures, might lead to higher costs and less cost-effective care. Many submissions welcomed the Government to set minimum benefit coverage and levels in the

HPS Standard Plan to safeguard the interests of the insured.

4.16 Some respondents believed that the standardized benefit limits should encourage judicious use of medical service. They urged the Government to take initiative to discuss with the medical and insurance sectors, as well as end-users on benefit coverage and level in order to come up with an acceptable and feasible benefit schedule, which would ensure sufficient coverage for access to private healthcare services, while focusing on the basic and essential medical treatments. Some submissions, on the other hand, pointed out that the coverage under the standardized plan should not be too limited and should be reviewed regularly in order to maintain sufficient coverage under the HPS.

4.17 Assessing the attractiveness of the basic benefit coverage from a consumer perspective, Survey 3A showed that 35% of the respondents considered the basic benefit coverage of the HPS attractive/very attractive, while 44% were neutral/indifferent. Another 19% found the basic benefit coverage unattractive/very unattractive. Most participants in Focus Group 3B (consumers who can decide to purchase private health insurance products for themselves and/or family members) agreed that the proposed coverage in the Standard Plan was adequate as the insurance should primarily target at and cover unanticipated and expensive treatments, while some expressed different opinions on how to refine the benefit coverage, such as the ceiling on the number of claimable pre- and post-admission specialist consultation.

Top-Up Benefits and Add-On Components

4.18 Some respondents expressed concerns about top-up benefits and additional components, in particular the co-ordination of benefits between different health insurance policies under the HPS. A number of submissions pointed out that, while the modular approach of HPS (i.e. core requirements plus optional top-up benefits and add-on components) would allow flexibility for HPS subscribers, the presence of top-up benefits and add-on components might limit the portability of HPS Plan between participating insurers and hence limit the competition between insurers and choice of consumers. Some of them urged the Government to see how to better co-ordinate the plans and top-up components among participating insurers under HPS to facilitate "real portability".

4.19 A number of submissions considered that rules and requirements of HPS should also apply to top-up benefits and add-on components to better safeguard consumers. In particular, some submissions expressed concerns that if top-up benefits and add-on components were not subject to the same rules and requirements as the core benefit coverage, that might create a loop-hole for insurers to circumvent the rules and requirements for consumer protection under the HPS. On the other hand, some respondents including the insurance industry considered that excessive regulation of the HPS top-up components would limit choice of consumers and discourage innovation of products. They considered that, with the Standard Plan in place, open competition and transparent operation in a free market would be adequate to ensure competitiveness of the top-up benefits and add-on components.

4.20 On the attractiveness of the arrangement of top-up components from a consumer perspective, 28% of the respondents in Survey 3A found the arrangement of top-up components attractive/very attractive, which the proportion was close to those who found the arrangement of top-up components unattractive/very unattractive (28%). A higher proportion of them were neutral/indifferent (41%).

Inclusion of Primary Care and Other Services

4.21 The proposed exclusion of primary care from the core benefit coverage attracted much discussion. Some submissions suggested extending the scheme coverage to include primary care services, maternity and the newborn care, with a view to making the plan more appealing to individuals and younger families. Some advocated that further consideration could be given to include limited number of certain specialist consultation, treatments at public hospitals such as the self-financed medical treatments and payable items for public and private services under the HA in the core coverage of the Standard Plan to increase the attractiveness of the HPS.

4.22 Some respondents supported the exclusion of routine primary care from the benefit coverage of the Standard Plan, but suggested offering incentives to those HPS participants who would undertake approved preventive care such as health checks, screening tests, health and well-being programmes, and disease management programmes. A few submissions said that the exclusion of general out-patient services under the HPS Standard Plan might become a deterring factor for subscribers to seek timely treatment, thus causing an increase in subsequent hospitalization cost. They claimed that exclusion of general out-patient medical services would render the HPS unattractive to the young and the healthy.

4.23 To better cater for the need of chronic patients and the elderly, some patient groups also suggested that the Standard Plan should include investigations, medications and specialized treatment, which were the common needs of the elderly and people suffering from chronic illness, apart from in-patient services and ambulatory procedures. Some concern groups further proposed to extend the core benefit coverage to provide full protection for the whole range of healthcare for the elderly and chronic disease patients, as well as long-term mental health care and medications for patients with mental illnesses.

4.24 On the other hand, some respondents pointed out that having it would entail high premium cost if the coverage of the Standard Plan was too extensive. They favoured keeping the core benefit coverage and levels to the minimum necessary, and leave the other services to the design of optional top-up benefits and add-on components, in order to keep the premium of the Standard Plan at a more affordable level to the general population, while at the same time allowing flexibility for patients who would be willing to pay additional premium for top-up benefits and add-on components. Others suggested that guidelines should be promulgated on diagnostic investigation procedures to avoid unnecessary investigations.

4.25 Among the submissions, there were also suggestions for covering Chinese Medicine under HPS, including Chinese Medicine out-patient consultations and treatments during and after hospitalization.

Insurance Premium and Co-payment

Premium Structure and Setting

4.26 A large number of views were expressed on structure and setting of the premium of health insurance plans under the HPS, including their levels and control over their future adjustment. There was general support for the proposed requirement for all private health insurance under the HPS, including HPS Standard Plans, to each publish an age-banded premium schedule. This is also borne out by the findings of Survey 1 which showed that 69% of the

respondents supported that participating insurers under the HPS should list out the premium of different age groups.

4.27 Assessing the attractiveness of the illustrative age-bracketed basic premium schedule for the HPS Standard Plan from a consumer perspective, Survey 3A showed that more than one-third (35%) of the respondents considered the premium levels applicable to them attractive/very attractive for them to purchase or switch to HPS, and 35% of the respondents were neutral/indifferent. Another 28% found the premium levels to be unattractive/ very unattractive. The survey indicated that, to those respondents who were neutral/indifferent to the illustrative premium levels of the HPS Standard Plan applicable to them or found them unattractive/very unattractive, affordability was not the single underlying factor, but rather the perceived comparative value of the HPS vis-à-vis public healthcare, as well as the perceived chance of being hospitalized and undergoing surgery.

4.28 In Focus Group 3B, a majority of the participants, particularly those with higher income and including those with chronic disease, considered that the illustrative premium levels of the HPS Plans were attractive to them. However, there was a common concern about the much higher premium levels applicable to the old-age groups, and, noting that those levels would likely further escalate in future, some of them worried that they might not be able to afford the premium when they retired. A few participants of the focus groups considered the illustrative premium levels too high, and this view was more common for the participants with lower income and currently uninsured.

4.29 On the other hand, a few submissions considered that the HPS would enable those who could afford private healthcare to have more choices of private health insurance, while those who could not afford it would still resort to the public system. Some respondents pointed out that health insurance premiums might be relatively much less affordable for retirees and disadvantaged groups, including many chronic disease patients and poor elderly persons who had to rely on the public healthcare system. Though the premium would be cheaper for the younger age groups, some considered the voluntary scheme might not be sufficient to attract them to get insured. Some individuals suggested adopting a life-time locked-in premium schedule (i.e. a premium schedule that is fixed once subscribed) under the HPS to encourage individuals to subscribe earlier and stay insured.

Premium Adjustment and Cost Control

4.30 Premium adjustment and cost control under the HPS attracted substantial interests during the consultation, especially on how the HPS would be able to ensure continued affordability of private health insurance and private healthcare services under the proposals for the HPS, and whether the HPS would be effective in keeping future insurance premium and medical charges under checks. Many respondents considered this the most important issue for the success of the HPS as a voluntary scheme of private health insurance.

4.31 Generally speaking, views received reflected a broad consensus that the reasonableness of private health insurance premium including its future adjustment would be crucial to secure the confidence of the community in the HPS. Many stressed the importance of having certainty of premium levels at the older age to assure subscribers that they would not be priced out of health insurance when they grew old with dwindling affordability. There was a considerable number of views calling for a stronger role of the Government in premium adjustment and cost control under

the HPS, for instance, in requiring approval for premium adjustment and exercising control over costs or even profit under the HPS.

4.32 The participants of Focus Group 3B in general agreed that the HPS premium should be under better control compared with existing health insurance products, since the proposed design of the HPS could allow more cost-effectiveness measures to be built in, and the Government should proactively control premium adjustment and deter unreasonable increase. Survey 3A reflected that 47% of the survey respondents considered it attractive/very attractive if the HPS required participating insurers to report data on costs, claims and expenses, thereby increasing transparency for premium adjustment (in contrast with 15% who found this scenario unattractive/very unattractive).

4.33 Many respondents supported the proposal to enhance the transparency of premium, claims and costs of health insurance plans including medical fees under the HPS, so as to allay consumers' concern on the reasonableness of premium levels and any future adjustment. Some considered that full transparency, sufficient competition plus clear premium adjustment guidelines should be able to keep premium levels under checks in a competitive market. Some suggested that premium adjustment guidelines with legal backing should be formulated to ensure compliance and better protect consumers. Some advocated for more vigilant monitoring over premium levels and their increase with a view to forestalling market collusion and industry cartel in the provision of health insurance.

4.34 A number of submissions received and opinions expressed in Focus Group 3B advocated for more stringent control measures to keep premium/fee increase under check. Some suggested mechanisms to standardize the premium levels of all HPS Standard Plans or to approve premium adjustment applications of these plans. Some went further to suggest regulating the claims ratio, costs/expenses and profit margin of HPS Standard Plans. In Survey 1, 79% respondents considered that the premium levels of health insurance plans and profit margin of participating insurers under the HPS should be regulated by legislation.

4.35 Some were concerned that the HPS, being a voluntary health insurance scheme, might lead to moral hazards or even abuses which would accelerate premium hike over and above rising medical cost due to technological advance and ageing demographics. Stringent control of premium increase was considered necessary and crucial for the long-term sustainability of the HPS. Survey 3A showed that over half (53%) of the respondents found it attractive/very attractive if the HPS premium is regulated by the Government, while 29% of them were neutral/indifferent and 17% considered premium regulation unattractive/very unattractive.

Co-Payment and Deductible

4.36 Relating to the discussion of keeping premium under checks, some respondents advocated the proposal to make co-payment a mandatory requirement for HPS Standard Plan. Some of them expected that, if subscribers were allowed to purchase top-up benefits to cover co-payment, moral hazard might arise from zero co-payment leading to higher medical claims and in turn increase in premium of the HPS Standard Plans. They considered that more stringent control would be needed for top-up benefits to health insurance plans under the HPS especially on co-ordination of benefits and co-payment requirements.

4.37 The proposed step-down co-insurance that required higher co-payment rate for smaller

claims but lower co-payment rate for bigger claims attracted many questions as most people were not familiar with the practice that few current health insurance products applied. That notwithstanding, Survey 3A reflected that 47% of the survey respondents found the co-insurance arrangement proposed in the consultation document acceptable/very acceptable, for the purpose of encouraging judicious use of healthcare, which in turn lowering the overall premium level, while 34% felt neutral/indifferent and 17% of the respondents found it unacceptable/very unacceptable.

4.38 There were also submissions which welcomed the concept of co-payment, but had reservations on deductibles as the younger age groups who opted for deductible for reduced premium level might not be able to obtain adequate benefit under certain circumstances, in particular for minor operations and treatments. They expressed concerns that these policy holders might have a greater tendency to go back to public hospital for minor treatments, thus defeating the purpose of the HPS to reduce the burden on the public sector. Some further suggested that those insured under the HPS but continued to use public sector services should be charged with higher fees, in order to recoup the implicit subsidies to the insurance scheme.

4.39 Some individuals considered that requiring co-insurance might reduce the attractiveness of health insurance plans under the HPS vis-à-vis current private health insurance products being offered in the market. To mitigate the adverse impact, they suggested applying co-payment only to those treatments with significant, evidence-based risk of moral hazard, while waiving co-payment for unavoidable admission and procedures with little scope for abuse.

4.40 The insurance industry considered that the proposed step-down co-insurance structure and the co-existence of co-insurance and deductibles under the HPS would be confusing and overcomplicating the insurance scheme to lay persons. They suggested using a straightforward co-payment system to remove the complexity of the deductible and creating a structure that would be easier for consumers to understand. An alternative they proposed was to allow private insurers to have flexibility in offering top-up benefits to cover co-insurance as the moral hazard on in-patient service should be relatively lower.

4.41 Some submissions viewed that choice of deductible (in return for lower premium) was rather personal and subject to one's own perception of health risk, and hence should be left to the market to decide whether to offer rather than to be made a standard requirement. In Survey 3A, 27% of the respondents found the deductible arrangement proposed in the Consultation Document attractive/very attractive, while 28% found such a deductible arrangement unattractive/very unattractive, with a higher proportion (42%) being neutral/indifferent.

Insurance Subscription

Guaranteed Acceptance and Renewal

4.42 There was broad support for the proposal to offer guaranteed acceptance and renewal under the HPS. A number of submissions pointed out that requiring all health insurance plans under HPS to offer guaranteed acceptance and renewal would be a major step forward in enhancing consumer protection, and considered this feature one of the greater competitive edges of health insurance plans under the HPS over existing health insurance products. Some submissions welcomed this feature as addressing the shortcomings of some existing health

insurance products which excluded or declined high-risk individuals from subscribing or renewing their insurance policies after making claims, and considered it a booster for individuals to consider subscribing to health insurance.

4.43 Some submissions pointed out that guaranteed acceptance and renewal should be accompanied by risk underwriting and premium loading when a person first started to subscribe to health insurance plans under HPS, and that the premium loading of the insured should not be increased after first subscription or on subsequent renewal even if the insured had made a claim. Otherwise if the insurers were allowed to freely increase premium or apply additional premium loading on renewal, the benefit of guaranteed acceptance and renewal would be greatly diminished. On the other hand, some pointed out that guaranteed acceptance and renewal might possibly increase the risk of the insurance pool, and if the risk was not adequately compensated by premium loading or otherwise (e.g. public subsidies), all the insured would be required to bear the resultant additional risk premium and claims.

4.44 The result of Survey 1 indicated that 72% of the respondents supported the proposal for private health insurers to accept all subscribers and provide them with lifelong, guaranteed renewal. And 68% respondents agreed that insurers should accept subscribers with pre-existing conditions after a specified waiting period. Similar views were noted in Survey 3A in which 64% of respondents said that the scheme features of guaranteed acceptance of enrolment and renewal for life were attractive/very attractive to them, while only 14% of them considered them unattractive/very unattractive.

4.45 The insurance industry expressed the view that there was a need to resolve technical issues relating to the proposal of guaranteed acceptance renewal, e.g. cases where material information was misrepresented by an applicant, and that the insurers might need to adjust the premium to cope with the risk accordingly which would be unfair to the majority who have been insured equitably. Some suggested that guaranteed renewal and initial coverage should be implemented with detailed regulations and rules to handle cases with incorrect declarations and falsely declared information. To ensure long term sustainability of the HPS scheme, they suggested that consideration should be given to provide reinsurance against excessive claims over the lifetime of each member to ensure the base premiums for particular insurers would not deteriorate. Some insurers also questioned why guaranteed acceptance and renewal should apply to top-up benefits and add-on components offered over and above the HPS Standard Plans.

Limit on Entry Age

4.46 The proposal of setting a limit on entry age under the HPS, i.e. individuals must start to subscribe health insurance plans before a certain age (say 65), received rather diverse views in the consultation. Many views agreed that allowing individuals to start subscribing health insurance at very old age might significantly increase the risks and undermine viability of insurance pools, especially if pre-existing conditions were to be covered after a certain waiting period, and that imposing an entry age limit might serve the purpose of risk management. It would also be more equitable to other insured who started subscribing health insurance at a younger age, who would otherwise have to share via higher premium the additional risks and claims arising from those who started subscribing at very old age.

4.47 However, a number of submissions expressed concerns that the proposed entry age limit would affect the choice for those at older ages. A number of submissions opined that the design

of the HPS in limiting those aged 65 or above to join the scheme only within the first year after launch with no premium loading cap would discourage the elderly from subscribing to HPS plans. Some other submissions were concerned that it would be difficult for chronic disease patients, who were usually at higher-age to subscribe to HPS plans despite the guaranteed acceptance and renewal requirements. Apart from the entry age limit, they believed the features of age-banded premium, premium loading and co-payment would also deter chronic disease patients from participating in the HPS.

4.48 Survey 3A showed that 40% of the respondents found the feature of accepting old-age enrolees above 65 in the first year of HPS implementation, though without cap on the premium loading, attractive/very attractive, while 26% of them considered this feature unattractive/very unattractive.

Access by High-Risk Groups

High-Risk Individuals

4.49 A substantial number of submissions commented on the proposals for HPS that aim at enabling access to health insurance by high-risk individuals. These proposals were put forth with a view to addressing a commonly cited shortcoming of current health insurance products, i.e. they are difficult for individuals with pre-existing health conditions or have higher health risks to subscribe. Many submissions were in support of enabling high-risk individuals to access health insurance plans under the HPS through regulation and subsidy. In particular, the proposals of allowing access by individuals with pre-existing medical conditions, capping the premium loading for individuals assessed to have higher health risks, and requiring insurers to establish a risk-equalization mechanism specifically a High Risk Pool to share out the risks of high-risk individuals under the HPS, attracted varying degree of support.

4.50 Some submissions including those from some patient groups further suggested that pre-existing conditions, high-risk individuals and the elderly should be accepted unconditionally into health insurance plans under the HPS. They considered that any restrictions or limitations on access by high-risk individuals would lead to uncertainty and reduce the attraction of health insurance plans under the HPS, thus reducing community acceptance of the voluntary HPS. On the other hand, some submissions, while not opposing to the objective of enabling access by high-risk individuals per se, pointed out that the acceptance of these individuals into the health insurance plans would affect the risk pools, and the terms and conditions for access would need to be carefully designed to minimize adverse selection and potential abuse, as well as to ensure viability of insurance pools.

4.51 A few respondents considered that admission of high-risk individuals would be "unfair" to healthy individuals, and raised objection to the proposal of making it mandatory for insurers to accept high-risk individuals under the HPS, for fear that it would lead to significant increase in insurance premium. Some considered that acceptance of high-risk individuals would aggravate adverse selection, increase the risk of insurance pools and make the HPS unsustainable. Some pointed out that accepting high-risk group and setting up of HRP might discourage the participation of healthy and younger people, and as a result undermine the risk-pooling effect of health insurance under the HPS and further undermine the sustainability of the scheme. Some also questioned whether subsidizing through private health insurance would be the most effective

way to help the high risk group.

4.52 Survey 1 showed that 84% of respondents agreed that the Government should require the insurance sector to establish a risk sharing mechanism under the HPS for high-risk individuals, such as patients with long-term diseases, so that they could be insured without causing a sharp hike in premium to other policyholders. The same Survey also showed that 71% of respondents supported capping premium loadings for high-risk subscribers under the HPS. In Focus Group 3B, some participants with good health status considered that although the HPR arrangement was disadvantageous to them currently, they would benefit from the arrangement when they grew old or their health condition deteriorated. They also supported the idea because it served the societal value of helping the needy and disadvantaged people. On the other hand, a few participants voiced their unwillingness to indirectly subsidize people with higher health risks through the HRP arrangement. They considered it unreasonable for other people to share one's health risk.

Acceptance of Pre-Existing Conditions

4.53 Among the various proposals to enable access by high-risk individuals, the proposed acceptance of those with pre-existing medical conditions in health insurance plans under the HPS attracted the most contentions. On the one hand, many respondents supported the proposed feature of accepting pre-existing conditions, considering this could benefit those high-risk individuals and provide them with genuine choices for accessing health insurance. They also considered it equitable to allow access by those with pre-existing conditions, after a reasonable waiting period and affordable premium loading, as after all the purpose of health insurance should be to enable risk pooling for healthcare needs.

4.54 Some patients groups, while welcoming the proposal, cautioned that clear definition was required to determine high-risk individuals and pre-existing conditions. They expressed concerns that the proposed premium loading cap and the length of waiting period might create entry barrier for those most in need of health insurance protection. There were views that the waiting period could be relaxed to enable more high-risk individuals to benefit. Some expressed concerns that not all high-risk individuals could afford health insurance in view of the premium loading, and the exclusion of general specialist out-patient services from the basic coverage of HPS might not provide adequate protection to chronic disease patients.

4.55 On the other hand, a number of respondents considered that health insurance should take on only "prospective risks" and hence pre-existing conditions should be excluded. They considered that the inclusion of pre-existing conditions into the insurance pool, even with waiting period and premium loading, would be "unfair" to those individuals who subscribed to health insurance early when they were still healthy, as the latter would be required to "cross-subsidize" the "retrospective risks" of these unhealthy individuals, unless the risks and claims of these individuals were adequately "compensated" by public subsidies.

4.56 Some submissions pointed out the requirement of no exclusion of congenital conditions would be acceptable and understandable, but the non-exclusion of sexually transmitted disease would be contentious since most of the cases could be considered as self-inflicted. Some noticed that there was insufficient support for mental illness and psychiatric problem at present in the private sector and the requirement of no exclusion of mental illness might not be meaningful to those who require such services.

4.57 Survey 3A showed that 56% of respondents found feature of covering pre-existing conditions subject to waiting period and premium loading attractive/very attractive, while 15% of them considered this feature unattractive/very unattractive.

Premium Loading Cap

4.58 Another proposal aiming at enabling access to health insurance by high-risk individuals is to set a cap on the premium loading that insurers may charge a high-risk individual after underwriting. Most of the views received supported the proposal, though some respondents considered that the proposed cap at three times the published premium too high. Some patient groups considered that 200% premium loading would be unaffordable to most high-risk individuals especially those with chronic diseases or other pre-existing conditions, and would render access by these individuals to health insurance impractical. Some suggested that the premium cap should be lowered. Some commented that premium loading, once set on first subscribing to health insurance plans under the HPS, should not be increased subsequently on claims or renewals, or else the cap would be rendered meaningless.

4.59 On the other hand, some respondents noted that the premium loading if capped would imply that high-risk individuals would be accepted into health insurance plans under the HPS without their risk premium fully compensated. They considered that it would be "unfair" for the residual risk premium to be borne by other healthy individuals. Some also pointed out that it would make health insurance plans under HPS less attractive than current health insurance products in the market to healthy individuals. Some suggested that the risk premium of these high-risk individuals should be subsidized by the Government. Meanwhile, some expressed concerns that this might even encourage arbitrage between HPS plans and non-HPS plans, with healthy individuals concentrated in non-HPS plans, while less healthy individuals concentrated in HPS plans, thus undermining the viability of the HPS.

4.60 Meanwhile, the insurance industry pointed out that the capping of premium loading would require compensation for the excess risk absorbed into the insurance pools as a result. They were thus keen to see more details on the proposal of subsidization for high-risk individuals and assess how the excess risk would be adequately compensated. Some insurers noted that current health insurance products were mostly based on exclusion underwriting; accepting high-risk individuals and underwriting their risks with high premium loading were uncommon and unfamiliar to the industry. They were concerned about the ability of insurers to underwrite these high-risk individuals and accurately assess their premium loading. Some also expressed concerns that the proposed risk equalization mechanism, guaranteed renewal, premium adjustment control and portability requirement, might expose health insurance plans to systemic risks when individual insurers, inadvertently or deliberately, over- or under-assessed the excess risk and premium loading of high-risk individuals.

Risk Equalization/High-Risk Pool (HRP) Reinsurance Mechanism

4.61 In connection with the proposal to accept high-risk individuals into health insurance plans under the HPS, many respondents who commented on the topic recognized in principle the need for some form of mechanism for risk equalization under the HPS, so that those health insurance pools which have absorbed extra high risks would be "compensated" such that their viability would not be unduly undermined, and that insurers would not have the perverse incentives to find ways to circumvent the requirements for accepting high-risk individuals. Risk

equalization was also recognized as a way of dealing with the excess risk of high-risk individuals arising from both the acceptance of pre-existing conditions and application of premium loading cap, with or without public subsidies.

4.62 Many submissions welcomed the setting up of a HRP under the HPS as a tool to facilitate access of high-risk group to subscribe to HPS for healthcare protection, through enlarging the risk pools of individual health insurance plans to facilitate better management of risk under a reinsurance mechanism. Views expressed over the HRP reinsurance mechanism mainly touched on the operation and funding of the HRP, including questions on how individuals were included into the HRP, whether the HRP would cover only the Standard Plans or also the top-up components, whether the HRP would be operated by the insurance industry or the Government, how insurers were expected to fund the HRP, and whether and how the Government would fund the HRP. The insurance industry expressed the view that more details on the operation of the HRP as a reinsurance mechanism would need to be carefully worked out together with insurers.

4.63 Some respondents expressed concerns that the extent of risk pooling under the HPS might be limited given the voluntary nature of the HPS, and that the proposed HRP might not be sufficient to deal with the excess risk of high-risk individuals if the penetration rate of health insurance under the HPS was not high enough. Some even considered that the set up of the HRP would be tantamount to requiring the healthy to subsidize the high-risk individuals insured under the HPS. Some insurers further expressed the view that the acceptance of many high-risk individuals and their inclusion into the proposed HRP represented uninsurable risk to insurers, and thus required funding injection from outside the insurance pool, in the form of levy on health insurance or injection by the Government. Many expected that long-term financial commitment by the Government to the HPR would be required.

4.64 From a consumer perspective, the result of Survey 3A indicated that 53% of the respondents found the HRP reinsurance mechanism attractive/very attractive, while 17% of them considered it unattractive/very unattractive.

Need for Underwriting Guidelines

4.65 A number of submissions pointed out that current health insurance products in the market tended to favour healthy subscribers over risky individuals. While the HPS rules and requirements including guaranteed acceptance and renewal, acceptance of high-risk individuals, and premium loading cap aimed at allowing equitable access to health insurance by all, these measures would be effective only if underpinned by transparent and competitive underwriting among the insurers. In particular, there would be a need to ensure a degree of consistency in underwriting, re-underwriting assessment of premium loading, adjustment of premium, and inclusion in high-risk pool under the HPS, be it on first subscription, on renewal, or on change of plans or insurers; otherwise, the intended purpose of many HPS features in protecting consumers would be rendered ineffective.

4.66 Meanwhile, in connection with proposed HRP as an industry-wide reinsurance mechanism, some insurers suggested that underwriting guidelines would be required for all participating insurers so as to ensure a uniform minimum standard in underwriting. In particular, the process of assigning "fair" and yet competitive risk premium and loading to individuals effectively and efficiently would become very important in ensuring that the HPS

could function as intended. Underwriting would also be important in ensuring the viability of the proposed HRP. Some respondents also suggested having an audit process in place to monitor the risk selection process of insurers to avoid moral hazards and arbitrage against the HRP, as well as to guard against potential systemic risks to insurance pools and the HRP under the HPS resulting from unsound underwriting by individual insurers.

Risk of Arbitrage and Moral Hazards

4.67 Meanwhile, some submissions further pointed out the risk of arbitrage by individual insurers in the insurance industry, whereby they might tend to off-load risky or unhealthy individuals onto health insurance plans under the HPS, given the industry-wide HRP as reinsurance mechanism possibly subsidized by the Government, and cream the healthy individuals into non-HPS health insurance plans not subject to the HPS supervisory framework. These respondents considered that, while many of the features of health insurance plans under the HPS might offer better protection than non-HPS products, some of the HPS requirements, e.g. acceptance of high-risk individuals, might also undermine the relative attractiveness of HPS plans vis-à-vis non-HPS plans. They considered that more stringent or vigilant measures would be required to prevent against arbitrage, e.g. imposing an audit mechanism on all health insurance plans under HPS or otherwise, applying a levy on all health insurance plans offered by insurers, or even requiring all health insurers to participate in the HPS and offer HPS plans.

4.68 Some respondents were concerned that the acceptance of high-risk individuals under the HPS and in particular the setting up of the HRP might induce greater moral hazards, where high-risk individuals might self-select for health insurance plans under the HPS, insurers might have less motivation to ensure judicious utilization by high-risk patients or curb potential abuses, and patients or their service providers might be tempted to over-utilize medical service. They suggested that the Government should consider installing a mechanism (e.g. incentive) to attract and retain enough new joiners to ensure the sustainability of the high-risk pool. Some respondents expressed the view that a mandatory scheme would be more effective in spreading out risks and reduce fluctuations in premium rates, and would obviate the need for periodic injection of tax payers' money into the HRP.

Portability

4.69 Members of the public generally welcomed the proposed feature of portability of health insurance plans under the HPS, i.e. a member of a health insurance plan under the HPS may, as a general principle, change plans and/or insurers without loss of coverage in general. This would also mean that in general an employee may continue subscription of the plan originally provided by his/her employer after switching jobs or on retirement. The public welcomed the proposed portability of Standard Plans under the HPS and considered this feature would offer HPS Standard Plans a competitive edge over existing health insurance products. Many submissions also considered portability in health insurance an important measure to safeguard consumer interests, and could enhance healthy competition among health insurers, which could enhance consumer's confidence and choice in the HPS.

4.70 Survey 1 showed that the vast majority of respondents (86%) considered that the plans under HPS should allow policyholders to switch among insurers and their coverage and benefits, including their pre-existing conditions and no-claim discounts could be continued after changing

jobs and retirement without undergoing re-underwriting. From a consumer perspective, Survey 3A reflected that 61% of the survey respondents found the portability feature attractive/very attractive, with only 15% of them considered otherwise.

4.71 A number of submissions, while supporting portability in principle, highlighted various operational issues and raised a number of technical difficulties on how portability could be done in practice. These include: whether portability applies only to HPS Standard Plans or extends also to top-up benefits or add-on components; how portability could be allowed between plans with different benefit coverage and levels offered by different insurers; how to make it portable between group insurance plans provided by different employers for an employee on switching jobs; whether and to what extent re-underwriting is allowed on change of insurers or plans; and how premium loading, both for those in the HRP or otherwise, should be treated on change of insurers or plans.

4.72 Some submission specifically pointed out that, when crafting the detailed rules, consideration should be given to how transfer between insurers could work smoothly under a regime where underwriting should normally take place once at the point of entry. Some respondents expressed concerns that portability might be rendered meaningless, if in practice it would be difficult for an individual who purchased a standard plan with top-up components to transfer his/her plan to other insurers who might not offer the same top-up components. Some insurers pointed out that switching of employees' health insurance between employers was a complicated issue and said that the Government should provide clear guidance on how such switching should be handled to avoid disputes. Some insurers were also concerned that full portability if taken to the extreme would allow high-risk individuals to freely change between insurers which would make it difficult to manage.

4.73 The insurance industry was generally agreeable to the principle of ensuring portability of health insurance plans under the HPS. However, they considered that further details would need to be worked out to ensure that the portability arrangements would be feasible. Many submissions especially those from the insurance industry expressed the view that details of the portability arrangements under the HPS should be carefully designed together with the insurers to minimize complications and ensure practicability.

Migration

4.74 Many employers welcomed the proposed migration features of the HPS, i.e. requiring insurers to offer an option for them to migrate their existing health insurance policies into health insurance plans under the HPS. They would like to know more about the details of the HPS, including the benefit coverage and level, incentive and migration arrangements, especially operational details on migration of health insurance plans (including their overseas staff, those resigned and retired staff members), as well as the administration procedures and costing involved. They would also like to know more about the interface between their existing medical benefit plans which emphasized on provision of out-patient benefit and the in-patient-oriented Standard Plan proposed under the HPS, and whether and how migration of their existing plans could be done without loss of benefits to employees.

4.75 In this connection, a number of employers expressed their concerns about the increasing cost for providing medical benefit to employees in view of rising medical costs. To facilitate their making a decision on whether or not to migrate to HPS plans, some of them would like to know in

what ways the proposed scheme could enhance cost control by improving transparency and competition on service standards and price in private health insurance and healthcare service markets. Some of them expressed concerns that, if their existing insurers would not be participating in the HPS, how they would be able to migrate their existing medical benefit plans to the HPS. Some also expressed concerns about some of the features of the HPS, e.g. the proposed High-Risk Pool and co-payment requirements, which might not sit well with their current medical benefit plans.

4.76 A considerable number of submissions from individual respondents were concerned about the complexity to achieve effective and seamless migration of various types of existing individual-based health insurance policies with different terms and coverage into the HPS. Some of them would like to know more details about the interface between their current insurance policies and health insurance plans to be offered by insurers under the HPS. Some submissions from employees expressed concerns on whether the benefit level and coverage of their current group insurance provided by employers might be affected when their employers chose to migrate to the HPS.

4.77 Similar to employers, some individual respondents were concerned about the lack of an option to migrate if their current insurers would not be participating in the HPS or would not have HPS insurance plans that could match their existing insurance. Some of them suggested that the Government should explore requiring all insurers who offer health insurance to participate in the HPS and offer HPS Plans that matches their existing product offerings, apart from HPS Standard Plans (or HPS core requirement and component). They considered this general requirement could better safeguard consumer interests and avoid possible 'cream-skimming' by insurers. Meanwhile, a few submissions cautioned that the HPS might limit the diversity of health insurance products in the market and suggested that its impact on the current market should be carefully assessed.

4.78 The insurance sector was in general agreeable to facilitating the migration of the existing health insurance policies to the HPS. However, some expressed doubts on the stability of the existing portfolio after migration and suggested that a risk selection process should be put in place to ensure that the pricing would be commensurate with the transferred risk. Many of them shared the view that the migration process should be carefully designed and managed to facilitate seamless bridging between the current policies and the plans under HPS for both group-policy and individual-policy holders.

Savings

Need for Savings

4.79 Not many submissions expressed views on the saving features of the HPS, but the views received were divergent. Some considered it desirable to have savings incorporated into the HPS to make insurance a more long-term and sustainable device for accessing private healthcare services. Others considered that savings required long term commitment from subscribers and its restricted use as laid out in the proposal might not be a welcomed feature. Among those who supported the incorporation of a savings element under the HPS, some believed that savings was an essential component to facilitate subscribers to stay insured at older age. They recognized that people with financial means should prepare for their own future healthcare needs in order to have a better life after retirement. In Survey 1, 58% of the respondents supported the Government to

require subscribers who had received incentives under the HPS to save for paying future premium.

4.80 A number of respondents considered that it would be too early to discuss the savings options since the key features of the HPS were not yet settled. They also had reservations on proposals for a subsidized savings feature and savings scheme which limited its usage after retirement to healthcare services only. Some expressed the view that whether savings should be considered as a requirement for health insurance plans under the HPS would depend on whether the Government would have a long-term commitment to providing public subsidies for savings under the HPS. A certain number of respondents were opposed to having a savings component under the scheme, citing their experience of savings under the Mandatory Provident Fund (MPF) which they alleged as not providing sufficient return but charging high administration costs. They also doubted whether the savings so accrued would be enough to finance medical needs after retirement.

4.81 On the other hand, a considerable number of submissions expressed reservations on incorporating a savings component into the HPS. Some of them did not consider it necessary to provide incentives via government contribution to the savings component, while others were concerned about the financial commitment on providing public subsidy to encourage savings which they believed the amount would be quite substantial and would be a long-term commitment on the part of the Government in terms of public finance. They suggested that the Government should concentrate resources on providing subsidy to the high-risk groups or offering direct premium discount to subscribers at the initial stage to encourage participation. Some respondents were supportive of the concept of voluntary savings for future healthcare needs, but considered that savings feature should not be incorporated as an integral part of the HPS standard package.

4.82 The insurance industry expressed general reservations about incorporating a savings component as a requirement for all health insurance plans under the HPS. They considered that the savings components might not be welcomed by consumers and would make HPS health insurance plans less attractive than existing health insurance products. They were also concerned about the administrative complexity of incorporating a savings component into health insurance plans and allowing migration of existing insurance policy holders to such plans. A few individual insurers expressed positive views about incorporating savings into HPS but considered that it would be administratively difficult for insurers to manage savings accounts and arrange premium rebate under a setting of full portability.

Options for Savings

4.83 Among those respondents who were positive to incorporating a savings component under the HPS, they expressed different views towards the three proposed options for savings put forth in the consultation.

4.84 The option of in-policy savings to pay future premium generally received lesser support among the three options. Some commented that it was inflexible as the savings could only be used for paying future premium. Some respondents also considered that a required savings for health insurance policies under the HPS would make them less attractive than non-HPS health insurance products, and would thus be feasible only in the context of a mandatory insurance scheme. The insurance industry pointed out that the inclusion of savings component might not be possible for those policies underwritten by general insurers due to the current regulatory

restrictions under the Insurance Companies Ordinance.

4.85 The option of saving to a medical savings account that could be used for healthcare purpose was acceptable to respondents who considered that it could give the insured some freedom in the use of savings and it would be relatively more attractive to younger customers. A few respondents were interested to know how flexible the savings could be used in funding the account-owner's medical expenses. Some suggested that the Government should encourage individuals to save for future insurance premiums through providing financial incentives. Some suggested the MPF system could be leveraged upon (the voluntary contribution option available under the MPF regime) for simplicity in administration if savings were to be considered under the HPS, and financial incentives, if any, could be injected into individual MPF accounts for future premium payment. However, some respondents asked if they could get back the savings if they withdrew from HPS after 65.

4.86 Most people preferred the option of offering loyalty incentive proportional to the length of individual subscribers staying insured under the HPS as an alternative to directly incorporating a savings component in health insurance plans under the HPS. Those who preferred to save on their own and with incentives for payment of premium from age 65 considered this option provided maximum flexibility to the insured. However, some believed the success of this option would depend on the incentives offered. They suggested that this option would be more attractive if policyholders could be allowed to use savings to pay for any medical expenses or to handle Government's rebate at their own discretion.

Financial Incentives

Provision of Public Subsidies

4.87 The question of whether and how public subsidy should be provided to support the implementation of the HPS, making use of the $50 billion earmarked in the fiscal reserve in support of healthcare reform or otherwise, had attracted considerable discussions among the various proposed HPS features. As stated in paragraph 3.21(d), rather divergent views were expressed on the issue of whether public subsidies should be provided for those subscribing to private health insurance and using private healthcare services, and on the use of the earmarked $50 billion for healthcare-related purpose in general. Some supported providing subsidies under the HPS to incentivize participation, some suggested other forms of financial incentives, others questioned the principle of providing any public subsidies at all.

4.88 For those in support of providing financial incentives, many considered that subscribers to health insurance should be provided with some form of public subsidies so as to encourage more of those who could afford it to take out health insurance and accordingly to make use of private services as an alternative to public services. Some also pointed out that many individuals, especially those from middle-income families, were in effect subject to "double-taxation" whereby they pay for public healthcare through tax and at the same time pay for their own private healthcare through health insurance or out-of-pocket. They considered that for those individuals subscribing to private health insurance and using private healthcare services over public healthcare, it would be equitable to provide them with a fair share of public subsidies for their healthcare.

4.89 On the other hand, a considerable number of submissions raised objection to the Government providing incentives for those who could afford it to take out private health insurance. Some respondents considered that while people supported voluntary private health insurance, it did not mean that they would support the use of public money to subsidize private health insurance. Some opposed the use of public fund to subsidize individuals to subscribe to health insurance for using private healthcare as they believed that it was not in line with the principle of effective use of public resources. They considered that it would not be cost-effective to use public money to subsidize people from taking out HPS plans as the insured might still choose public services and as a result it could not reduce the burden of the public sector. Some argued that the HPS would likely benefit those who could afford to have better healthcare choices and protection, and thus providing public subsidies for them using taxpayers' money would go against the principle of promoting greater equity in access to healthcare. Some also expressed reservations on using public money to subsidize the uptake of private insurance, for fear that any such subsidies might benefit more the private insurers and healthcare providers than the insured themselves.

4.90 Some respondents were concerned that providing public subsidies for private health insurance and private healthcare might aggravate the inflation of medical fees for private healthcare services, if there is inadequate capacity and competition in the private health insurance and private healthcare services markets. Some were also concerned that providing subsidies might aggravate moral hazards of private health insurance and private healthcare services, and would in turn adversely affect those subscribing them and using them.

Offering Incentives for HPS

4.91 Among the views supporting provision of financial incentives under HPS, some considered that financial incentives should be provided to better enable the scheme to get off the ground and to achieve its stated objectives (including protecting consumers, promoting transparency and competition, and relieving pressure on public system). Some views considered that financial incentives provided under the HPS needed not necessarily be permanent. There were also suggestions for providing incentives to encourage family-based participation to cover members of all ages in a family including children and elderly family members. Different views were received towards the three specific forms of financial incentives under HPS proposed in the consultation (See paragraphs 4.96-4.104 below).

4.92 Some supported providing public subsidy targeting specific groups (the high-risk, elderly or young age) to assist them in getting health insurance coverage, as opposed to providing general public subsidies for all subscribing to private health insurance and using private healthcare services. Some agreed that the proposed financial incentives could encourage more people to join the HPS, yet they suggested higher priority should be given to relieving the financial burden of those who needed healthcare the most in order to enable them to have affordable access to the HPS, rather than to enhance the attractiveness of the scheme for the young and the healthy.

4.93 However, some respondents who supported provision of financial incentives under the HPS considered that the amount of subsidy proposed insufficient and unappealing to the general public. They suggested increasing the amount of subsidy and providing the subsidy on a long-term sustainable basis, or offering tax concession as an alternative form of subsidy.

4.94 The results from Survey 1 indicated that many respondents were in general supportive of Government's proposal to provide incentives to HPS subscribers. Some 84% of the respondents agreed that subsidy should be provided to the elderly to join the HPS and the government incentives should be proportional to the length of the period which the individual stayed insured under the scheme. At the same time, 70% of the respondents supported the Government in offering incentives to new joiners of the scheme in the initial years of implementation.

4.95 The discussion in Focus Group 3B revealed that if financial incentives were provided, participants who were positive towards the HPS generally showed even greater interest while some of those who refused or hesitated to consider joining stated they were willing to re-consider. This was consistent with the results in Survey 3A where 70% of the surveyed respondents who did not find the illustrative premium levels attractive were willing to join the HPS if the incentives offered were attractive.

Protection for the High-Risk Groups

4.96 Survey 1 reflected that 75% of the respondents supported the Government to subsidize high-risk subscribers in order to facilitate their access to health insurance hitherto debarred, and to minimize the potential premium increase arising from their participation. Many submissions considered public support for the high-risk groups necessary and justified, with a view to enhancing the accessibility of high risk groups to standardized and regulated health insurance under HPS. For those who supported injection to be provided to enable high-risk groups to access to HPS, a number of submissions considered that Government injection would be necessary to enable the high-risk individuals to get insured.

4.97 Some submissions suggested that the Government could consider using the $50 billion to subsidize chronic disease patients for long-term treatment under the HPS. Others suggested providing financial support and incentives to attract the elderly to take up private health insurance and allowing more flexibility in waiting time and reimbursement ratios for subscribers with pre-existing conditions. Some respondents, on the other hand, expressed concern on injection of public money to support the HRP reinsurance mechanism as it would be difficult to regulate and prevent insurance industry from abusing the fund. A few submissions had reservations on subsidizing high-risk groups to use private healthcare and suggested that high-risk individuals should be protected by public healthcare sector direct.

No-Claim Discount (NCD)

4.98 Survey 1 reflected that 76% of the respondents supported that all the participating insurers should offer NCD to subscribers of the HPS. In Survey 3A, 39% of the respondents found the proposed measure of providing 30% NCD upfront for those joining the HPS within the first year of launch attractive/very attractive, 38% of them were neutral/indifferent, while 22% considered this unattractive/very unattractive. For those who supported the provision of NCD, some considered that no-claim discount could attract more low-risk individuals and young people to join the HPS. Some suggested offering a progressive increase of NCD in each consecutive year to encourage subscribers to maintain a healthy lifestyle.

4.99 There were also submissions against providing financial incentives for the proposed NCD, and questioned whether it was necessary and appropriate to put in place NCD under the

HPS as some might avoid early treatment or fall back on the public system in order to preserve their NCD. Some believed that there had been an increasing number of people subscribing to private insurance and there would be no need to offer NCD to new subscribers. A considerable number of submissions expressed doubt on the attractiveness of NCD to the young and healthy as many private health insurance policies in the market had already been offering similar discount. Some also questioned whether the discount would be a short term incentives only.

4.100 A number of insurers were concerned that participating insurers would have less flexibility in offering innovative incentives to attract subscribers if the NCD schedule was mandated for all health insurance plans under the HPS. Instead they suggested that the Government should offer a 30% "welcome discount" to new entrants directly, while insurers would individually design and offer NCD based on claims history and applicable premium schedule. Some further suggested that any welcome discounts or no-claim bonuses should not be portable.

4.101 For group medical insurance markets, the insurance sector pointed out that the current pricing for group policies had already factored in historical claims pattern and thus it would be superfluous to require the offer of NCD. They also pointed out that the calculation of NCD in group policy would be complicated when only a few staff members under a group policy made minor medical claims. In order to mitigate the risk, some employers might opt for terminating the group policies and subsidizing individual employees to take out individual policy instead. This would take away the advantage of group discount in premium for the covered members and would benefit insurers only.

Premium Rebate for Long-Time Subscribers

4.102 In order to encourage subscribers to stay insured when they grew old, many respondents welcomed the proposed option of providing financial incentive in the form of premium rebate after age 65. That rebate would reward individuals who start their health insurance subscription early, reward subscribers for staying insured for the long-term, and also lower the premium to be paid at older age. Some even suggested offering rebate of a certain percentage of the premium to those individuals aged of 65 or above who had no claims from the scheme. On incentivising long-time subscribers of HPS, Survey 1 founded that 67% of the respondents supported the Government to assist people who have taken out private healthcare insurance so that they could continue to pay the premium and choose to use private services in their old age in order to lessen the burden on public healthcare system.

4.103 A number of submissions which supported providing premium rebate for long-time subscribers raised questions on how the rebate would be implemented in practice. These included: how the premium rebate rate would be determined, whether by entry age, length of subscription, and/or age of providing rebate; whether the premium rebate would cover top-up benefits or add-on components over and above the HPS Standard Plan; whether premium rebate rate would vary according to type and/or premium of HPS Plans subscribed; whether short-term breaks in subscription, say in between jobs or during temporary unemployment, would be allowed; and whether the premium rebate would be reduced if the insured made claims. Some also questioned whether the premium rebate should be recouped, or higher service fees should be charged, if the insured choose to revert to public healthcare services instead, so as to avoid double-dipping.

4.104 However, some considered that the rebate would be attractive only to those employers currently offering health insurance to their employees and those who had taken out health insurance policies already, but not to the uninsured. A number of submissions pointed out that premium rebate would create significant and continuous financial commitment on the part of the Government. Some of them went further to question whether the provision of long-term premium rebate would be sustainable. Some considered that the Government should commit to provide further funding as and when needed.

Direct Premium Subsidies

4.105 A number of submissions suggested offering direct subsidies for premium of health insurance plans under the HPS, instead of offering other forms of financial incentives. They considered that direct premium subsidies would be more effective in attracting participation. There were many different views expressed on how premium subsidies could be offered, including proposals targeting different age/population groups. Some suggested offering premium discount to boost up subscription at the initial implementation stage. Some supported the provision of initial promotional discount instead of NCD, as the latter might encourage subscribers to forego necessary hospitalization or choose the public sector for healthcare services.

4.106 Some suggested providing premium subsidies targeting the younger age groups, in order to attract the young and healthy into the insurance pools under the HPS to make them more viable and sustainable. Some submissions suggested that financial incentives should be provided to encourage children to enrol in the HPS, and to encourage subscription on a family basis. Some suggested providing premium subsidies specifically for the older age groups, given that the age-banded premium is much higher for them, and these groups would probably need assistance the most in getting and staying insured at a time when they would be most in need of the protection of health insurance. Some suggested providing direct premium subsidies for high-risk individuals such as chronic disease patients who need to pay higher premium, instead of providing indirect financial incentives through the HRP, as the former would directly benefit the patients and allow them more choices. There were also suggestions that direct premium subsidies should be provided to assist the lower income and under-privileged groups to enrol in health insurance plans under the HPS, as these groups could not easily afford the premium of private health insurance. Some considered that in allocating financial incentives, priority should be accorded to the disadvantaged and low-income groups according to needs.

4.107 A number of submissions suggested that premium subsidies needed not be permanent in nature, and the $50 billion fiscal reserve could be used as seed money to generate return for providing premium subsidies on a self-sustaining basis or extend the period of providing premium subsidies. There were other different views on the design of premium subsidies and the target groups of such subsidies. Some advocated further discussion on the design of the incentive with regard to the objectives of HPS.

4.108 Some submissions, on the other hand, question the usefulness and effectiveness of offering premium subsidies for subscribers, noting that premium subsidies might not necessarily lead to higher take-up rate in voluntary health insurance scheme. Some expressed concerns on the likelihood of direct premium subsidies inducing moral hazards on the part of individual subscribers and insurance practitioners in the subscription of private health insurance, and in turn private healthcare providers in the provision of private healthcare services to the insured.

Other Financial Incentives

4.109 A number of submissions offered suggestions for other forms of financial incentives under the HPS or more generally for private health insurance and private healthcare services. Some suggested providing incentives to induce HPS subscribers to seek preventive care at the primary care level and to reward them for staying healthy (e.g. keeping blood pressure and blood sugar level in check) and maintaining a healthy lifestyle (e.g. quit smoking and regularly exercise). Some specifically suggested offering subsidy to those HPS subscribers who underwent regular body check-up. They believed such measure would not only attract more people to join the scheme but could also promote preventive care in the community.

4.110 Some went further to suggest that incentives should be provided to subsidize direct for healthcare services through public-private-partnership, with a view to achieving better outcomes and promoting value-for-money healthcare services. Some respondents considered that direct subsidies for healthcare services, if appropriately administered with stringent control over cost and quality, might be more effective in achieving the objectives of relieving pressure on public system than through subsidizing health insurance plans under the HPS. Some also considered that targeted subsidization or purchase of private healthcare services (e.g. cataract surgeries), with the aim of relieving long queues and waiting time in public hospitals, would also be more effective in delivering healthcare to the population.

4.111 A number of respondents considered that providing tax incentives would be effective in encouraging more people to purchase health insurance policy. They were of the view that tax incentives would help attracting tax-paying individuals who otherwise might not consider insuring themselves, and encouraging those who have been insuring themselves to continue doing so. They thus proposed to offer tax deduction for those who subscribe to health insurance plans under the HPS. Some went further to suggest that tax deduction should be offered to anyone who subscribe to private health insurance including those currently offered in the market.

4.112 Some suggested providing tax rebate to families to join the scheme as a whole unit, i.e. parents and children, and especially with grand-parents together. They believed this would promote the coverage of the elderly members in a family who usually had greater demand for secondary or institutional care. Others suggested extending tax exemption to companies in order to encourage employers to take out HPS Plans for their employees.

Other Views on Financial Incentives and Use of $50 Billion

4.113 Apart from views on the provision of financial incentives (under the HPS or otherwise) making use of the $50 billion earmarked from the fiscal reserve to support healthcare reform, there were a number of submissions which held a very strong view that a more effective and efficient use of the $50 billion would be using it on public healthcare system, rather than supporting the uptake of private health insurance. Some suggested that the $50 billion should be used to set up a reserve fund for the public healthcare system to meet the future healthcare needs of the entire population in view of our ageing population. Some further suggested investing the $50 billion to further improve the existing public services immediately, especially strengthening the public healthcare safety net, improvement of drug formulary in public hospitals, extending PPP projects as well as enhancing primary care services for the benefit of those in need.

4.114 Instead of incentivising people to subscribe to the HPS, some submissions suggested

that the $50 billion reserve should be used to enhance primary and chronic disease care or improve public healthcare services. There were also suggestions for the Government to make use of the $50 billion to set up an ageing population fund, as seed money to meet part of the long-term financing needs for healthcare services as well as other community care services necessary in support of Hong Kong's ageing population. There were also discussions over provision of subsidies to different population groups and targeted groups for healthcare services that are in line with the objectives of HPS.

Chapter 5 PUBLIC VIEWS ON HEALTHCARE SUPPORTING INFRASTRUCTURE

Overview

5.1 Healthcare manpower, service capacity and supporting infrastructure of the healthcare system were issues predominant in the discussion in connection with the proposed HPS during the public consultation. There was broad recognition that ensuring adequate supply of healthcare manpower with high professional standard, expanding capacity of the healthcare system to provide quality healthcare services, and having in place the necessary infrastructure to support the delivery of healthcare services and implementation of the HPS would be essential to the success of overall healthcare reform including the HPS. There was overwhelming support for the Government to take proactive steps to address these issues.

5.2 Most submissions considered healthcare manpower planning and professional development was the most important issue in taking forward healthcare reform, and that the objectives of the HPS could only be realized if the issue of manpower was addressed fully. Without adequate healthcare manpower and service capacity, many expressed concerns that the implementation of HPS could further strain the healthcare system and aggravate medical inflation. A number of submissions suggested conducting a comprehensive review of healthcare manpower planning and professional development to devise a long-term strategy that could support and sustain the reform of the healthcare system long into the future.

5.3 Recognizing the value of the HPS in enhancing consumer protection, market competition and transparency in private health insurance and healthcare services, many submissions pointed to the need for a rigorous supervisory framework for the HPS to ensure that it could achieve its stated objectives and the various features could be delivered as intended. Many submissions urged the Government to further develop a robust legislative framework and institutional structure for the governance and supervision of the HPS, including administering the specifications and requirements for health insurance plans under the HPS as well as monitoring the achievements of the HPS objectives and deliverables.

5.4 Apart from supervision, there were also views that the Government could play a more active role in facilitating supply of quality-assured and value-for-money health insurance and healthcare services in the market, e.g. providing infrastructure and taking measures to support the provision of health insurance and healthcare services in support of the HPS, especially in promoting DRG-based packaged service and charging. Some went further to suggest that the Government should consider involving itself in the provision of health insurance and healthcare services under the HPS in order to provide a competitive benchmark for the private sectors.

Healthcare Manpower Planning and Professional Development

5.5 Most submissions considered that the success of the healthcare reform as a whole and the HPS in particular would depend tremendously on the availability and quality of healthcare professionals in Hong Kong. They emphasized that having a steady and adequate supply of healthcare manpower of high professional standard was instrumental to the sustainable development of the overall healthcare system. Without a sustained supply of quality healthcare professionals, the public support for healthcare reform and in turn the HPS could wane.

5.6 Many respondents expressed concerns that rising demand for private healthcare services, including those from non-local residents, would lead to escalating charges if there was no corresponding increase in healthcare manpower and service capacity in the private market. Some submissions considered that the sharp increase in private healthcare expenditure in recent years already showed that there was a shortage of healthcare manpower and service capacity in the private sectors, and the implementation of the HPS could aggravate the situation without fundamentally addressing the issue of manpower supply.

5.7 At the same time, some submissions expressed concerns that the continued demand for healthcare services and in turn manpower in the private sector could lead to "brain-drain" from the public sector, especially specialists and nurses, thus further straining the public healthcare system and affecting the level and quality of public healthcare services. They feared that in the circumstances, the manpower level and quality of the public healthcare system would decline and waiting time for public healthcare services would lengthen despite the Government's commitment to increase public health expenditure.

5.8 Some respondents noted that the public sector had served the important role of training local healthcare professionals for the whole healthcare system, and thus a flow of manpower from the public to private sector was not necessarily unhealthy. However, excessive flow of public sector manpower to the private sector could lead to dilution of experience in the public sector and in turn affect training of younger professionals, which could not be replenished simply by training more new healthcare professionals.

5.9 To support healthcare reform including the implementation of the HPS, a number of submissions pointed out the urgency for the Government to review the healthcare manpower of the healthcare system in Hong Kong as a whole covering both the public and private sectors. A number of submissions, including those from professional bodies and medical sector, suggested the Government to conduct a comprehensive manpower survey and planning to determine the manpower requirement and the relevant training needs, and consider ways to increase the supply of healthcare professionals while upholding professional standard and quality. Some submissions also pointed to the need to enhance the professional development for various healthcare professions, with a view to strengthening the regulation of service quality and professionalism, and upholding the high professional standards of Hong Kong's healthcare professions renowned in the region. Suggestions made in this regard included further increasing local training of healthcare manpower, enhancing the professional development of the various healthcare professions, widening the source of manpower supply subject to meeting the same high quality and professional standards, and strengthening the regulatory framework of various healthcare professions.

Training of Healthcare Manpower

5.10 Among the submissions, there was an overwhelming call for the Government to take steps to ensure the supply and quality of manpower in various healthcare professions, particularly doctors and nurses, for the whole healthcare sector. While noting the increasing student intake for healthcare professional training in local tertiary institutions (e.g. medical students at the two medical schools had been increased to 320 per year from the 2009/10 academic year onwards) and welcoming the Government's close monitoring of the local manpower situation, many respondents urged the Government to take more proactive measures to ensure a steady and adequate supply of healthcare manpower, and at the same time maintaining the high professional standard of the

healthcare professions, both near- and long-term.

5.11 As reflected in Survey 1, 91% and 92% of respondents supported the Government to increase the manpower of doctors and nurses respectively for the implementation of the HPS. Survey 2A found that 53% of the responding medical professionals supported the Government to increase local doctor training quota as a means to increase medical manpower in Hong Kong. Focus Group 2B on medical professionals showed that it was a consensus among the participants that adequate long-term manpower supply was fundamental to the healthy development of the healthcare system in Hong Kong, including both the public and private sectors. In general, the strengthening of manpower training and professional development was considered a key to a stable supply of quality healthcare manpower professionals so as to meet the healthcare needs of the ageing population.

5.12 Meanwhile, some submissions from the medical profession suggested that doctors in the private sector could be made more productive to absorb the increase in demands if more beds were available in private hospitals. Some submissions considered that the apparent manpower shortage had more to do with mismatch in training and skills among specialties, and imbalances between public and private sector in working conditions and remuneration. Different views were also expressed in Focus Group 2B on specific issues over manpower supply: most participants from the public healthcare sector agreed that there was a need to further increase the training of doctors to meet the increasing healthcare demand of the community; while most participants from private medical sector did not consider that the implementation of HPS would lead to shortage of private doctor services as market supply was adequate and flexible. Some participants pointed out that increasing medical student training quota alone could not solve the manpower problem completely and immediately.

Widening Sources of Healthcare Manpower

5.13 Apart from increasing local training of healthcare manpower, many submissions also pointed to other ways of widening sources of healthcare manpower to serve local needs. Some respondents noted that since reunification Hong Kong's medical sector had deprived itself from a traditional source of doctor supply from British Commonwealth countries. Some submissions pointed out that few doctors trained outside Hong Kong had been able to pass the examinations for registration with the local medical profession since reunification, including many students of Hong Kong trained abroad in internationally renowned medical schools. Some employer groups and professional bodies considered that the current medical sector was tantamount to a "closed shop", and believed that both the local community and the healthcare industry would benefit from "opening up" by recruiting qualified overseas doctors with sufficient safeguards on quality assurance and professional standards. They considered this source could be an immediate means to relieve the shortage of healthcare professionals.

5.14 The support for wider sources of healthcare manpower was reflected in public opinion survey: Survey 1 indicated that 73% of the respondent supported the Government to allow overseas specialists, after passing the local accreditation requirements to practise in Hong Kong to relieve the shortage of healthcare professionals; 68% of them agreed that those Hong Kong residents who had acquired overseas specialist qualification and passed the local accreditation requirements should be allowed to practise in Hong Kong; more specifically, 66% and 52% of the respondents agreed to allow specialists from places other than Mainland China and specialists from Mainland China respectively to practise in Hong Kong after passing the local accreditation

requirements.

5.15 By comparison, the medical profession was more cautious about intake of non-local doctors to address the manpower issue, noting that there would be concerns about the professional standards of these non-local doctors, and that drastically increasing supply of and competition among doctors might adversely affect the professional conduct and autonomy of medical practitioners. In Survey 2A, 48% of the responding medical professionals agreed to attract qualified specialists who were Hong Kong residents but trained abroad to practise in Hong Kong, and 33% agreed to attract qualified specialists trained outside Hong Kong (except Mainland China) to practise in Hong Kong while only 13% agreed to attract qualified specialists trained in Mainland China to practise in Hong Kong. There was also a view that the local medical profession as a whole was not short in numbers, but rather short of skills in individual specialities. Some respondents from the private medical sector considered this the result of a failure in healthcare manpower planning, which hitherto had been conducted solely by the public healthcare sector.

5.16 Focus Group 2B among medical professionals also reflected that participants had mixed views on the intake of non-local doctors to practise in Hong Kong. Some participants, especially those from the public sector, thought that this would be useful to address manpower shortage provided that the qualification of the doctors admitted was up to standard. They also thought that the intake programme could be tailored to fit the needs and shortages in different specialty fields. On the other hand, some participants, especially those from the private sector, had great reservation for the reason that it would be difficult to ensure that the professional standard of the non-local doctors was on par with local doctors. However, participants generally agreed on the need for a comprehensive and objective assessment of the future healthcare manpower need, with the assessment taking a global view and not being confined to considerations surrounding the HPS only.

5.17 Meanwhile, there were also suggestions for adopting measures that could make better use of the existing manpower in both the public and private medical sectors, taking advantage of some degree of flexibility in the service throughout of the existing doctor workforce. Some respondents suggested, for instance, allowing private doctors to work on a part-time basis in public hospitals, and allowing public doctors to take private patients on a limited basis. Some considered that this would help mitigate the dilution of experience in the public healthcare sector especially in training younger professionals, and prevent the exodus of experienced public doctors to the private sector.

Healthcare Professional Development

5.18 Many submissions recognized the high standard of professionalism and dedication of our healthcare workforce, which was considered an edge of Hong Kong's healthcare system and industry. Many submissions supported that measures should be taken in order to ensure the high professional standards of our healthcare professions could be maintained, as steps were being taken to increase manpower and expand capacity of our healthcare system. Some of the submissions went further to suggest that the Government should, by way of conducting a comprehensive healthcare manpower review, examine the working conditions, remuneration, manpower supply, training, development and regulation etc., of the various healthcare professions, with a view to meeting their training and development needs, as well as promoting quality and professionalism. Some submissions were of the view that quality assurance of healthcare

services should be further strengthened to better safeguard consumers' interests, in particular over the use of private healthcare services under HPS.

5.19 While noting the high standards of professionalism of our healthcare manpower, a number of submissions suggested that it would be beneficial to examine the current mechanisms in Hong Kong for setting and upholding professional standards in different professions, as compared with measures adopted for healthcare professions in other advanced economies, and consider various tools to further strengthen professional standard of healthcare services they provide. These would include, for example, the existing arrangements of Continuous Medical Education (CME) and Continuous Professional Development (CPD), and the application of peer review, clinical audits, standard setting, quality assurance or other mechanisms that would help upkeep the professional standard of our healthcare manpower with international standard and development.

5.20 Survey 2A on medical professionals showed that 73% of respondents supported the Government to strengthen monitoring of the private healthcare sector by improving collection, collation and dissemination of statistics and data associated with patient care and outcomes. Meanwhile, Focus Group 2B on medical professionals found that participants were cautious on the effectiveness of certain novel ideas to enhance quality assurance in the private healthcare market. Taking medical services as an example, some participants questioned the effectiveness of a proposal to introduce indicators for quality assurance, and cautioned against the potential downside risks. Some participants opined that it would be more effective to enhance patient education so that patients could make informed choice which in effect helped keeping the quality of care in check.

Healthcare Professional Regulatory Framework

5.21 To enhance professional development and upkeep professional standard in healthcare sector, a number of submissions from the community suggested that a comprehensive review of healthcare manpower should also cover the regulatory framework for the healthcare professions, including the functions and compositions of the existing statutory regulatory bodies for healthcare professionals (such as doctor and nurse) that were required to register to practice by law, as well as the appropriate regulatory structure for healthcare professionals (such as dieticians and audiologists) currently not subject to professional registration by law in Hong Kong. Some of them suggested that the review could serve as an opportunity to facilitate the review of the existing regulatory structure for healthcare professions with reference to our evolving healthcare system.

5.22 Recognizing professional autonomy of the medical profession, some respondents in the community considered that a review of its existing regulatory regime would be necessary to suit the changing environment and bring it up-to-date with international development. Some respondents considered that a modern professional regulatory regime would need to be more responsive to the community's expectations for accountability on quality and professionalism. This in turn could better inspire confidence in the professional standard of the profession and safeguard the interests of the community as a whole, contributing to the professional standing and development of the medical sector as it would continue to expand and evolve as an important part of the healthcare system.

5.23 Meanwhile, Focus Group 2B found that participating medical professionals generally

opined that the existing quality assurance framework encompassing the regulatory and professional accreditation requirements implemented by the Medical Council of Hong Kong and the Hong Kong Academy of Medicine was adequate. Some submissions from medical sector expressed that they did not see the need to create any new supervisory body for healthcare services. When asked about the more specific possible proposals in refining the existing supervisory regime, 33% of the responding medical professionals in Survey 2A agreed that the Government should enhance lay representation on the Medical Council while 52% agreed that a statutory Medical Ombudsman should be established to handle medical complaints, disputes and incidents to ensure the quality of private healthcare services.

Healthcare Service Provision

Expanding Private Healthcare Capacity

5.24 Many submissions pointed out that the implementation of the HPS would require significant expansion in capacity for private healthcare especially hospital services in tandem with increase in manpower supply of healthcare professionals. A number of submissions took the view that the existing capacity of the private healthcare sector was not sufficient to cope with the increasing demand, and continued increase in demand for private healthcare sector would only increase medical charges and push up medical inflation. In the absence of a favourable supporting environment, they expressed concerns that the HPS would further increase the demand for private healthcare services and private hospital beds. In Survey 2A, 47% of the responding medical professionals agreed that the implementation of HPS would increase the pressure on healthcare infrastructure and workforce supply.

5.25 A number of submissions emphasized that the success of the HPS depended on having a favourable supporting infrastructure, in particular sufficient capacity among private hospitals to meet the demand for private healthcare services including that arising from the implementation of the HPS. Many of them in general supported the proposal of increasing private hospital capacity to meet the increasing demand of private healthcare services arising from the launching of the HPS. This was in keeping with the findings of Survey 1 which indicated that 75% of respondents supported the Government to increase the number of private hospital beds to prepare for the introduction of the scheme. Survey 2A revealed that 77% of the responding medical professionals agreed that the Government should increase the number of beds in existing private hospitals, and 74% agreed that the Government should increase the number of private hospitals in order to enhance the supply of private healthcare services.

5.26 Some medical professional bodies were concerned about the adequacy of private hospital beds and expressed concerns that the situation would deteriorate even without the implementation of the HPS. While noting the Government had earmarked four pieces of land for private hospital development with required ratio on the provision of standard beds, and some private hospitals had proposed or were planning further development to expand capacity, some still expressed doubts on whether the additional capacity arising from these expansions could satisfy the increasing demand of private service. Some emphasized the need for careful planning of private healthcare capacity in order to maintain public confidence in the HPS. Some urged the Government to respond to the emerging demand for healthcare services from non-local patients (e.g. those from Mainland China) which might adversely affect the benefits of the local patients and their families.

Healthcare Services and Medical Industry Development

5.27 Some submissions expressed specific concerns on whether the private healthcare sector, even with the expanded capacity with new development and planned redevelopment, would have sufficient capacity to cope with the demand from the huge overseas and Mainland market alongside the local population. Some expressed doubts on whether the private sector would be interested in serving the local population by providing affordable services through the HPS tightly regulated by the Government, when the demand for services from non-local residents falling outside the HPS framework continue to grow. Some further doubted the ability of the Government in assessing the demand for healthcare services from outside Hong Kong and planning manpower and services development accordingly.

5.28 Among submissions which had expressed these views, many advocated that the Government should take a lead in adopting measures that could facilitate the development of the medical industry as a service sector, and ensuring that there would be sufficient provision of healthcare services to local residents through the HPS. They urged the Government to take into consideration the supply and demand of Hong Kong's evolving and growing medical industry, when reviewing manpower and implementing the HPS. Some submissions pointed out that the introduction of HPS, together with corresponding healthcare supporting infrastructure to be developed, would represent an opportunity to further strengthen Hong Kong medical industry as a key pillar of service industry, through providing value-for-money and quality-assured healthcare services to meet both local and overseas demands.

5.29 Apart from facilitating the development of new private hospitals and private healthcare services, suggestions were raised on other ways of increasing overall capacity for healthcare services. These include for instance exploring measures that would allow or encourage existing private hospitals to expand their service capacity; and exploring different models of public-private-partnership in delivering hospital services, e.g. allowing unused space in public hospitals to be used by private medical practitioners, or purchasing medical services from the private sector. Some also suggested that, where private hospitals might not have sufficient capacity to meet the demand for high quality private healthcare services arising from the implementation of the HPS, the Government should consider expanding private services provided by the HA charged on a cost-recovery basis. They believed such proposals could alleviate the exodus of specialist doctors, and enable patients to have more choice for private healthcare service. A few submissions went further to suggest exploring the feasibility of facilitating Hong Kong people to seek healthcare services in Mainland China.

Service Quality and Charging

5.30 A significant number of views on the HPS focused on whether and how the Government could ensure that the services provided by private hospitals and doctors would be value-for-money and quality-assured, especially if such services were incentivized or subsidized. Many of them considered the quality and affordability of private healthcare services crucial to the success of the HPS. The call for value-for-money private healthcare services was echoed by the result of opinion survey. As reflected by the result of Survey 1, 85% of the respondents agreed that the Government should increase competition and transparency of the private healthcare service market; 77% of the respondents supported regulating the charges of private hospitals and medical practitioners.

5.31 A number of respondents expressed that they would be interested to choose and pay for private services as an alternative of public healthcare, but were worried that their payments might be nibbled away by the increasing charges of private hospitals and doctors. They considered that the current HPS proposals did not appear to provide sufficient reassurance on affordability of private healthcare services. There were concerns from the community about the future affordability of medical services, when charges for such services continued to escalate as a result of medical inflation in the future. About 38% of medical professionals in Survey 2A held the view that the implementation of the HPS might cause an escalation in private medical fees and health insurance premium.

5.32 A number of measures that aimed to improve transparency, increase competition and ensure quality of private healthcare services were put forward for consultation. These included (i) improving collection, collation and dissemination of statistics and data associated with patient care and outcomes, (ii) collecting and publishing service and price statistics of private healthcare services, (iii) establishing a statutory mechanism for health insurance claims arbitration, (iv) in line with global practice, requiring hospital accreditation as a licensing condition of private hospitals, (v) requiring peer review or clinical audits of healthcare services to be undertaken by clinicians, and (vi) publishing costs of equivalent public healthcare services alongside prices of private healthcare services for comparison.

Service and Price Transparency

5.33 Survey 2A revealed that 69% of responding medical professionals supported the Government to collect and publish service and pricing statistics of private healthcare services and 63% of respondents supported the Government to publish the costs of equivalent public healthcare services alongside prices of private healthcare services for comparison. However, apart from enhancing service and pricing transparency through passive collection and publication of statistics alone, a number of submissions pointed to the need for taking more proactive measures to safeguard consumer interests.

5.34 Some respondents were of the view that transparency and competition alone under an entirely free-market approach might not guarantee the cost-efficiency of healthcare services. Some individuals and organizations expressed concerns that individual consumers were in a difficult position to seek value-for-money in healthcare services, and insurers had little incentives under the current market situation to bargain with private healthcare service providers for cost-efficiency. Some thus suggested that the Government should determine the service charges under the HPS through negotiation with private healthcare service providers. They believed that an effective control over the increasing medical cost in private sector would make the HPS more affordable and attractive to the general public in the long run. Some further suggested that the Government should assume a more active role, including exploring different models such as public-private partnership in the provision of healthcare services, so as to ensure reasonable service quality and service charge.

5.35 Some private healthcare providers, on the other hand, considered that the transparency of existing private healthcare sector was adequate: the charging for private healthcare services by doctors and hospitals was always clearly and transparently stated in patient bills, the quality of private healthcare services by doctors were regulated by the Medical Council, and the standard of private hospitals was regulated by the Department of Health. Notwithstanding the significant increase in private healthcare costs as well as complaint cases over private healthcare services through health insurance, private healthcare providers generally considered the current market

situation satisfactory and were not in favour of any further government intervention into the existing private healthcare market.

5.36 A few submissions noticed that individual healthcare service providers might adopt different charges for insured and non-insured patients, and this might lead to higher health insurance premium and affect the interests of HPS subscribers in the long run. They suggested that appropriate measures should be adopted under the HPS to ensure that the charges of all service providers were fair and equitable, and to prevent abuse of the reimbursement system. In their view, these measures would help minimize the risk of injudicious use or abuse of healthcare services and enhance the financial sustainability of the HPS. Survey 2A showed that 61% of responding medical professionals considered abuse of health insurance (e.g. provide unnecessary services, max out charges according to benefit limit) apparent at present; and 45% of them considered that the implementation of HPS would increase incidents of medically unnecessary healthcare services provided by private hospitals and doctors.

Quality Assurance and Benchmarking

5.37 The community in general welcomed the proposal to enhance quality assurance in healthcare services. Many respondents recognized the need to strengthen quality assurance measures in both public and private healthcare systems. A number of submissions, including those from consumer groups and medical sectors, considered that quality assurance of private healthcare services would be important to ensure proper health outcomes and build up consumer confidence. In addition, consumers should be made better aware of healthcare professional directories such as specialist register and primary care doctors' directory, etc., to help them make informed choices. Some respondents considered that taking robust quality assurance measures in private healthcare services would be important in ensuring public confidence in the HPS in delivering quality-assured and value-for-money services.

5.38 Many submissions favoured the application of hospital accreditation in public and private hospitals with a view to enhancing consumer protection. Some medical professionals pointed out that there should be strengthened quality assurance measures for private hospitals, building on the existing regulatory and licensing regime for private hospitals under the Department of Health, with a view to boosting public confidence in the private healthcare system. As reflected in Survey 2A, 68% of responding medical professionals agreed that hospital accreditation should become a licensing condition for private hospitals. Some submissions further considered that more transparent and objective service benchmarks and pricing information of healthcare services provided by private hospitals could be collected and published to enhance consumer information.

5.39 A number of submissions also welcomed the exploration of clinical audit and peer review as quality assurance tools in healthcare services. Some agreed that clinical review would be conducive to the cross-fertilisation of expertise and experience among healthcare professionals, and help promote good healthcare practice in the entire system. Some healthcare professionals, on the other hand, suggested that the adoption of any clinical and peer review should be considered in great details and should involve healthcare professional bodies, such as the Hong Kong Academy of Medicine. As reflected in Survey 2A, 64% of respondents agreed that peer review or clinical audits should be required in order to keep abreast with global practice.

5.40 Some submissions suggested establishing appropriate performance benchmarks to assess the service quality of private healthcare and the results of which should be made public.

These opinions were in keeping with the findings of Survey 2A showing that 73% of the responding medical professionals supported the Government to improve collection, collation and dissemination of statistics and data associated with patient care and outcomes. Some healthcare providers believed benchmarking could enhance consumer confidence, while some noted that quality measurement should be introduced with caution in order to provide fair and informative reference for patients. Some healthcare providers raised concerns that the introduction of clinical benchmarking might deter some private healthcare providers from treating difficult and risky cases. Some suggested specifically that the Government and the public healthcare sector should continue to work closely with healthcare professional bodies, especially the Hong Kong Academy of Medicine and its Colleges, in establishing suitable and appropriate benchmarks for the purpose of quality assurance.

DRG-Based Packaged Services and Charging

Packaged Charging for Cost Transparency

5.41 A number of submissions pointed to cost containment as an important factor in the long-term viability of any insurance-based scheme, and considered that benchmarking based on diagnosis-related groups (DRG) with transparency in charges would be instrumental to keeping track of costs for private healthcare services and in turn HPS Plans. Many thus supported incorporating packaged pricing as a core element of the HPS. Some participants of Focus Group 3B appreciated the concept of DRG-based charging for allowing simplified billing, predictable charges and certainty in out-of-pocket payments. Some of them considered that payment uncertainty under itemized charging had discouraged them from choosing private healthcare services.

5.42 A number of submissions from employer groups also opined that packaged charging could encourage healthy competition among healthcare providers and health insurers to keep costs under check. Many employer groups noted rapidly rising private medical charges, and believed that DRG-based packaged charging would enable the charging for private healthcare services be made more transparent to be kept track of. Some participants of Focus Group 3B also shared similar views and considered that DRG-based packaged charging would help patients make better comparison of charges between private hospitals, even though some doubted if patients would have time to do price comparison when they urgently needed medical treatments.

5.43 Most of the medical professionals participating in Focus Group 2B considered that the objective of HPS to increase price transparency on the private healthcare market was important. Some participants thought that the current healthcare market still had room to improve in terms of price transparency and self-adjustment forces to control cost. They opined that greater use of DRG-based pricing method could potentially strengthen price benchmarking to the benefit of patient confidence and medical cost containment. On the other hand, some medical professionals considered that there was no lack of price transparency in the itemized charging currently applied in the private healthcare market, and a shift from itemized to packaged charging could not guarantee better clarity and certainty in medical cost to patients.

Packaged Charging from Consumer Perspective

5.44 Generally speaking, members of the public need time to understand the concept and benefits of DRG-based packaged services and charging, which was new to Hong Kong even though practised in the healthcare system (whether public or private) in many other advanced

economies. Most of the submissions received from those who were in favour of applying procedure- or diagnosis-based packaged services and charging (based on Diagnosis-Related Groups (DRGs)) in the provision of private healthcare services under the HPS. Many submissions considered that DRG-based service provision and charging could substantially enhance the service transparency and payment certainty of private healthcare services, which would be conducive to building consumer confidence in the HPS.

5.45 These views expressed in submissions matched with the result of Survey 1 which showed that 76% of respondents supported the introduction of packaged charging for private healthcare services so that the insured would have a better estimation of the medical charge involved. Survey 3A also indicated that 53% of the survey respondents considered the packaged charging feature attractive/very attractive, while 14% of them found this feature unattractive/very unattractive. However, respondents also expressed concerns about the feasibility of DRG benefit structure without the commitment from the healthcare sector. Some participants of Focus Group 3B expressed concerns that their choice of healthcare providers would be limited if private hospitals and doctors were unwilling to adopt DRG-based pricing.

5.46 On the other hand, some patient groups were concerned that the quality of healthcare service might be adversely affected if packaged charging was adopted. Some pointed out that private healthcare providers might be tempted to treat less complicated cases to minimize risk-taking under packaged charges. Participants in Focus Group 3B also shared similar worries that the quality of treatment might be compromised when packaged charges were fixed and all-inclusive. Some participants were concerned about the risk of up-coding, in which a provider might mark up charges to reach the packaged benefit limit.

Technical Feasibility of DRG-Based Services and Charging

5.47 Given that DRG is new to Hong Kong despite being applied for over two decades in many other healthcare systems, many submissions raised questions on its technical feasibility of applying to Hong Kong. Some individual stakeholders held the view that the mode of packaged charging which had been used currently in other countries might not be viable in Hong Kong. Most questions raised on the application of DRG, however, concerned the details of technical application and administrative operation, on which many other economies had experience, in both public and private systems, and under both social insurance and private insurance. There were, on the other hand, a number of respondents, including those from the medical profession who, pointed out that there was no inherent reason why the DRG system proven elsewhere could not be adapted and applied in Hong Kong.

5.48 On the feasibility of DRG-based service provision and charging, Survey 2A showed that 51% of the responding medical professionals agreed that it should be feasible for healthcare service providers to set their charges for common treatment or procedures based on DRG. On the technicality of applying packaged pricing in healthcare setting, about 37% of medical professionals believed that it was feasible to set hospital charges and doctor fees for common treatment or procedures based on DRG, while 53% and 29% considered it viable to set hospital charges alone (except doctor fees) and doctor fees alone respectively. 34% of the responding medical professionals considered DRG-based charging to be feasible for at least 50% of their own work cases.

5.49 To facilitate the development of packaged charging in private healthcare market, some respondents suggested that consideration could be given for private services provided by the

Hospital Authority to start adopting DRG-based packaged charging on a trial basis. This would provide an opportunity for testing the feasibility of applying DRG-based packaged charging, its acceptance and attractiveness to the public, and the impact on service provision and healthcare costs. Applying DRG-based packaged charging in the public sector on a cost-recovery basis would also provide useful reference benchmarks for similar services provided in the private sector, and in turn facilitate the development and application of DRG for private healthcare services, premium setting and product design of the HPS by insurers, and in turn competitive offer of DRG-based services and pricing by private hospitals.

DRG-Based Services and Charging from Provider Perspective

5.50 Certain medical professional bodies agreed packaged charging had its merit in limiting the expected payment incurred by patients, but considered that it should not be imposed upon insurers or healthcare service providers as a way to drive down doctors' charges. They believed that under the current market, doctor's charge which was a determining factor of the overall packaged cost was not under the control of private hospitals, and the overall charge for private in-patient services would be different from doctor to doctor with different management protocols. They suggested that private hospitals could set up packages of which the hospital charges were fully documented using an evidence-based treatment protocol based on a normal low-risk condition. Any extra services provided by hospitals for the high-risk patients would be charged only when required so that the low-risk patients would be equitably protected.

5.51 In Survey 2A among medical professionals, 70% considered that DRG-based charging would increase certainty of private healthcare charges; 72% expected it would increase price transparency and competitiveness of clinical practice in the private healthcare sector; 34% anticipated that it would facilitate the development of team-based care in line with global best practice; and 43% would expect a reduction of claim disputes and associated administrative burden to private healthcare providers.

5.52 On the other hand, 56% of the respondents of Survey 2A were concerned that DRG-based charging would reduce professional autonomy of private doctors, 31% thought it might cause a reduction in the income of private healthcare providers, 33% worried about that it might lead to a compromise in the quality of care that private doctors provided to patients, while 38% held the view that it would reduce the bargaining power of private doctors with admission rights versus that of private hospitals.

5.53 In Focus Group 2B among medical professionals, participants generally agreed that DRG-based pricing method could be considered and might bring some benefits to the healthcare system. However, many had concerns on its feasibility. Further still, some medical professionals in Focus Group 2B regarded the application of DRG-based pricing and charging a de facto government intervention into the price setting of private healthcare services in a free market, which they deemed unjustified.

Provision of DRG-Based Services

5.54 Overall the majority of views acknowledged that the adoption of a transparent packaged charging based on DRG for provision of healthcare service with explicitly marked price available to the public would be crucial to the success of the HPS. Given that DRG is new to Hong Kong, some submissions suggested the Government should take the lead to develop a centralized information platform to facilitate the application of DRG on health insurance and provision of DRG-based healthcare services. Some went further to suggest that the Government should play a

more active role to facilitate the adoption of DRG by the private sector as a basis for provision and charging of services, and the provision of benchmarked private healthcare services using DRG-based packaged pricing. In Focus Group 3B, it was almost a consensus among the participants that even without the HPS, and regardless of the choice of packaged or itemized charging under the HPS, the Government should exercise more control over how healthcare providers, especially private hospitals, charged their customers because the charges were often diverse and not transparent enough.

5.55 A number of submissions cast doubt on whether private healthcare service providers would be willing to adopt packaged charging in providing medical services, and whether the Government would be ready to take up the role of setting benchmark pricing and services, if the private sector was not interested in offering packaged charging service. They suggested that the Government should take the lead in developing the DRG-based benefit structure, and monitor the long term operation of packaged charging. This echoed with the result of Survey 1 which reflected that 75% of the respondents supported the Government to offer its own private healthcare service if private sector could not provide sufficient private healthcare services at packaged charging.

Provision of Healthcare Service under HPS

5.56 Many respondents considered that the success of HPS would require adequate supply of quality private healthcare services under the HPS framework to meet the increasing demand from the local population. Recognizing the Government's effort in facilitating private hospital development, they considered that the Government should work closely with the private healthcare sector to ensure adequate supply of hospital beds and healthcare services for the insured in accordance with the HPS, while closely monitoring any undue price escalation of private healthcare services after the introduction of the HPS. However, some were concerned that the existing private sector might not have enough experienced healthcare professionals and the necessary resources and capacity to fully absorb the increasing local demand for private healthcare services, especially when facing influx of demand from outside Hong Kong.

5.57 In general, medical practitioners were more positive that practising specialists would be willing to provide services under the HPS and their service charges would be driven by the pressure for greater transparency and competition in the private market. Some opined that it would be difficult to predict the development of private sector as the supply, demand and charges of private healthcare services were uncertain and subject to many factors, not least the launching of the HPS. However, some respondents expressed concerns that private healthcare providers might be reluctant to join the HPS due to saturation of private hospitals and lack of competition, especially in specialties where there would be acute shortage of manpower in the foreseeable future and yet demand from both local and outside Hong Kong was expected to continue to increase.

5.58 Given the uncertainty in supply of healthcare services in support of the HPS, a number of submissions considered that the Government should consider setting up its own mechanism to provide quality-assured private healthcare services, with a view to benchmarking market practice and providing value-for-money choices for consumers, in particular HPS subscribers, especially if there was inadequate provision of quality-assured private healthcare services in the market. Some of the views urged the Government to explore possible alternatives of providing quality-assured healthcare services, including where necessary the Government's involvement in

providing such services should the private sector fail to respond, in order to safeguard consumers' interests and ensure the objective of HPS could be met.

HPS Supervisory Framework

5.59 In the Consultation Document, we proposed that the supervisory framework for private health insurance and private healthcare services in connection with the proposed HPS would comprise three elements, viz. –

(a) prudential regulation to ensure the financial solvency of participating insurers under the HPS, which will continue to rest with the Office of the Commissioner of Insurance under the Insurance Companies Ordinance, Cap. 41;

(b) quality assurance on healthcare services under the HPS, including quality, standard, accreditation, benchmarking and statistics collation, by the Department of Health in its role as the regulatory and licensing authority for private hospitals; and

(c) scheme supervision covering various aspects of the HPS scheme, including its administration and various measures to ensure service quality and price transparency, to be undertaken by a new dedicated agency.

5.60 On prudential regulation, a consensual view emerged from the submissions that this should continue to be handled under the existing framework for such by the Office of the Commissioner of Insurance. It was noted that the current prudential regulatory regime itself was being reviewed and reformed. However, almost all views expressed on the subject considered that in general prudential regulation of the insurance sector as a whole, of which medical insurance formed only a part, should continue to be dealt with separately from the specific implementation and administration of the HPS and supervision of private health insurance and private healthcare services thereunder. In particular, it was noted that the latter would require specific expertise concerning health insurance and healthcare services.

5.61 On quality assurance, its importance to the HPS and the need for strengthening the existing regulatory regime for quality assurance in healthcare services were widely recognized. The challenge, as some submissions pointed out, was how to make it achievable given the Government's limited role and presence in the regulation of private hospitals offering private healthcare services. Many recognized that with the rolling out of government-sanctioned hospital accreditation and the extension of the electronic health record (eHR) platform to private hospitals in the coming years, the Government's capability and readiness in strengthening regulation of private hospitals and the private healthcare services they provided should be enhanced for quality assurance under the HPS.

5.62 On scheme supervision, there was a general recognition among the submissions that a necessary and appropriate supervisory framework needed to be put in place for the smooth operation of the HPS and for ensuring that its key features – including those designed to enhance consumer protection, market competition and transparency – were achievable. This supervisory framework should be separated from and should not adversely affect the existing prudential regulatory regime. However, views differed on what would be necessary and appropriate to be regulated, with a wide range of views being expressed varying in the degree that they considered the Government should be involved in the regulation and supervision of private health insurance

and private healthcare services and their providers under the HPS.

5.63 Many respondents were concerned about consumer interests and considered that the supervisory framework had to have full legal backing, underpinned by a statutory authority with "real teeth" entrusted with the legal responsibilities to oversee, regulate and, where necessary, enforce the HPS scheme, including product registration, premium setting and adjustment, benefit limits with a procedure and/or diagnosis-based structure, terms and conditions of the Standard Plan, underwriting and claims pertinent to the Standard Plan, rules and conditions applicable to the high-risk pool, operation and administration of the claims arbitration/mediation mechanism, etc. For this camp of submissions, the supervisory framework should feature a strong government presence with sufficient levers to counter actions that might undermine the realization of the stated objectives of the HPS in terms of safeguarding consumer protection and enhancing market transparency and competition.

5.64 On the other hand, there were also views, especially those from the health insurance industry, suggesting that the supervisory framework should be as simple and market-friendly as possible. They considered that health insurance companies and products were already subject to prudential regulation under the Insurance Companies Ordinance, Cap. 41. They believed the supervisory framework should not undermine the operation of the market, and that excessive regulation under too "restrictive" a framework would deter insurers from participating in the HPS. Some went further to suggest that health insurance should only be subject to prudential regulation, and the rest of the HPS should be left to the self-regulation or self-discipline by the industry. For this camp of submissions, matters such as premium setting and adjustment, top-up and add-on elements in addition to the Standard Plan, etc., should best be left to the market to decide in a free and unfettered manner.

5.65 An account of the key specific issues raised from the submissions concerning scheme supervision is given in the ensued paragraphs.

Transparency on Health Insurance

5.66 There was general consensus that information and market transparency of health insurance should be a basic requirement in the supervisory framework for private health insurance, both to safeguard consumer interests and enhance competition. The range of views received suggested that transparency should cover product features and pricing information on health insurance that facilitate comparison and choice by consumers, as well as insurance claim and operation information that would have a bearing on health insurance cost and premium. Some submissions further suggested that such transparency should be afforded not only to health insurance offered under the HPS but across-the-board for the purpose of enhancing consumer protection for health insurance as a whole.

5.67 There was general support for the Government to take steps to ensure transparency on health insurance. Survey 1 showed that more than 80% of the respondents supported Government to increase competition and transparency in the private healthcare insurance market, and around 80% of its respondents were in favour of requesting participating insurers to submit detailed costing information to the Government under the HPS. Some consumer and patient groups pointed out that there were inadequate consumer safeguards on medical riders, top-up health insurance products or services provided in the market. They urged the Government to regulate insurers under the supervisory framework in respect of both standard plans and top-up

products under the HPS.

5.68 Apart from making available information on health insurance products to the public, there were also suggestions for requiring participating insurers to provide to the supervisory authority information relating to insurance costs, including claims, commissions, administrative expenses and profits, and for making information publicly available in a meaningful but not commercially sensitive manner (e.g. in aggregate form without attribution). Some suggested that a dedicated website should be established so that health insurance-related information, including product information and insurance costs could be made readily accessible to members of the public in an intelligible form to facilitate consumers in making an informed choice on health insurance.

Continuity of Health Insurance

5.69 Various features of the HPS were designed with the aim to safeguard consumer interests and enhance market competition by ensuring that health insurance policies could provide continuous and sustained protection without disruption to consumers. A key requirement of the supervisory framework would therefore be ensuring that such continuity could be accorded in practice under the HPS, in terms of requiring transparent underwriting and premium loading assessment, meaningful terms for guaranteed renewal, genuine portability of policies between insurers, and uninterrupted and uncompromised coverage for insured individuals including those with higher risks.

5.70 As a number of submissions especially from the insurance industry pointed out, many technical details would be involved and hurdles would need to be overcome to enable continuity especially portability of health insurance. In particular, with the requirement of taking on high-risk individuals, guaranteeing renewal, and allowing portability, the handling and management of high-risk individuals under the HPS would become crucial to avoid risk-selection by individual insurers, and to accord meaningful continuity and portability to the insured. These submissions pointed to the need for the Government to work closely with the insurance industry to ensure that the arrangements and mechanisms would be feasible.

5.71 Concerning the continuity of insurance provision, some professional bodies noticed that currently there were no exit requirements on private health insurers. They suggested that the Government should consider imposing a minimum joining period (e.g. 10 years) for all participating insurers of the HPS under the supervisory framework and require them to guarantee the continuity of all accepted policies even after they withdrew from the scheme in order to protect the rights of all insured. They also suggested the Government to draw up precautions and follow-up measures to protect consumers of health insurance under the HPS in case a participating insurer withdrew, in addition to the measures in place under the existing prudential regulatory framework to protect the insured in the event of insolvency.

Premium Setting and Adjustment

5.72 There were diametrically opposed views on whether, how far and how stringent should premium setting and adjustment be regulated under the supervisory framework for the HPS, depending on the perspective of the proponents.

5.73 At one end of the spectrum, most submissions were concerned about affordability of

health insurance premium for HPS subscribers, not just at present or in the near-term but more importantly over the long run. Consumers, they argued, would hesitate to subscribe to HPS plans in the absence of sufficient guarantee on the affordability of the premium – both present and future. They took the view that the setting of premium level and its future adjustment should not be left lightly and entirely to market forces, as the current free market for private health insurance had shown that insurers would tend to pass on increase in medical charges into insurance premium without necessarily controlling for costs and utilizations. These views considered that consumer interests, and in turn the sustainability of the HPS, could be safeguarded only through a robust regulatory system under which the level and adjustment of HPS insurance premium was subject to stringent approval by an independent and credible authority. Some even suggested that both the premium level and adjustment should be set by an authority conferred with such a power by legislation. This was echoed in Survey 1 which showed that around 80% respondents were in favour of imposing price control or profit control by legislation under the HPS.

5.74 At the other end of the spectrum, there were views – not just those of the insurance industry but also professional bodies and academics in economics and finance fields – drawing our attention to the fact that commercial viability would also be fundamental to the success and sustainability of the HPS. They favoured a more market-oriented approach in the setting of premium and adjustment, possibly coupled with a mechanism for monitoring by the supervisory agency to ensure market competition and detect any market inefficiencies, domination or collusion. They accepted that guidelines should be published on premium, but such guidelines should not be binding upon participating insurers whom should be given the flexibility to determine on their own what premium should be charged having regard to a host of factors. They argued that market forces would be the best tool to ensure that the premium level and future adjustment remained competitive. They further pointed out that insurers might opt out from the HPS if premium setting and adjustment was imposed upon them without regard to commercial viability.

5.75 Between these two ends of the spectrum, most respondents considered that certain form and degree of regulation and/or control, apart from simply market transparency and competition, would be needed over setting and adjustment of health insurance premium to provide reassurance to consumers on affordability both short- and long-term, without unduly undermining financial viability of health insurance plans. Many of them noted that premium setting and adjustment would be a contentious issue under the HPS. Some pointed out that the crux of the matter was medical charges which had been increasing rapidly over the years. They suggested that reference should be made to practices overseas on the range of feasible premium regulatory regimes, the pros and cons pertinent to each of them, the context and circumstances unique to each regulatory regime, as well as the local concerns and considerations that should be taken into account when assessing feasible practices with a potential for adoption in Hong Kong.

Cost and Profit Control of Health Insurance

5.76 Some submissions drew attention to the imposition of a medical loss ratio (the ratio of medical claims to insurance premium collected) in the Healthcare Reform in the United States on health insurers, as a means to ensure that premium payment went towards claims rather than being eaten up by overheads such as administrative expenses. They suggested that consideration should be given to impose similarly a minimum medical loss ratio on participating insurers under the HPS, citing statistics provided in Annex B to the consultation document that the claim ratio of individually-purchased private health insurance was about 60% on average versus that of some 80% for group plans. They considered that consumer interests could be better protected under

the HPS if a medical loss ratio was imposed by law applicable to all participating insurers. Some went further to suggest that the profit of insurers on Standard Plans under the HPS should be capped to ensure that consumers would be afforded the best deal on Standard Plans. Survey 1 showed that around 80% of respondents were in support of price control or profit control by legislation under the HPS.

5.77 There were, on the other hand, views against the adoption of medical loss ratio as too restrictive, which argued that it would not be easy to set an appropriate medical loss ratio. Too stringent a ratio would drive away insurers, and that a one-size-fits-all ratio would deter insurers from exercising greater control over claims (e.g. to reduce abuses). Some respondents from the insurance industry considered that there were many factors affecting the reported medical loss ratio, and the ratio on its own might not be a good enough indicator of the performance of a private health insurance plan and its insurer. Some also pointed to the fact that many health insurance plans were being sold as riders to or as a package together with other insurance products, most commonly life products, and hence the differences in reported medical loss ratio might also be influenced by how costs and profits were booked. Some respondents from the insurance industry also considered that competition would effectively make the highly standardized HPS Standard Plans only marginally if at all profitable. They considered that whether or not a mandated medical loss ratio or profit cap was desirable and feasible should be thoroughly deliberated with all relevant factors taken into account, including consulting the insurance industry and other relevant stakeholders.

5.78 Meanwhile, there were views pointing out that the premium level and the need for future adjustment of HPS Standard Plan depended to a large extent on medical fees and charges by private practitioners in the market. While recognizing that private practitioners had always had the freedom to set their own fees and charges in the private healthcare sector as a free market, many considered that the Government should, apart from ensuring transparency and promoting competition, exercise some degree of control or influence and at the very least a benchmarking function under the supervisory framework for the HPS, with regard to medical fees and charges. The benchmarks would, as some suggested, be reflected in the benefit limits and structure of the HPS Standard Plan. They recognized that private practitioners could not be mandated to follow the benefit limits, but the benchmarking should have an influence on market practice over time such that patients would have a reliable source to refer to when making comparison. At the very least, the benchmarks would provide a yardstick for measuring the relative cost-efficiency of the private sector vis-à-vis the public sector, and in turn provide a basis for assessing the cost-efficiency of the system as a whole.

5.79 Against the above background, there was thus overwhelming support for achieving transparency of insurance costs (including claims, commissions, administrative expenses and profits) and medical charges (including claims) (see also paragraphs 5.66-5.68 above) and requiring provision of such information by both health insurers and healthcare providers under the HPS supervisory framework. While views submitted did not suggest the specifics, there was a general expectation that such requirements should be mandatory for all, and hence would need to be backed by legislation. However, some suggested that transparency and benchmarking alone would not be sufficient to make the HPS work, and there must be an adequate number of private practitioners willing to offer services at the benefit limits as prescribed under the HPS Standard Plan. Some feared that private practitioners might not be forthcoming, in the light of increasing demand for medical services from people outside Hong Kong. They suggested that the Government should factor in such risk and propose possible measures to mitigate it when

drawing up the details of the supervisory framework.

5.80 In this connection, we note that there were views, including those from the medical profession, cautioning against the complexities and technical difficulties that might be encountered in the course of drawing up procedure and/or diagnosis-based benefit limits. Some, while recognising the technicalities involved, suggested that the Government could make a start with HA private services and build up the system step by step in consultation with the stakeholders concerned.

Claims Arbitration/Mediation Mechanism

5.81 The availability of an equitable and well-functioning claims arbitration/mediation mechanism was considered important in most submissions. They considered that this was necessary to safeguard consumer interests and inspire public confidence in the HPS by addressing the shortcomings of existing market practices. Many considered that the Government should play a more active role as a neutral third-party in the mechanism as it would be difficult for subscribers, insurers and providers to come to terms with each other.

5.82 We note that under Survey 1, around 90% of its respondents agreed with the proposal to establish a claims arbitration/mediation mechanism to handle complaints arising from claims in order to protect the rights of the insured. Survey 2A revealed that 69% of the responding medical professionals supported the Government to establish a statutory mechanism for health insurance claims arbitration/mediation. Some participants of Focus Group 3B considered that their confidence in joining the HPS would increase if an effective claims arbitration/mediation mechanism would be set up under the HPS, though some of them were cautious about the effectiveness of the mechanism in avoiding dispute settlement at court level.

5.83 Some concern groups went further to suggest that the claims arbitration/mediation mechanism should be made transparent and independent, as well as given legal backing to ensure its impartiality and effectiveness in protecting consumers' interests. To maintain impartiality, they suggested that all the key stakeholders including doctors, patient groups, insurance and health service providers should be invited to join the proposed body to handle any disputes over health insurance claims and arbitrate/mediate disagreements between patients, private health insurers and private healthcare providers over such claims. Some considered that public/layman participation in the mechanism would be crucial to inspire public confidence and reassure that public interests were safeguarded.

5.84 That said, some submissions took a different view, and considered the existing regulation over the insurance sector was sufficient, with no need to set up a new body to arbitrate/mediate claims against well-designed and honestly marketed products under the HPS. Instead of setting up a new government-regulated claims arbitration/mediation mechanism, some insurance bodies suggested that a more cost-effective way was to align the adjudication mechanism with the existing Insurance Claims Complaints Bureau (ICCB) operated by the insurance industry. They considered that the function of the new arbitration body might overlap with the existing ICCB, and urged the Government to review and expand the function of the ICCB instead.

Health Insurance Plans under HPS

Participation of Insurers in HPS

5.85 A number of submissions noted that in order for the HPS to deliver its benefits to provide more quality-assured and value-for-money choice of private health insurance, wide participation of insurers to offer a broad range of health insurance plans would be essential. Only through more competitive choice of health insurance services tailored to consumers' individual needs could the benefits of the HPS be realized. To ensure genuine competition and choice under the HPS, some respondents believed that there would be a need for more private health insurers to participate in the HPS and offer attractive competing health insurance plans under the HPS. They suggested that Government should take a role to ensure sufficiently low entry barrier into the market so as to facilitate fresh entrants with new capital and ideas to drive competition and keep down costs.

5.86 The insurance industry, while indicating support to the HPS concept, had expressed both general interests and concerns on the introduction of the HPS. Many insurers recognized the value of HPS in providing a more stable environment for development of private health insurance and instilling greater market competition, transparency and certainty in private healthcare services. Many in the industry considered that the implementation of the HPS might bring potential expansion to the health insurance market, but at the same time would also bring significant challenges to individual insurers who might need to face more fierce competition, more stringent regulation, and potentially more business risk under the HPS. Some further questioned whether the potential expansion could be realized, given the already high penetration of private health insurance in Hong Kong. That said, most insurers expressed the view that they remained interested in offering health insurance under the HPS framework so long as the HPS requirements were workable and regulations were not too burdensome.

5.87 In this regard, some respondents from the insurance industry considered that the existing licensing regime for insurance business might not facilitate all underwriters currently providing health insurance to participate in the HPS to offer more choices for consumers. In particular, they noted that the current division between life business and general business might make it difficult for life insurers to provide health insurance plans under the HPS in competition with general insurers. On the other hand, some respondents noted that if a savings component was required to be included, that might make it difficult for general insurers to participate in the HPS. They suggested that the HPS should be formulated having full regard to the existing legislation and regulations for the insurance industry, in particular the Insurance Companies Ordinance to enable wide participation of insurers.

5.88 Meanwhile, some submissions pointed out that if only a few insurers participated in the HPS, that might leave new customers with fewer choice of insurers offering HPS Plans, and existing customers with no option for migration to the HPS. Some further believed that even if insurers participated in the HPS and yet continued to offer private health insurance products outside the HPS framework (non-HPS products), that might create potential for the insurers to arbitrage against the HPS by keeping healthy individuals to their unregulated non-HPS products while offloading high-risk individuals to HPS Plans. Either case would adversely affect the attractiveness and viability of the HPS. Suggestions were thus made that the Government should consider requiring insurers participating in the HPS to include the HPS Standard Plan in all their health insurance plans, or further still to require all insurers who intend to offer health insurance

to participate in the HPS. However, the details of these as well as their feasibility would require further examination.

Government's Involvement in Health Insurance Provision

5.89 Some respondents expressed concerns on whether private insurers would be interested to offer HPS Plans because of the stringent requirements and regulation imposed, if their participation was voluntary. They pointed out that health insurance, despite its rapid growth in the past decade, still remained a relatively small segment of the insurance industry as a whole, and return margin on health insurance had been meagre in comparison with other lines of insurance business. Thus the interest and participation of insurers in the HPS could not be taken for granted. In this regard, the insurance industry had expressed the view that the HPS Standard Plan, given its stringent requirements and regulations and its highly standardized as an insurance product, was unlikely to be profitable and its premium would likely be very competitive. Some expressed the view that this would in turn diminish insurers' interests in participating in HPS or at least in offering HPS Standard Plan, even though they might still be attracted to the market for top-up benefits and add-on components.

5.90 To ensure the availability of health insurance plans under the HPS, especially the HPS Standard Plan meeting the core requirements and specifications, some submissions suggested that the Government should explore a more active and direct role in ensuring the provision of HPS Plans, if private insurers were not interested or not able to offer adequate choice of sufficiently competitive HPS Plans. In particular, the suggestion was made to explore the possibility of the Government being involved in making available HPS Plans, with a view to establishing a benchmark in the private sector to promote healthy competition in the market for the benefit of consumers. This might take different forms, including, for instance, sourcing NGOs or private firms as partners to offer HPS Plans, operating a centralized core HPS Plan and the High-Risk Pool for individual insurers to offer top-ups, or setting up a public company to offer HPS Plans direct to the public.

5.91 Similar view was also noted in Survey 1 which indicated that 76% of the respondents agreed that the Government should set up its own mechanism to provide health insurance if private insurers could not comply with the prerequisite standards in offering the HPS. The insurance industry also expressed the view that so long as any competition would be on a level-playing field, they would not be against the Government's closer involvement in offering health insurance under the HPS. On the other hand, some professional bodies considered that any form of government-involved health insurance would end up becoming another publicly funded subsidy scheme. Some medical bodies had reservations over any insurance scheme run by public entity as they were concerned that it might divert public resources from those who needed them most.

Employers-Provided Health Insurance under HPS

5.92 Some submissions considered that the participation of employers would be important to ensuring the successful implementation of the HPS. They considered that employers' participation, especially large employers with a large number of employees in both public and private sectors, could help provide a large and stable pool for health insurance plans under the HPS. Noting that many existing small and medium enterprises had difficulties in subscribing to group plans in view of their small number of employees, some respondents suggested that

incentives could be considered to motivate them to make use of health insurance plans under the HPS to provide medical scheme for their employees.

5.93 Some respondents also suggested the Government to encourage large employers to migrate their existing medical insurance plans to the HPS. The insurance industry also specifically asked if the Government as an employer would consider making use of the HPS to offer medical benefit schemes to government employees. A few submissions suggested that the Government should consider taking a lead in offering HPS Plans to civil servants, which would in turn help reduce the demand pressure on Hospital Authority from civil servants, provide civil servants with a wider choice of healthcare services, and provide a large membership base for the HPS initial implementation.

5.94 Some submissions expressed concerns about potential reduction in existing medical benefits for employees if employers chose to migrate their existing health insurance to the HPS, since the decision rested solely with employers and individual employees could not have a choice of their own. Some asked that the Government should be cautious and put in place appropriate safeguards to prevent employers from reducing medical benefits upon migration to the HPS.

Potential Risks and Mitigation

Lack of a Large and Balanced Risk-Pool

5.95 A number of submissions pointed out that the sustainability and viability of the HPS depended on building a large and balanced risk-pool; and considered that the financial sustainability of the HPS would depend on the participation of young and healthy groups in order to maintain a balanced risk pool. Some submissions expressed concerns about the sustainability of the HPS if it could not attract a critical mass of young and healthy participants, and there could be a vicious cycle of low participation, imbalanced risk-pools, heavy claims, costly charges, premium hike, leading to even lower participation. Some respondents pointed out that if private insurers would be allowed to offer plans that would compete with the HPS, the young and healthy groups might be more attracted to join the competing plans, leaving the HPS with the elderly and less healthy groups. This would seriously affect the sustainability of HPS.

5.96 Some respondents suggested a combination of carrot and stick, providing incentives to attract individuals especially young and healthy lives to join, while putting in place measures to minimize adverse selection. Some submissions suggested that financial incentives targeting at the younger generation should be provided so as to encourage young and healthy lives to join the HPS. Some suggested that the Government should mount an extensive public campaign to enhance the overall public awareness of the importance of health insurance and encourage early participation. Some suggested focusing efforts to induce large employers to migrate the insurance plans for their employees to the HPS in order to build up a critical mass.

5.97 On the other hand, some submissions considered that this risk should be mitigated by more stringent regulatory measures, in order to guard against adverse selection and cream-skimming by insurers under the HPS, which would defeat the objectives of the scheme. For those who favoured more stringent regulatory measures, some of them suggested that the Government should explore whether HPS Plans should be made a mandatory component for all health insurance with coverage of in-patient and ambulatory procedures. That would avoid

undue arbitrage by insurers between HPS and non-HPS plans. That, however, requires very careful examination of the details and feasibility, as well as its impact on the existing health insurance market.

Lack of Interest from Insurers and Healthcare Providers

5.98 A number of submissions considered that the success of a voluntary HPS would heavily depend on the support and participation of private insurers and healthcare providers. Some of them opined that it would be of great importance to encourage private insurers and healthcare providers to participate in HPS to provide choices for consumers and promote healthy competition in the market.

5.99 Some of the submissions suggested the Government should actively take measures to guard against cream-skimming by insurers and healthcare providers vis-à-vis the public system. Some went further to advise that the Government should take early precaution by installing efficient control knobs when designing the HPS to minimize adverse selection by individuals and cream-skimming by health insures and healthcare providers, including the possibility to explore requiring participating insurers to incorporate HPS into all their health insurance plans or requiring all insurers or making HPS mandatory for all insurers offering health insurance.

5.100 Some submissions expressed concerns on the lukewarm response of the private sector towards the HPS, especially in view of continued influx of demand for healthcare services from outside Hong Kong. Some suggested that the Government should assume a more active and direct role, including direct provision of HPS plans and DRG-based packaged services, preferably on a level-playing field with other market participants, especially in the case where the private insurers and healthcare service providers were unable to provide health insurance and value-for-money healthcare services to consumers in line with the objectives and requirements of HPS. They considered that the Government should be ultimately responsible for ensuring adequate supply of HPS plans and healthcare services, with a view to safeguarding consumer interests.

Lack of Control over Premium Escalation and Medical Inflation

5.101 Many submissions emphasized that the sustainability of the healthcare system depended to a large extent on controlling the inflation of medical costs against the backdrop of ageing demographic profile and advancing medical technology in all advanced economies. Some respondents, while supporting the implementation of HPS to reform the private health insurance and private healthcare services sector and to enhance the overall cost-effectiveness and efficiency of the healthcare system as a whole, considered that control of medical cost and inflation would be a key factor in the long-term benefit and viability of the HPS. In this regard, a number of submissions considered the HPS proposals too weak in its control over insurance premium and medical charges, and relied too much on market transparency and competition.

5.102 A number of submissions suggested that more specific measures should be introduced to ensure effective cost-control under the voluntary HPS. To enable better cost-control under a health insurance system, a number of submissions suggested that transparent service and pricing information and objective benchmarks would be useful for members of the public in comparing and choosing healthcare services being offered in the private markets. Many respondents considered that the Government should thus establish the necessary information infrastructure,

including supporting IT infrastructure for health insurance administration, to monitor service and pricing information to support the supervisory functions and make available benchmarking information to the public. Some also saw the need for establishing a system to monitor the market situation of private health insurance and private healthcare services, with a view to detecting and minimizing moral hazards and other abuses, especially if public subsidies were involved. Some also proposed to set up an evaluation framework to review the effectiveness of the HPS against health outcomes and appropriate indicators and mitigate potential risk of the HPS.

5.103 Some respondents pointed to overseas experience and claimed that the expansion of private health insurance could lead to greater risk in the healthcare system. They considered that it would be difficult to control cost through private health insurance, and it would lead to medical price increase and induce unnecessary demand for private healthcare services. Some considered that private insurance would not be an appropriate measure to contain costs, enhance efficiency and deal with ageing population. Referring to international experience, they argued that healthcare system relying on private insurance tended to be more expensive and it was unlikely to directly help relieving the burden of the public healthcare system. Some noted the need to provide incentives in a voluntary scheme but they were concerned about the use of public subsidy without a strong intent to control future costs. They urged the Government to provide financial incentives with reference to the objectives of HPS.

Read-Across Implications for the Public System

5.104 A number of submissions expressed concerns on whether the funding and quality of public healthcare would suffer as a result of introducing HPS. Many of them considered that the introduction of HPS might likely aggravate the draining of experienced healthcare professionals from public to private sector, and as a result those who had to rely on public healthcare would be adversely affected, rather than be benefitting, from the introduction of HPS. Some of them were concerned that waiting time and quality of public services might be worsened. A number of submissions were also concerned that public funding on healthcare might be reduced as the Government would allocate resources to support the development of private healthcare services under the HPS.

5.105 While noting the Government has been increasing its recurrent budget on healthcare and investing significantly in the public healthcare system with a view to improving public services, many submissions, especially those from patient and under-privileged groups, urged the Government to reaffirm its continued and undiminished commitment to public healthcare in the course of taking forward the healthcare reform especially when taking measures on the private healthcare sector. Some specifically pointed out that the Government should invest more in the four target areas of public healthcare, and further increase its funding target for public healthcare.

5.106 Meanwhile, some respondents noted that whether the objectives and benefits of the HPS could be achieved would require a careful balancing between the public and private sector, in terms of both manpower and resource allocation, as well as close monitoring of the quality, efficiency, cost-effectiveness and value-for-money of healthcare services in both sectors. Noting that the implementation of the HPS would require close monitoring of private healthcare service quality, quantity, pricing and possibly outcomes, some respondents considered that the same should be applied throughout the healthcare system, including in the public sector, so as to establish comparable benchmarks on services quality and efficiency.

Rationalization of Healthcare Resources between Public and Private Sector

5.107 A number of submissions suggested that, in the long run, the issue of price differentiation between the highly subsidized public system and private sectors should also be addressed to better reflect the true healthcare cost to the community. Some submissions pointed to the need for rationalization of healthcare fees in public sector with a view to enhancing the financial sustainability of the public healthcare system, promoting the judicious use of public healthcare services, and ensuring sufficient resources for the target service areas and population groups. Under Survey 1, 60% of the respondents supported fee increase as a means to finance the healthcare needs of low-income families, disadvantaged groups and people with severe illness.

5.108 A few submissions further suggested that the Government should continue to invest proportionally more resources in the public healthcare system, so as to strengthen public healthcare services alongside implementing the HPS. Some respondents further suggested that more targeted improvements to public healthcare provision should be done, particularly improving the existing mechanism of drug formulary, shortening waiting queue and enhancing specialist out-patient care in the public sector. They viewed that the suggestion was in line with HPS objective to better focus the public healthcare system on its target services and enhanced healthcare protection for low-income and under-privileged groups through strengthening public healthcare system.

Chapter 6 CONCLUSION AND WAY FORWARD

Healthcare Reform On-going

6.1 Further to the first stage public consultation in 2008, we have been taking forward healthcare reform to improve the quality and enhance the sustainability of our healthcare system. The Government is on its way of meeting its pledge to increase the recurrent funding for health to 17% of its recurrent budget in 2012: the Government's recurrent funding for health has increased from $31.6 billion in 2007-08 to $39.9 billion in 2011-12, its share of the Government's recurrent expenditure has increased from 15.9% to 16.5% correspondingly.

6.2 We have been making use of the increased funding to improve services of the public healthcare system, including strengthening support for people with mental illness and healthcare services for the benefit of the elderly. The increased funding has better enabled the public system to focus on serving its target areas and safety net, i.e. acute and emergency care, services for low-income and under-privileged groups, catastrophic and complex illness requiring high cost and team work, as well as training of healthcare professionals.

6.3 We have also been implementing various service reform proposals, including implementing various initiatives to enhance delivery of comprehensive primary care in the community in accordance with our primary care development strategy, developing a patient-oriented electronic health record sharing infrastructure straddling both public and private sectors, and taking steps to promote public-private partnership in the delivery of healthcare to provide more choice of value-for-money and cost-efficient healthcare.

6.4 With the Second Stage Public Consultation on Healthcare Reform completed, we are now in a position to consolidate the views received and decide on the way forward for the next steps to be taken in healthcare reform, especially the reform of the private healthcare sector and the introduction of the HPS as a government-regulated framework for voluntary private health insurance as a supplementary healthcare financing.

Conclusions from Second Stage Public Consultation

6.5 Based on our continuous efforts in coming up with consensus on the healthcare reform process, the views and suggestions received in the second stage public consultation further reaffirmed our efforts and build up the momentum to move forward. Having studied and analyzed the views received, we consider that what we should do on healthcare reform in future should be guided by the following –

(a) the consultation outcome reaffirms the broad-based community support for the Government's healthcare reform vision of developing our dual healthcare system, with a public system continued to be strengthened as its core, complemented by a competitive and transparent private sector;

(b) there is overwhelming public call for strengthening supervision and regulation over private health insurance and healthcare services, amidst rapidly increasing insured population and private healthcare expenditure, to address current shortcomings that undermine the long-term sustainability of the private sector;

(c) there is support for the Government to take forward the proposed HPS with the aims of providing value-for-money choices to members of the public, improving competition, transparency and efficiency of the private sector, and relieving the pressure on the public sector so as to better focus on serving its target areas;

(d) the success of the HPS depends very much on strengthening the supporting infrastructure for the healthcare system, most crucially healthcare manpower supply and private healthcare capacity, and putting in place the supervisory framework and institutional governance to ensure the objectives of HPS are met;

(e) the HPS features – e.g. underwriting, portability, plan migration, standardized terms and conditions, and the modus operandi of the high-risk pool – require further examination and deliberation in consultation with relevant stakeholders to thrash out details that are feasible, practicable and, where possible, desirable;

(f) efforts should be made prior to implementation of the HPS to facilitate development of the healthcare service market so that insurers and healthcare providers are better prepared and equipped to provide services that are in line with the principles and requirements of the HPS in preparation for its implementation; and

(g) there should be put in place engagement platforms on which stakeholders are represented and through which communication and deliberation could be made to forge maximum consensus while respecting differences in views and stances in the course of developing concrete proposals for implementation.

Way Forward for HPS - A Three-Pronged Action Plan

6.6 Complementing our comprehensive healthcare service reforms, the Government will move forward to **reform the private healthcare sector to enhance the overall cost-effectiveness and efficiency of the healthcare system as a whole, alongside strengthening our public healthcare system**. We see a need to **take forward the HPS to facilitate the development of a private market segment, between current public services and traditional private market, that could enhance market competition and provide the local population, especially middle-income families, with quality assurance and price transparency in private healthcare services as an alternative**. Doing so would also provide a stable environment for the private healthcare market to further develop as an industry to tap the opportunities arising from demands outside Hong Kong.

6.7 To take forward the HPS and prepare for its implementation, we propose that a three-pronged action plan should be taken forward over the next two years (i.e. from mid-2011 to first half 2013) to establish platforms to engage relevant stakeholders; to formulate necessary plans for enhancing manpower and capacity of the healthcare system; to formulate legislative and institutional proposals for a supervisory framework for health insurance and healthcare service markets under HPS; and to facilitate development of healthcare services. The three prongs are described in the following sections.

(a) Review Healthcare Manpower Planning and Professional Development

6.8 The consultation reaffirmed that the expansion of capacity of the healthcare system as a

whole, and the development of the private healthcare sector in particular, will require strengthening manpower supply and professional development among the healthcare professions.

6.9 We propose to conduct a strategic review on healthcare manpower planning and professional development for various healthcare professions, including doctor, nurses and other healthcare professionals. The strategic review will assess manpower needs in the various healthcare professions, taking into account the population healthcare needs in particular the increase of demand for healthcare services arising from ageing population (for instance the need to strengthen services for the elderly population and on mental health), the evolution of healthcare service delivery models, the changes in support of healthcare reform, and the potential increase in demand for private healthcare services, including those arising from known and planned private hospital developments and healthcare market changes, with a view to making objective recommendations on healthcare manpower planning and supply to support the sustainable development of the healthcare system as a whole.

6.10 Alongside assessment of manpower needs, there is also a need for the strategic review to recommend measures on professional development to upkeep the professional qualities of the various healthcare professions. It will cover the regulatory structure for the healthcare professions, including the functions and compositions of the existing statutory regulatory bodies for registered healthcare professionals, as well as the healthcare professionals currently not subject to professional registration. It will also examine the existing mechanisms for setting and upholding professional standards in different professions, and consider various tools to further strengthen professional standard of healthcare services they provide. These would include, for example, the existing arrangements of Continuous Medical Education (CME) and Continuous Professional Development (CPD), the feasibility of peer review, clinical audits or other mechanisms that help ensure professional standards.

6.11 To take forward the strategic review, we propose to set up a **high-level Steering Committee on Strategic Manpower Review** comprising renowned international experts and local dignitaries in the healthcare professions under Food and Health Bureau (FHB) **to steer the strategic review and engage the various healthcare professions and stakeholders in the process**. Subject to the outcome of the exercise, the Steering Committee will propose means to meet projected healthcare manpower needs and address bottlenecks in both public and private healthcare sectors, including professional training and development plans and other necessary measures, and put forward recommendations to strengthen professional regulation to ensure qualities and standards of healthcare professions to support the sustainable development of the healthcare system as a whole. We expect the Steering Committee to tender its recommendations by early 2013.

(b) Formulate Supervisory Framework for HPS

6.12 With strong support received in the consultation for regulating private health insurance and private healthcare services for consumer protection, we have to formulate detailed legislative and institutional proposals to establish a supervisory framework for health insurance and healthcare service markets under HPS. To ensure that desirability and feasibility of the proposals are thoroughly examined, we need to engage the relevant stakeholders in the process. We thus propose to set up a **Working Group on Health Protection Scheme** comprising relevant stakeholders **to steer the formulation of necessary and feasible proposals for HPS**.

6.13 The Working Group will be formed under the aegis of the current Health and Medical Development Advisory Committee (HMDAC) chaired by the Secretary for Food and Health, and will explore the setting up of a statutory authority for HPS administration and supervision and the provision of financial incentives in line with the objectives of HPS. In particular, we envisage that the Working Group on HPS would, among other things –

(a) articulate specific goals and deliverables of HPS, propose measures to mitigate potential risks of the HPS, identify areas and make proposals for matters requiring Government intervention justified on grounds of enhancing the long-term sustainability of our healthcare system and safeguarding legitimate public interest;

(b) formulate proposals for necessary regulation of health insurance and healthcare services under HPS through amending existing legislation or enacting new legislation and propose detailed institutional set-up for the setting up of a statutory authority for supervising and administering HPS;

(c) develop the key components of the Standard Plan under HPS and formulate rules and mechanisms to support the operation of HPS, including the modus operandi of the high-risk pool and the claims arbitration/mediation mechanism, as well as any other market infrastructure required to support HPS implementation;

(d) examine the need for and extent of the Government's involvement in the provision of health insurance and healthcare services under the HPS, having regard to the viability and sustainability of any proposition, the financial and regulatory implications for the Government, among other relevant considerations; and

(e) deliberate on and make recommendations on the provision of public subsidy, specifically the use of the $50 billion fiscal reserve earmarked to support healthcare reform, to provide financial incentives under the HPS or for other purposes in connection with healthcare reform, having regard to the objectives of reform and other relevant considerations.

6.14 We plan to set up the Working Group by end 2011, involving representatives from key stakeholders including insurance sector, medical sector, patient and consumer groups, employer groups and academics, to facilitate effective stakeholder engagement in order to gain public and sectoral support to the proposals. We expect that the Working Group will tender its proposals and recommendations by early 2013.

(c) Facilitate Healthcare Service Development

6.15 To address the views we received from the consultation over the healthcare supporting infrastructure and prepare for the implementation of HPS, we need to expand the capacity of the healthcare system through encouraging development of private hospital facilities capable of offering value-for-money packaged services. This is being taken forward as part of the disposal of the reserved land for private hospital development. One of the considerations for the disposal of the land is to ensure that the private hospitals to be developed thereupon would be able to provide packaged services in support of the future implementation of HPS and could benefit the local population disposed to purchase private health insurance and utilize private healthcare services.

6.16 Meanwhile, we also need to facilitate market changes in support of the development of a more transparent and competitive healthcare service market, offering quality-assured and value-for-money services for the public. To this end, we envisage that there would be a need to explore the following measures, with a view to paving the way for the implementation of HPS, especially pending the completion of the two other actions plans outlined above –

(a) devise possible means to monitor healthcare services and charges, and collate service quality and cost/price data, in both public and private healthcare sector, for the sake of enhancing transparency, comparison and benchmarking;

(b) formulate DRG prototypes having regard to current market practices in the private healthcare sector and propose DRG cost benchmarks based on available cost/price data for common procedures, to provide a starting basis for implementation of DRG under HPS;

(c) develop an electronic platform that supports data collation and administration of DRG-based charging in private healthcare setting, with a view to facilitating adoption of DRG-based services and charging by both insurers and healthcare providers; and

(d) promote the adoption of DRG-based packaged services and charging in the private healthcare sector through implementation of public-private-partnership initiatives and purchase of specific services from the private sector to augment public healthcare services.

6.17 We will establish within the Food and Health Bureau a dedicated office to support the three prongs of the action plan outlined above, including support for the Steering Committee on Strategic Manpower Review and the HMDAC Working Group on HPS. It will also co-ordinate and take forward initiatives on healthcare service development, including the implementation of public-private initiatives and purchase of private healthcare services. The support office will draw on the existing expertise in the public sector including the Food and Health Bureau, Department of Health and Hospital Authority.

Vote of Thanks

6.18 We would like to take this opportunity to express our sincere thanks to all members of the community for their support of and contribution to the two-stage public consultation on healthcare reform in one form or another. Their insightful views and valuable suggestions put to us during the consultations have helped us better understand public expectations, and provided us with the foundation to move forward on healthcare reform.

6.19 We would also like to record our gratitude for the guidance by Members of the Health and Medical Development Advisory Committee and its Working Group on Healthcare Financing, who have provided us with essential steer on healthcare reform; and the advice by members of the Consultative Group on Voluntary Supplementary Financing Scheme, who have provided us with indispensable inputs in the formulation of the proposals for the Health Protection Scheme.

APPENDIX A SUMMARY OF PROPOSALS FOR HEALTH PROTECTION SCHEME AND VIEWS RECEIVED IN CONSULTATION

	Proposals/Parameters	Summary of Views Received
Scheme Objectives	• Health Protection Scheme (HPS) is a standardized and regulated private health insurance scheme based on voluntary participation. The HPS is proposed with the following objectives – - Provide more choices with better protection to those who are able and willing to pay for private health insurance and private healthcare services. - Relieve public queues by enabling more people to choose private services and focus public healthcare on target service areas and population groups. - Better enable people with health insurance to stay insured and make premium payment at older age and meet their healthcare needs through private services. - Enhance transparency, competition, value-for-money and consumer protection in private health insurance and private healthcare services.	• Majority of views obtained during the consultation supported the direction of the Government to reform the private healthcare sector, including both private health insurance and private healthcare services. Many respondents pointed out the current shortcomings of private health insurance and private healthcare services and supported the need for reform. • The community generally concurred with the direction of having the public and private healthcare systems to operate on a dual-track system. Many respondents agreed that the introduction of a voluntary HPS was a positive step forward. Some, however, suggested the public system should play an overwhelmingly dominating role and the Government should focus its efforts and resources on improving the public system alone. • By providing a quality and affordable alternative to public healthcare, the public generally agreed that HPS could expand the capacity of the healthcare system as a whole and enable more people to use private healthcare on a sustained basis, thereby relieving demand pressure for public healthcare services and benefiting those who need to rely on the public healthcare system.
Scheme Concept	• HPS is proposed as a standardized and regulated framework for health insurance under its aegis. Health insurance plans to be offered under the HPS (HPS Plans) are required to meet the core requirements and specifications (please refer to scheme features below for details) for health insurance standardized under the HPS. • The HPS is designed to be modular. Individuals may choose to subscribe to HPS Plans on a voluntary basis, and enjoy the provisions under the HPS for consumer protection and other advantages offered by HPS Plans.	• Many agreed that insurers participating in the HPS should offer standardized health insurance plans in accordance with the core requirements and specifications, and to comply with scheme rules and requirements specified under the HPS for the sake of consumer protection. • The community in general agreed that HPS to be designed as a voluntary scheme. Some suggested that more stringent measures should be considered to guard against adverse selection and cream-skimming by insurers. A few suggested that, if a voluntary scheme was proven non-sustainable on its own, consideration should be given to introduce a mandatory insurance scheme.

	Proposals/Parameters	Summary of Views Received
SCHEME FEATURES		
Benefit Coverage	• The Standard Plan(s) will be designed to ensure the insured to access affordable private healthcare for medical conditions requiring hospital admissions or ambulatory procedures – together with associated specialist services and diagnostic imaging – and chemotherapy or radiotherapy for cancer. • Higher benefit limits and/or broader service coverage (e.g. out-patient, dental, maternity, etc.) could be provided on top of Standard Plan(s) as add-ons.	• Members of the public generally appreciated the proposal to confine the coverage of the Standard Plan(s) to provide targeted protection for unanticipated and expensive treatments. They were generally receptive to the proposal that the more predictable items should be covered by add-ons to allow flexibility and hold down the premium of the Standard Plan(s). • Some considered that the Standard Plan(s) could be improved by including primary care services.
Benefit Limits	• The Standard Plan(s) will be designed to provide the insured with adequate coverage to access general ward class of private healthcare services when needed. • Lump-sum benefit limits will be set for common procedures with packaged charging according to standardized diagnosis-related groups (DRG) as benefit limits of Standard Plan(s). Itemized benefit schedule will be available in the absence of packaged charging (e.g. complex or uncommon procedures). The adoption of packaged services and charging by DRG will be examined together with stakeholders in developing the details of the proposed HPS.	• Members of the public generally considered that HPS could enable the insured to have sufficient protection to access private healthcare services when needed. They welcomed the proposal to encourage packaged services and charging in the private sector based on DRG and considered that this would help address concerns over rising medical costs in the private sector, uncertainty over payment beforehand and lack of pricing transparency. • Some went further to suggest that the Government should consider providing DRG-based packaged services in a more direct manner, including direct provision through Hospital Authority.
Premium	• Transparent age-banded premium schedule will be published and applied for each individual Standard Plan under HPS. High-risk loading and premium will be capped at three times of the published premium. • The mechanism of governing premium adjustment will be examined together with stakeholders in developing the details of the proposed HPS, having regard to, among other things, the need to address concerns over unreasonable increase in premium.	• Members of the public generally appreciated transparent and age-banded premium schedule to be applied to HPS. While most welcomed premium cap for high-risk groups, some expressed concerns over affordability of high-risk individuals. • While noting that guidelines were proposed to be published on premium adjustment, members of public pointed out that there must be strong and concrete measures to assure the public that there would not be unreasonable premium escalation in future years upon implementation of the HPS.
Co-payment	• There will be standardized co-payment arrangements under HPS. The levels will be further examined together with stakeholders in developing the details of the proposed HPS.	• Members of the public generally appreciated the proposal to promote shared responsibility and curb moral hazards under HPS.

	Proposals/Parameters	Summary of Views Received
No-claim Discount	• The offer of no-claim discount (say up to 30% of premium) will be further examined together with stakeholders in developing the details of the proposed HPS.	• The views on no-claim discount were diverse. Some supported the proposal while some questioned whether it was necessary and appropriate to put in place no-claim discount under the HPS as subscribers might avoid early treatment or fall back on the public system in order to preserve their no-claim discount.
Acceptance	• HPS will accept all applicants subject where necessary to entry age limit, underwriting and premium loading.	• Members of the public generally supported guarantee acceptance under HPS.
Entry Age	• The limit on entry age will be further examined together with stakeholders in developing the details of the proposed HPS.	• The views on the limit were diverse. Some agreed that the proposed age limit of 65 might serve the purpose of risk management, but a number of submissions expressed concerns that the limit would affect the choice for those at older ages.
Pre-existing Conditions	• HPS will accept pre-existing conditions subject to a one-year waiting period and time-limited reimbursement limits (25% for second year and 50% for third year), with full coverage thereafter.	• Many submissions were in support of opening up the HPS to high-risk individuals through government regulation and subsidy. • There were suggestions that the waiting period – proposed to be one year plus partial reimbursement in year two and three – could be relaxed to enable more high-risk individuals to benefit. On the other hand, a few considered that admission of high-risk individuals might not be fair to healthy lives and it might aggravate anti-selection under the HPS.
Pooling of High-Risk Subscribers	• A High-Risk Pool (HRP) mechanism will be set up under HPS, funded by premium of high-risk policies and reinsurance premium from participating insurers to absorb risk of high-risk subscribers, with injection from the Government into the HRP where necessary.	• Members of the public generally appreciated the set up of HRP. Some considered that Government injection would be necessary to enable the high-risks individuals to get insured.
Renewal	• There will be guaranteed renewal for life under HPS.	• Many submissions were in support of guaranteed renewal of HPS Standard Plan(s).
Portability	• Fully portable for Standard Plan(s) as a matter of principle between insurers, on retirement or leaving employment. Details, including practical arrangements and the need for re-underwriting under specific circumstances, will be examined together with stakeholders in developing the details of the proposed HPS.	• Members of the public generally appreciated portability which could promote healthy competition in health insurance market. Some pointed out that, when crafting the detailed rules, consideration should be given to how transfer between insurers could work smoothly under a regime where underwriting should normally take place once at point of entry.

	Proposals/Parameters	Summary of Views Received
Migration from Existing Plans	• Insurance industry will be required to facilitate migration of existing holders of non-HPS policies to HPS Standard Plan(s). Participating insurers will be required to offer their existing health insurance policy holders an option to transfer to HPS without subject to re-underwriting within a period (say one year) after introduction of HPS. Details, including where necessary and justified, whether more stringent rules should be introduced, will be examined together with stakeholders in developing the details of the proposed HPS.	• Members of the public generally considered smooth migration would be essential to facilitate existing policy holders to opt for HPS. Some suggested that efforts should be made to encourage and induce employers to migrate the insurance plans for their employees to the HPS in order to make up the critical mass. Some also suggested that sufficient incentives should be provided to attract healthy lives to join and stay within HPS.
Transparency of Insurance Costs	• Participating insurers will be required to be transparent in insurance costs including claims, administration and commission under HPS.	• Many submissions welcomed enhanced transparency over existing market practice of private health insurance sector.
Savings for Future Healthcare	• The desirability of including a savings feature in HPS will be examined together with stakeholders in developing the details of the proposed HPS.	• The views were diverse. Some considered it desirable to have savings incorporated into the HPS. Some, however, considered that savings were too long term and its restricted use might not be welcome to all.
SUPPORTING INFRASTRUCTURE FOR HEALTH PROTECTION SCHEME		
Healthcare Capacity	• The capacity of the healthcare system will be expanded through encouraging development of private hospital facilities, including new private hospital developments at the four pieces of land earmarked, capable of offering value-for-money packaged services.	• Many respondents stressed that success of HPS and healthcare reform hinged on whether our healthcare system as a whole had adequate capacity and healthcare infrastructure. Many viewed that HPS would stimulate demand for private healthcare services.
Service Provision Based on Packaged Charging	• Essential market infrastructure for transparency and benchmarking will be developed to support the implementation of HPS. • Packaged services and charging will be promoted through purchasing of common healthcare services or procedures as appropriate.	• Many submissions emphasized the importance over the availability of services based on packaged charging to the success of HPS. Lukewarm reactions of the current private healthcare sector to offer packaged service and pricing, especially in view of continued influx of demand from outside Hong Kong, were cited by some respondents as factors potentially undermining the feasibility of HPS.
Healthcare Manpower	• A comprehensive strategic review on manpower planning and professional development of healthcare professions will be conducted, with the aim to formulate plans to ensure manpower supply and professional qualities to meet future needs, both near-term and long-term.	• Many stressed that having a steady and adequate supply of healthcare manpower was instrumental to the sustainability of the overall healthcare system. Some concerned that HPS would aggravate the demand for healthcare manpower. Some specifically pointed out that the implementation of the HPS would cause brain drain in the public system if manpower supply was in a shortage.

	Proposals/Parameters	Summary of Views Received
Potential Options for Healthcare Service and Health Insurance Provision	• As we have pointed out in the consultation document, the Government would consider setting up its own mechanism to provide, as a competitive benchmark for market participants, the public with more choices of health insurance plans and/or healthcare services at packaged charging as and where necessary. • The need for and extent of the Government's involvement in provision of health insurance and healthcare services under the HPS will be further examined, having regard to the viability and sustainability of any proposition, the financial and regulatory implications for the Government, among other relevant considerations.	• A number of respondents pointed out that HPS depended on the support and participation of insurers and private healthcare service providers. To ensure the success of the HPS, some suggested that the Government should assume a more active and direct role, including direct provision of HPS plans and DRG-based packaged services on a level-playing field with other market participants.
Government Regulation	• The Standard Plan(s) will be standardized and supervised by the Government to safeguard consumer interests. A supervisory framework will be set up under HPS to protect consumers and safeguard their interests, enhance transparency and competition in private sector, and ensure the provision of quality-assured and value-for-money services.	• The consultation reflected strong public support for regulating private health insurance and private healthcare services. Most of the views received considered it important to put in place a regulatory regime to supervise the HPS. On the other hand, there were views cautioning against over-regulation.
Health Insurance Claims Arbitration/ Mediation Mechanism	• A dispute arbitration/mediation mechanism will be set up under HPS, in consultation with relevant stakeholders, to enhance consumer protection on claims disputes.	• Most of the views supported the setting up of a dispute arbitration/mediation mechanism. A few, however, suggested that claims disputes should more appropriately be handled by the existing regime in the industry.
Possible Incentive from Public Subsidy	• The provision of public subsidy, specifically the use of the $50 billion fiscal reserve earmarked to support healthcare reform, to provide financial incentives under HPS or for other purposes will be examined in connection with healthcare reform, having regard to the objectives of reform and other relevant considerations.	• There were mixed views on whether public subsidy should be provided to support the implementation of the HPS, and, if yes, for whom, for what and to what extent.

APPENDIX B MEETINGS OF PANEL ON HEALTH SERVICES OF LEGISLATIVE COUNCIL RELATED TO HEALTHCARE REFORM SECOND STAGE PUBLIC CONSULTATION

Date	Meeting
6 October 2010	Special Meeting, Panel on Health Services - Briefing by the Secretary for Food and Health on Healthcare Reform Second Stage Public Consultation Document
11 December 2010	Special Meeting, Panel on Health Services - Briefing by the Under Secretary for Food and Health on Healthcare Reform Second Stage Public Consultation Document
13 December 2010	Regular Meeting, Panel on Health Services - Briefing by the Under Secretary for Food and Health on Healthcare Reform Second Stage Public Consultation Document

The links to the notes of the meetings and the submissions of the deputations are available on the healthcare reform second stage website (http://www.MyHealthMyChoice.gov.hk).

APPENDIX C MEETINGS AND MOTIONS OF DISTRICT COUNCILS RELATED TO HEALTHCARE REFORM SECOND STAGE PUBLIC CONSULTATION

District Council	Date	Motion/Chairman's Conclusion/Meeting Conclusion
Central and Western	6 Jan 2011	Meeting Conclusion: The Vice Chairman agreed that Health Protection Scheme (HPS) could help a group of people, who were either retired or not eligible for private medical insurance, without affecting public medical resources. In long term, HPS could consolidate more resources for improving public medical service. In conclusion, most of the members who had spoken up were in support of HPS.
Eastern	17 Dec 2010	Motion Passed: "The Eastern District Council supported the government to implement the Health Protection Scheme in a 'voluntary and government-regulated' principle and also supported strengthening public healthcare service and at the same time improving the private healthcare market to ensure that all Hong Kong citizens no matter they used the public or private service, could receive the protection they should get; urged the government to continue consulting the views of the citizens so that the quality healthcare service of Hong Kong could develop on a sustained basis."
Islands	3 Jan 2011	Chairman's Conclusion: The Chairman concluded that members in general supported Healthcare Reform and the Health Protection Scheme.
Kowloon City	11 Nov 2010	Meeting Conclusion: Upon discussion, Members were generally in support of the main direction of the Government.
Kwai Tsing	11 Nov 2010	Chairman's Conclusion: Chairman concluded that consumer protection should be safeguarded within both public and private health insurance markets and quality healthcare service maintained to meet societal needs.
Kwun Tong	2 Nov 2010	Chairman's Conclusion: The Chairman concluded that Councillors were generally supportive of the Scheme premised on "voluntary participation" and "government regulation". It was hoped that the general public could be properly protected by both public and private healthcare services and the quality healthcare system in Hong Kong could continue to enjoy long-term sustainability.
North	9 Dec 2010	Chairman's Conclusion: Concluding the views of Members, the North District Council supported the Health Protection Scheme. It was hoped that the Food and Health Bureau would give careful consideration to Members' suggestions.
Sai Kung	12 Nov 2010	Motion Passed: "The Sai Kung District Council supported the Voluntary Health Protection Scheme to be regulated and monitored by the Government in the Healthcare Reform Second Stage Consultation Document."
Sha Tin	25 Nov 2010	Chairman's Conclusion: Members' response to the Health Protection Scheme was generally positive. They supported the general direction of the Scheme and made suggestions on the details of the Scheme for the FHB's consideration. The Chairman expressed thankfulness to Prof. Gabriel LEUNG and representatives from the FHB for briefing Members on the consultation paper and listening to Members' views.
Southern	18 Nov 2010	Meeting Conclusion: (i) Prof Gabriel M Leung JP remarked that insurance, like the "contribution" and "money-bidding" mechanism of traditional mutual aid committee, required participants to pool together resources to achieve risk-pooling. Food and Health Bureau (FHB) would disseminate this message through policy promotion and education, and hoped that Southern District Council, as a representative of public opinions, would explain the details of Health Protection Scheme (HPS) to residents and reflect their opinions and questions to HPS in return. Prof Leung appreciated Members' general support to the direction of HPS, and FHB would consider Members' suggestions on the details of HPS. (ii) The Chairlady agreed with Prof Gabriel M Leung JP, and she thanked Prof

District Council	Date	Motion/Chairman's Conclusion/Meeting Conclusion
		Leung and the two FHB representatives for joining the meeting. Because of time constraint, Members could raise questions, if any, to the FHB personnel concerned later on.
Sham Shui Po	2 Nov 2010	Chairman's Conclusion: The Chairman concluded that Members supported in principle the implementation of Health Protection Scheme (HPS) for voluntary participation with regulation by the Government. Members also welcomed Government's consideration in providing financial incentives to encourage the public to take part. It was believed that those joining HPS could obtain adequate medical protection. The Chairman hoped that the Government would listen to public views in the implementation of HPS.
Tai Po	4 Jan 2011	Chairman's Conclusion: The Chairman concluded that seven Members had just taken turn to speak and they generally approved of the main direction of the Health Protection Scheme (HPS) proposed by the government although they expressed concerns on various issues. They considered it was most important that the standard of existing public healthcare services was not affected by the HPS. Moreover, Members were concerned about the malpractices in the present health insurance market and urged the government to follow-up. Should Members still have any concerns after this meeting, they could air their opinions to the Food and Health Bureau (FHB) as the consultation period was not yet over. The Chairman believed that the FHB would seriously consider Members' views put forth at this meeting and take follow-up actions.
Tsuen Wan	30 Nov 2010	Chairman's Conclusion: Members in general supported the major direction of the Health Protection Scheme and urged the Government to reform private healthcare services and maintain quality of public medical services. Besides, Members appreciated the Government's efforts on promoting medical fees with packaged charging for common procedures, enhancing transparency of charging and strengthening its monitoring role.
Tuen Mun	2 Nov 2010	Chairman's Conclusion: The Chairman concluded that Tuen Mun District Council welcomed Healthcare Reform Second Stage Public Consultation which enabled Members to have a better understanding of the Scheme contained in the paper and facilitated their discussion. Some Members gave enormous support to the Scheme while some Members raised concerns. To sum up, the Chairman opined that the Government should take into consideration of views of Members and various sectors when formulating details in order to come up with a more comprehensive scheme.
Wan Chai	16 Nov 2010	Meeting Conclusion: The Vice Chairman concluded that Councillors generally agreed to the main direction of the scheme and were positive about it. Meanwhile, they gave some suggestions on the details of the scheme. Some Councillors raised that the Government might consider setting up an independent institute for medical insurance for the ease of mind of the public.
Wong Tai Sin	4 Jan 2011	Chairman's Conclusion: The Chairman thanked Prof. Gabriel LEUNG for attending the meeting, and commented that Members supported HPS in general. He requested FHB representatives to note and follow up on Members' views, and reminded Members that further comments on HPS might be addressed to Prof. LEUNG or FHB by 7 January 2011, the end of the consultation period.
Yau Tsim Mong	9 Dec 2010	Chairman's Conclusion: Councillors generally agreed with the direction of the voluntary medical insurance scheme. They requested the Administration to consider the need of grassroot groups and to maintain the quality of public healthcare services.
Yuen Long	9 Dec 2010	Meeting Conclusion: Members were generally supported of the Health Protection Scheme proposed by the Food and Health Bureau.

The links to the notes of the DC meetings, the motions passed and the concluding statement of the Chairmen/Meeting are available on the healthcare reform second stage website (http://www.MyHealthMyChoice.gov.hk)

APPENDIX D BRIEFING SESSIONS, FORUMS, SEMINARS AND OTHER EVENTS RELATED TO HEALTHCARE REFORM SECOND STAGE PUBLIC CONSULTATION

Date	Name of Organizations / Bodies / Events
7 October 2010	District Council Chairmen and Vice-Chairmen
	Democratic Alliance for the Betterment and Progress of Hong Kong (DAB)
	Hong Kong Academy of Medicine
	Forum organized by Food and Health Bureau (FHB) for Board Members and Senior Staff of Hospital Authority
10 October 2010	City Forum
14 October 2010	Standing Committee Meeting on Medical and Dental Facilities for Civil Servants
19 October 2010	The Hong Kong Retirement Schemes Association
	Business and Professionals Federation of Hong Kong
20 October 2010	Democratic Party (DP)
27 October 2010	Elderly Commission
30 October 2010	District forum organized by Tuen Mun Branch of DP
2 November 2010	Rotary Club of Hong Kong Northwest
	Seminar organized by Legislative Councillor Hon Paul Chan Mo-po
4 November 2010	Non-official Members of the Commission on Strategic Development
	Trade Practices Committee of the Consumer Council
9 November 2010	Hong Kong Joint Council for People with Disabilities
11 November 2010	The Chinese General Chamber of Commerce
14 November 2010	Society for Community Organization
15 November 2010	Forum organized by FHB for staff members, members of Hospital Governing Committees and Regional Advisory Committees of Hospital Authority (Hong Kong Island session)
	Hong Kong Professionals and Senior Executives Association
16 November 2010	Briefing organized by FHB for Staff Members of Department of Health
18 November 2010	Forum organized by FHB for local doctors and dentists
19 November 2010	Mainland-Hong Kong High Level Health Forum organized by Hospital Authority and Hong Kong Academy of Medicine
	Forum organized by FHB for local doctors and dentists
	District Forum organized by DAB New Territories West (Tsuen Wan) Branch
22 November 2010	District Forum organized by DAB Kowloon East (Kwun Tong) Branch
23 November 2010	Forum organized by FHB for staff members, members of Hospital Governing Committees and Regional Advisory Committees of Hospital Authority (Kowloon session)
	Hong Kong Association of the Pharmaceutical Industry
	District Forum organized by DAB North (Fanling) Branch
24 November 2010	Hong Kong College of Health Service Executives
	Women's Commission

Date	Name of Organizations / Bodies / Events
25 November 2010	Forum organized by FHB for Non Government Organizations (Welfare Groups) and patient groups
26 November 2010	Seminar on Healthcare Reform organized by Centre for Social Policy Studies, Department of Applied Social Sciences of The Hong Kong Polytechnic University
	Forum organized by FHB for Nursing and allied health associations
27 November 2010	Symposium on Healthcare Reform co-organized by The Professional Commons and Contemporary China Research Project, City University of Hong Kong
	Public Forum co-organized by Roundtable Community, Hong Kong ICC Lee Shau Kee School of Creativity and Kowloon City District Council
28 November 2010	Seminar on Healthcare Reform organized by Civil Force
29 November 2010	Forum organized by FHB for staff members, members of Hospital Governing Committees and Regional Advisory Committees of Hospital Authority (New Territories session)
30 November 2010	Civil Force Shatin and Sai Kung District Councillors
	Employers' Federation of Hong Kong
	Hong Kong Women Professionals & Entrepreneurs Association
	Community Forum organized by FHB (Kowloon and New Territories session)
2 December 2010	District Forum organized by DAB Kowloon West Branch
3 December 2010	The Hong Kong Island Federation
	District Forum organized by DAB Hong Kong Island Branch
7 December 2010	The American Chamber of Commerce in Hong Kong
	Zonta Clubs
8 December 2010	Community Forum organized by FHB (Hong Kong Island session)
9 December 2010	Community forum organized by Yan Chai Hospital Board Secretariat
	Exchange Session with Youth organized by the Commission on Youth
10 December 2010	Student Interview of Secretary for Food and Health
	District Forum organized by Joint Office of DP Lam Wai-kei, Wu Chi-wai and Li Wah-ming
11 December 2010	Public Forum organized by Power for Democracy
12 December 2010	District Forum organized by DP Kowloon West Branch
14 December 2010	Symposium on Healthcare Reform in Hong Kong organized by The School of Public Health and Primary Care of The Chinese University of Hong Kong, and sponsored by the Hong Kong Federation of Insurers
	General Agents and Managers Association of Hong Kong
18 December 2010	District Forum organized by Office of Emily Lau, Legislative Councillor and Office of Ray Au Chun Wah
	Public Policy Roundtable Forum on Medical Financing (co-organized by the Governance in Asia Research Centre, CityU and SynergyNet)
21 December 2010	Seminar on Healthcare Reform organized by the Hong Kong Council of Social Services

APPENDIX E LIST OF WRITTEN SUBMISSIONS RECEIVED IN HEALTHCARE REFORM SECOND STAGE PUBLIC CONSULTATION

Submissions from Organizations

Serial No. 序 號	Name 名 稱
O001	Bank of China Group Insurance Company Limited
O002	BSc in Physiotherapy Program, Department of Rehabilitation Science, The Hong Kong Polytechnic University
O003	Bupa (Asia) Limited
O004	Business and Professionals Federation of Hong Kong
O005	Chinese Medicine Society, Medical Society, Hong Kong University Students' Union
O006	CIGNA Worldwide Life Insurance Company
O007	Consumer Council
O008	Department of Family Medicine and Primary Care, the University of Hong Kong
O009	Employers' Federation of Hong Kong
O010	Equal Opportunities Commission
O011	Healthcare Policy Forum
O012	Hong Kong Academy of Medicine
O013	Hong Kong Civic Association
O014	Hong Kong College of Community Medicine
O015	Hong Kong College of Health Service Executive
O016	Hong Kong College of Orthopaedic Surgeons
O017	Hong Kong College of Radiologists
O018	Hong Kong Democratic Foundation
O019	Hong Kong Dental Association
O020	Hong Kong Doctors Union
O021	Hong Kong General Chamber of Commerce
O022	Hong Kong Private Hospital Association
O023	Hong Kong Psychogeriatric Association
O024	Hong Kong Women Doctors Association
O025	Hong Kong Women Professionals & Entrepreneurs Association
O026	Hospital Authority
O027	HSBC Insurance
O028	Institute of Financial Planners of Hong Kong
O029	Kidney Diseases Prevention and Treatment Group, YTM Community Network, The Hong Kong Medical Association
O030	Police Force Council Staff Associations
O031	School of Public Health and Primary Care, The Chinese University of Hong Kong and The Hong Kong Federation of Insurers
O032	Swiss Reinsurance Company Limited
O033	The Family Planning Association of Hong Kong
O034	The Government Doctors' Association
O035	The Hong Kong College of Family Physicians
O036	The Hong Kong Confederation of Insurance Brokers
O037	The Hong Kong Federation of Insurers

Serial No. 序 號	Name 名 稱
O038	The Hong Kong Geriatrics Society
O039	The Hong Kong Medical Association
O040	The Hong Kong Retirement Schemes Association
O041	The Hong Kong Society for Rehabilitation
O042	The Life Underwriters Association of Hong Kong Limited
O043	The Practising Pharmacists Association of Hong Kong
O044	United Christian Nethersole Community Health Service
O045	Zonta Club of Hong Kong II
O046	Zonta Club of Kowloon
O047	107 動力
O048	三十會
O049	公民力量
O050	公共專業聯盟
O051	公務員醫療及牙科福利聯席
O052	民主黨
O053	民主黨大埔工作隊
O054	民主黨黃大仙黨團
O055	民建聯
O056	民建聯大埔支部
O057	民建聯黃大仙支部
O058	明愛九龍社區中心
O059	東九龍居民委員會
O060	東華三院
O061	社會保障學會
O062	長期病患者關注醫療改革聯席
O063	政府紀律部隊人員總工會
O064	香港人壽保險經理協會
O065	香港人權監察
O066	香港大學中醫全科學士(全日制)校友會
O067	香港大學公共衛生學院
O068	香港大學專業進修學院中醫同學會
O069	香港女障協進會
O070	香港工會聯合會
O071	香港工業總會
O072	香港中華廠商聯合會
O073	香港中華總商會
O074	香港公立醫院心臟醫生協會
O075	香港民主民生協進會
O076	香港西北區扶輪社
O077	香港私人執業專科醫生協會
O078	香港社區組織協會及香港老人權益聯盟
O079	香港社會服務聯會
O080	香港保險中介人商會
O081	香港科研製藥聯會
O082	香港風濕病基金會
O083	香港哮喘會
O084	香港弱智人士家長聯會

Serial No. 序 號	Name 名 稱
O085	香港特區政府公務僱員總工會
O086	香港脊醫學會
O087	香港退休公務員福利聯誼會
O088	香港骨髓移植復康會
O089	香港健康網絡及 Baby 親子雜誌
O090	香港基督教協進會社會公義與民生關注委員會
O091	香港基督教服務處
O092	香港專業及資深行政人員協會
O093	香港復康聯盟
O094	香港註冊中醫學會
O095	香港傷殘青年協會
O096	香港愛滋病基金會
O097	香港義肢矯師協會
O098	香港聖公會麥理浩夫人中心
O099	香港聖公會福利協會
O0100	香港醫院藥劑師學會
O0101	香港醫務委員會執照醫生協會
O0102	香港護士協會
O0103	香港護理學院
O0104	病人互助組織聯盟
O0105	基督教香港信義會長者綜合服務「天地男兒協會」
O0106	救世軍油麻地長者社區服務中心長者政策關注小組
O0107	連心社
O0108	博愛醫院
O0109	智經研究中心
O0110	港九勞工社團聯會
O0111	善愿會
O0112	腎友聯
O0113	新力量網絡
O0114	新界社團聯會
O0115	新論壇
O0116	經濟動力
O0117	維社
O0118	醫保計劃 青年關注組
O0119	醫療政策評議會
O0120	關注長者權益大聯盟
O0121	關社大使
O0122	關懷香港
O0123	關懷愛心互助組

Copies of the written submissions are available on the healthcare reform second stage website (http://www.MyHealthMyChoice.gov.hk).

Remarks:
There are two submissions which the originators have requested confidentiality.

Submissions from Individuals

Serial No 序 號	Name 名 稱
I001	(The sender requested anonymity) (來信人要求以不具名方式公開)
I002	Frenda Lau
I003	關心醫療的小香港人
I004	Rudolf Frei
I005	Thomas Un
I006	Benedict CHEUNG
I007	Irfan Ali Awan
I008	Wilson Yu
I009	Robert Kemp
I010	Perica Chan
I011	Perica Chan
I012	Abid Khan
I013	Lau Hau To Nelson
I014	(The sender requested anonymity) (來信人要求以不具名方式公開)
I015	Lee
I016	朱先生
I017	Roger Houghton
I018	(The sender requested confidentiality)
I019	Chau Chi Ki
I020	Lau dan Chu
I021	陳詠恩
I022	Raphael Yan
I023	Elizabeth Yong
I024	羅先生
I025	毛錦源
I026	Mangie Wong
I027	CHAN CHOI NGOR
I028	Elton
I029	Mr Yip
I030	Cecilia Tam
I031	(The sender requested anonymity) (來信人要求以不具名方式公開)
I032	李國明先生
I033	Anton
I034	謝
I035	Yuen Wing Sze Maggie
I036	Joan Chan
I037	Samson Tang
I038	李先生
I039	Crystal
I040	(Name not provided) (沒有署名)
I041	CHOW Kin Leung
I042	Li Pok lai Stephen
I043	陳小姐
I044	Michael
I045	Elton
I046	anna Yen
I047	Dr Donny Tang
I048	何小姐
I049	Cheng
I050	Joe
I051	Helen Chu
I052	Judy Yuen
I053	黃麗蓮
I054	Andy

Serial No 序 號	Name 名 稱
I055	mr lee
I056	David Lai
I057	潘國平
I058	Wong Yeung Hoi
I059	Edward Cheng
I060	(The sender requested confidentiality)
I061	陳小姐
I062	Dr H P Chow
I063	A Hong Kong Citizen
I064	(The sender requested confidentiality)
I065	期望病者也可得到幸福的人
I066	Tang citizen
I067	Arisa
I068	陳澤龍
I069	莫煜光
I070	莫煜光
I071	陳志國
I072	Vin
I073	Dr. LIU Kai Ling
I074	Peter Poon
I075	陳小遠
I076	Chan Kwing Lam
I077	余濟珍
I078	Alex Shum
I079	S C Tang
I080	羅日光
I081	Kevin Harman
I082	Li Soo Kuen
I083	Dr. Ng Wai Chung
I084	Leung Kwok On
I085	W C Wong
I086	ck
I087	A Hong Kong Citizen
I088	ncwken
I089	A Hong Kong Citizen
I090	Jerry Chanson
I091	CHAN EVA
I092	Matthew Tang
I093	大多數市民意願
I094	Leo
I095	choi wing hong
I096	patrick chan
I097	monny
I098	Winnie Chow
I099	Amy Xu
I100	(Name not provided) (沒有署名)
I101	Wong Pak Hoi
I102	Vicky Cheng
I103	Herbert Michael
I104	Cyrus
I105	Ms Chan
I106	Mandy Chu
I107	Dr Walter W K King
I108	簡翰祥
I109	Dr Lawrence Fan
I110	Ivan Yuen
I111	中華基督教青年會中學中五級同學

Serial No 序 號	Name 名 稱
I112	Alice Kung
I113	趙沛恆
I114	P C Leung
I115	(The sender requested anonymity) (來信人要求以不具名方式公開)
I116	Peter KONG
I117	劉志康
I118	Ka Lok YUEN
I119	Ms Leung
I120	Forest K C Wong
I121	Mr. Yuen Kwok Ki
I122	市民
I123	Chan K Y
I124	ST
I125	Patrick Lau
I126	陳卓華
I127	(Sender's name cannot be ascertained) (未能確定來信人署名)
I128	畢先生
I129	Alan Wong
I130	Ozwell E. Spencer
I131	(Name not provided) (沒有署名)
I132	蔡少娟
I133	(Sender's name cannot be ascertained) (未能確定來信人署名)
I134	一市民
I135	(The sender requested anonymity) (來信人要求以不具名方式公開)
I136	陶候
I137	陳惠娟, 黃毅
I138	Kenneth K W Lam
I139	wingwing
I140	Ed Ng
I141	Au Lap Keung
I142	六十歲的市民
I143	Ambrose Chan
I144	william
I145	Sylvia Wong
I146	方成彬
I147	Chung Hing Pui
I148	沙田區議員黃嘉榮、梁家輝
I149	K S Jong
I150	L N
I151	CHOW CHI HANG
I152	Allen Cheung
I153	Michael HO Sung Hon
I154	Lau Hin Yiu
I155	狄香苓
I156	Timmy
I157	Ma Tai Sang
I158	王耀文
I159	一名普通的永久居民
I160	Henry Naw
I161	Poon SH
I162	Jessica Chau
I163	Jamie Wong
I164	黃國樑
I165	Liu Chih Yang
I166	(Name not provided) (沒有署名)
I167	范國輝
I168	Diane
I169	Miss Leung
I170	Wendy Leung
I171	Kathleen
I172	蘇小姐
I173	Sky Ma
I174	Ken
I175	Kimberly J. Schaudt
I176	Nicole Chan
I177	peter
I178	Alison Tam
I179	Cho Lun Wong
I180	李先生
I181	W.C. Shum
I182	Anne Tong
I183	林成龍
I184	市民
I185	一名未老先需的人
I186	Pang Ching Lam, Lucy
I187	甘先生
I188	Jon-Alvan Yap
I189	(The sender requested anonymity) (來信人要求以不具名方式公開)
I190	suky yan
I191	(The sender requested anonymity) (來信人要求以不具名方式公開)
I192	S.C. Tang
I193	MS. LAM
I194	Joy Al-Sofi
I195	A HKSAR Citizen
I196	蕭昆明
I197	K.C. Lim
I198	黃炎強
I199	Felix Lo
I200	Awongwc
I201	Andy
I202	judy yuen
I203	邱小姐
I204	希望得到好的醫療人
I205	立法會議員李國麟
I206	黃大仙(瓊富)區議員胡志偉
I207	李松光
I208	Francis Liu
I209	FGG
I210	T. K. Cheung
I211	Dorcas Lau
I212	Mr .Lam
I213	朱賢文
I214	Agnes Ng
I215	HL
I216	fion
I217	Cathy Lau
I218	Jo McBride
I219	Lau Jackie Choi Hung
I220	hk2carrie
I221	顧迺英
I222	潘大永
I223	寶覺中學中四學生
I224	CC Ha
I225	香港市民伍先生

Serial No 序 號	Name 名 稱
I226	Lei Yan Kit
I227	楊慶材
I228	Michael Ng
I229	廖女士
I230	無名士
I231	陳偉森教授
I232	張元興
I233	howard
I234	陳志國
I235	Dr Anthony C T Leung
I236	Edward Cheng
I237	S. F. Ho
I238	Stanley Wong
I239	Chan Yik Chuen
I240	May Li
I241	(The sender requested anonymity) (來信人要求以不具名方式公開)
I242	Dr. LAM Tzit Yuen David
I243	廖錦添
I244	Linda Lee
I245	Prof Su Liu
I246	李國平
I247	黃建良
I248	Cheung
I249	Mr YUEN
I250	黃文傑
I251	蔡鴻寧
I252	SYL
I253	蔡志鋒
I254	Zoron Tsang
I255	馬國偉
I256	(The sender requested anonymity) (來信人要求以不具名方式公開)
I257	香港中文大學醫學院院長霍泰輝
I258	papaya milk
I259	中產人仕
I260	KAI WYN
I261	O Szeto
I262	張展智
I263	撰寫新聞稿的發言人鄭先生
I264	Li Nga Mei
I265	何栢綸
I266	Chow Hung Yu
I267	CHAU Yuen Lam
I268	張子俊
I269	李傑輝
I270	林秀玉
I271	(The sender requested anonymity) (來信人要求以不具名方式公開)
I272	May
I273	CHAU YUK SIM
I274	Kate Leung
I275	Chan On Chun
I276	鄒崇銘
I277	Ethan Chan
I278	Lee Ka Lai
I279	Wong Kwok Kee
I280	Ms. Lau
I281	LEE Lak See
I282	Wilson Chan
I283	(Name not provided)

Serial No 序 號	Name 名 稱
	(沒有署名)
I284	王安然
I285	謝偉明
I286	Clara
I287	何心愉
I288	吳國鏘
I289	Alfred KW Lai
I290	Peter Ho
I291	sze leunh ho
I292	Michael Keung
I293	Eric Tse
I294	六位中五學生的意見
I295	Diana (代表一群長期病患者)
I296	李慧明
I297	Kenneth
I298	俞小姐
I299	Dicky Wong
I300	(The sender requested anonymity) (來信人要求以不具名方式公開)
I301	Maria Lai
I302	Du Yuk Wing
I303	西貢區議員 陳繼偉
I304	香港一群長者
I305	王海怀
I306	yiu yuk ching
I307	Nick Lau
I308	Tung
I309	WAN CHI SHING
I310	邱先生
I311	一群柏金遜症病人
I312	Danny Ho
I313	Miss Wong
I314	畢劍華
I315	Lam Carman
I316	Gabriel Chu
I317	Fan, Kelvin Chung Cheung
I318	Shum Kinwai
I319	CT Hung
I320	Danny
I321	David Wong
I322	Paul Wong
I323	Prof David R Phillips
I324	Venus Wong
I325	陳耿新註冊中醫,劉美余註冊中醫
I326	wong sau fan
I327	香港市民
I328	(The sender requested anonymity) (來信人要求以不具名方式公開)
I329	Helen Parker
I330	羅先生
I331	方麗華
I332	Colin Campbell
I333	(The sender requested anonymity) (來信人要求以不具名方式公開)
I334	社民連立法會黃毓民議員
I335	Dr. Alvin CY Chan
I336	Yu Keung Peter Sze
I337	woon han tse
I338	冼競齊
I339	梁大衛
I340	劉梁秋萍

Serial No 序 號	Name 名 稱
I341	Bonnie Leung
I342	蘇敏婷
I343	張廷海
I344	Ho Tak On
I345	李玲玲
I346	一市民
I347	Wu Wai Yee
I348	張健明
I349	Mr. Donald LUI Po-ying
I350	灣仔區議員麥國風
I351	Keith
I352	40 orthopaedic surgeons
I353	麥子文
I354	YAU TAK HIM
I355	伍先生
I356	Li Kwong Wing
I357	Dr. WONG Yee Him
I358	Tai Ming Hin Gary
I359	Ng Chung
I360	香港永久公民
I361	Miss Yip
I362	Augustus Lau
I363	Lau Chun Wai
I364	(The sender requested anonymity) (來信人要求以不具名方式公開)
I365	CHU Wing-hong
I366	(The sender requested anonymity) (來信人要求以不具名方式公開)
I367	Dr. Mary Kwong
I368	梁希倫
I369	Kelvin Ling

Serial No 序 號	Name 名 稱
I370	Choi Ka Man
I371	Mercy Li
I372	Wong Yee
I373	Harvey Pong
I374	woon han tse
I375	heart
I376	不願公開姓名或電郵的市民
I377	Barry Mok
I378	李先生
I379	Dr Anthony K Y Lee
I380	Ching Yi Fung
I381	香港市民
I382	(Name not provided) 沒有署名
I383	David Todd
I384	(Sender's name cannot be ascertained) (未能確定來信人署名)
I385	I law
I386	C.S.TSUI
I387	吳富兒
I388	何女士
I389	Albert
I390	香港一市民
I391	Fan Yee Han
I392	鄧豔琪
I393	Fiona Chan
I394	Fiona Chan
I395	ann chan
I396	甘榮佳
I397	劉先生

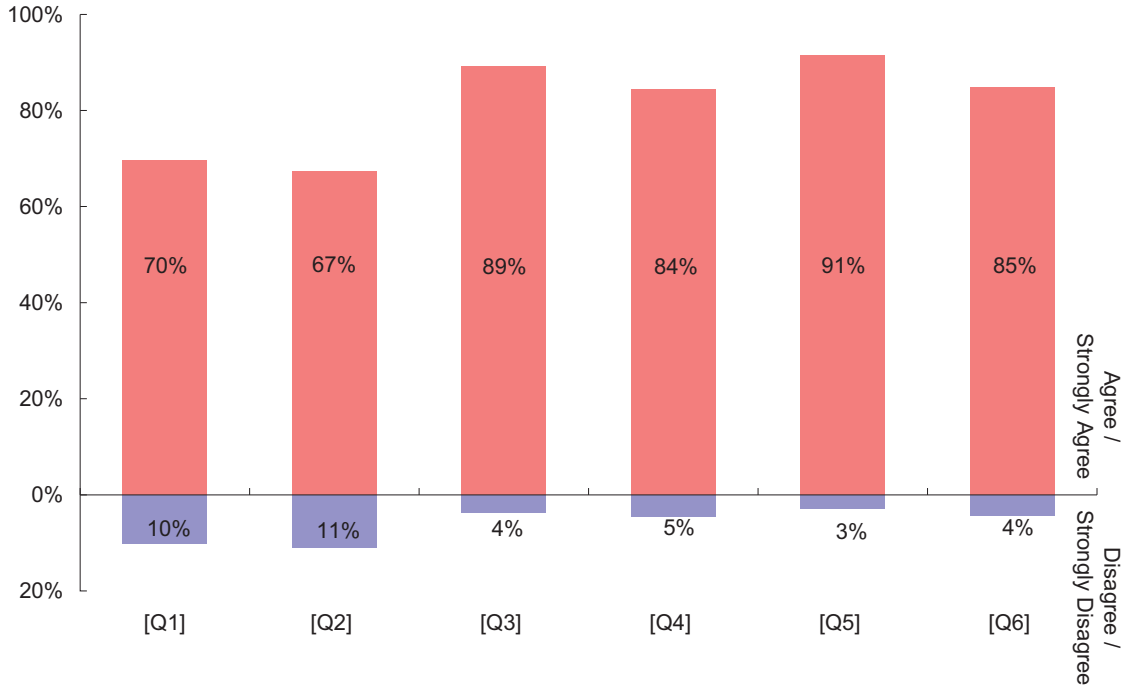
Copies of the written submissions are available on the healthcare reform second stage website (http://www.MyHealthMyChoice.gov.hk).

Remarks:
There are 42 submissions which originators have requested confidentiality.

APPENDIX F SURVEY 1 – SUMMARY OF KEY FINDINGS
PUBLIC OPINION SURVEY ON SUPPLEMENTARY HEALTHCARE FINANCING

The Food and Health Bureau commissioned Consumer Search Hong Kong Limited to conduct a Public Opinion Survey on Supplementary Healthcare Financing to survey the public's views on the healthcare financing reform, particularly on the proposals for the Health Protection Scheme, as a voluntary supplementary financing scheme put forward in the second stage public consultation on healthcare reform. The survey was conducted via telephone interviews during November 2010 to April 2011, and a total of 5 021 persons were successfully interviewed. Questions covered a sample from at least 2 000 to 5 021 respondents. Please refer to the healthcare reform second stage website (http://www.MyHealthMyChoice.gov.hk) for the full report on this opinion survey.

Figure 1 Views on Reform and Regulation of Private Healthcare Insurance and Private Healthcare Services



[Q1] Do you agree that the Government should encourage using private healthcare services for those who could afford it, such that public healthcare services could better focus on serving the low-income families, disadvantaged groups and people with severe illness?

[Q2] Do you agree that the Government should provide assistance to those who had taken out private health insurance so that they could continue to pay the premium and use private healthcare services in their old age, so as to relieve the burden on public healthcare services?

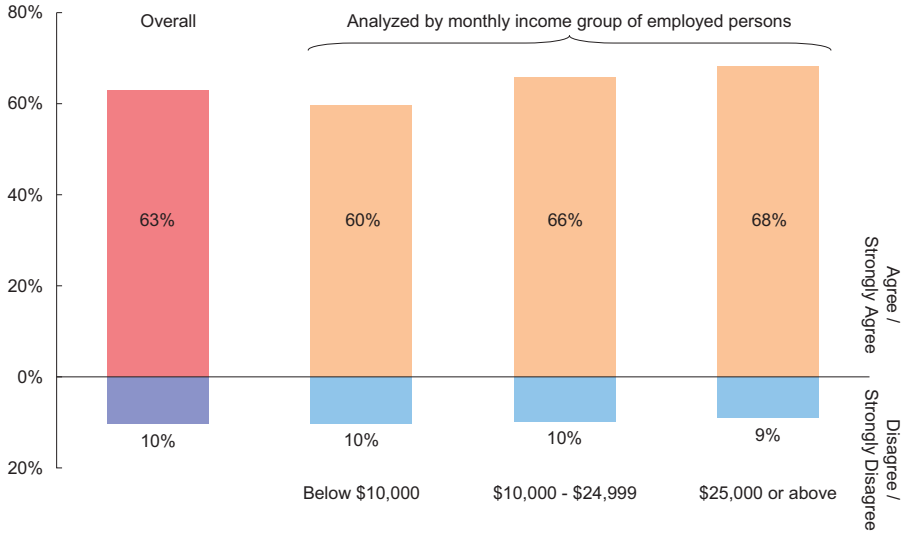
[Q3] Do you agree that the Government should regulate private health insurance in order to provide better protection to the consumers?

[Q4] Do you agree that the Government should enhance competition and transparency of the private health insurance market?

[Q5] Do you agree that the Government should regulate private healthcare service in order to provide better protection to the consumers?

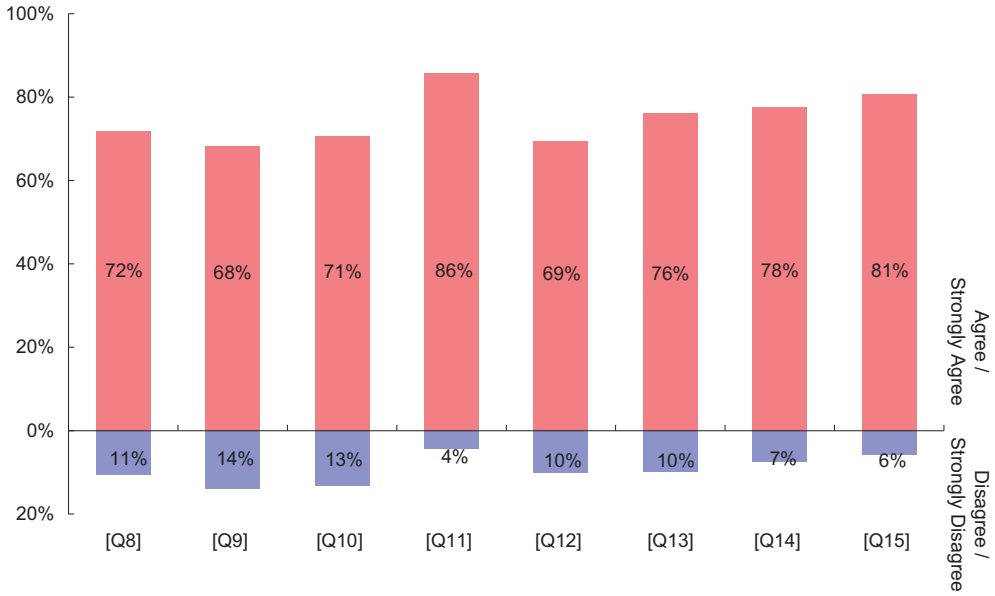
[Q6] Do you agree that the Government should enhance competition and transparency of the private healthcare service market?

Figure 2 Views on Implementing Health Protection Scheme



[Q7] (Introduction: The Government proposed the setting up of a voluntary Health Protection Scheme, in which private health insurance and private healthcare services would be standardized and regulated by the Government in order to provide voluntary private health insurance to the public with the aforementioned objectives.) Do you agree that the Government should implement the Health Protection Scheme for voluntary participation?

Figure 3 Views on Design of Health Protection Scheme



Do you agree that under the Health Protection Scheme, insurance companies should comply with the following requirements?

[Q8] No turn-away of subscribers and guaranteed renewal for life

[Q9] To cover the pre-existing medical conditions of the insured after the required waiting period

[Q10] The premium loadings for high-risk subscribers should not be higher than the prescribed upper limit of the Scheme

[Q11] Subscribers could change insurance companies or they would remain insured on switching jobs, leaving employment or upon retirement, and their original coverage and no-claim discount could be carried over

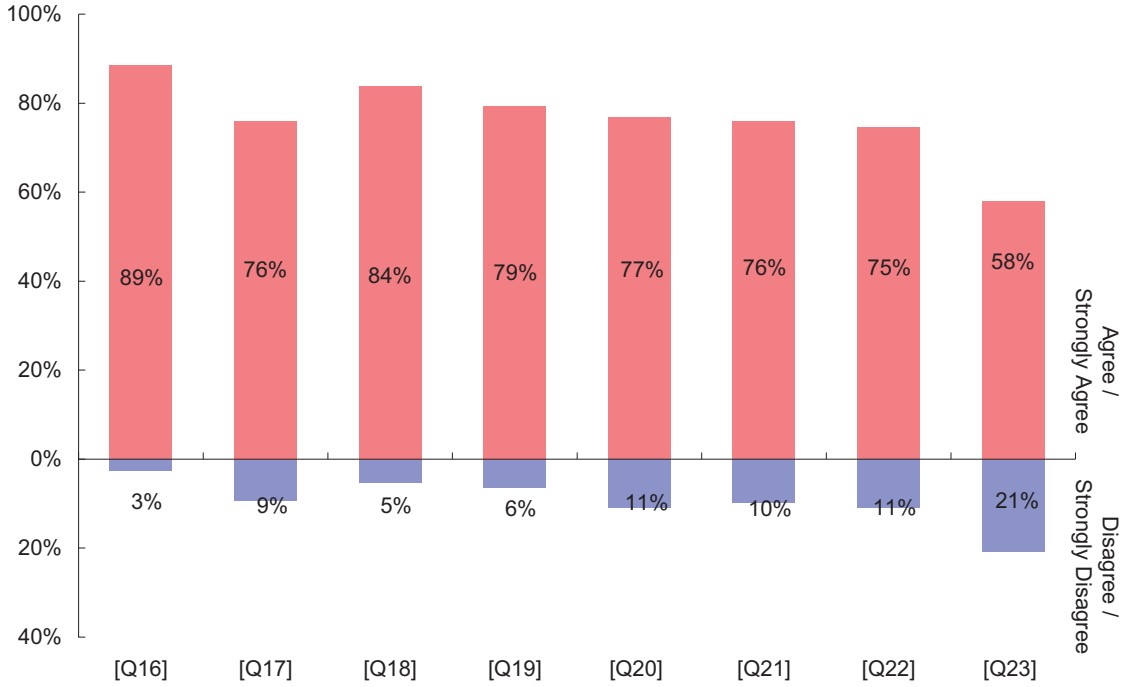
[Q12] To list out the premium for different age groups and make reference to the premium adjustment guidelines for any change in the premium schedule

[Q13] To offer specified no-claim discounts to the subscribers

[Q14] To submit to the Government all information on insurance costs, including claims, commissions, administrative fees and other expenses, as well as information on profits

[Q15] To standardize the definitions, terms and conditions of the insurance policies in order to minimize any argument arisen from claims

Figure 4 Views on Supporting Infrastructure for Health Protection Scheme



Do you agree that under the Health Protection Scheme, the Government should take the following actions?

[Q16] To establish a medical claims arbitration mechanism for handling any complaints arising from claims in order to protect the rights of the insured

[Q17] To introduce packaged charging for private healthcare services so that the public could estimate the total medical charges to be paid when they use private healthcare services

[Q18] To stipulate that the insurance industry should set up a risk pooling mechanism for the claims of high risk persons, such as those with chronic disease, so that they could be insured while the premium for other insured persons would not be raised substantially

[Q19] To legislate for regulating the premium and profit margin of the participated insurance companies

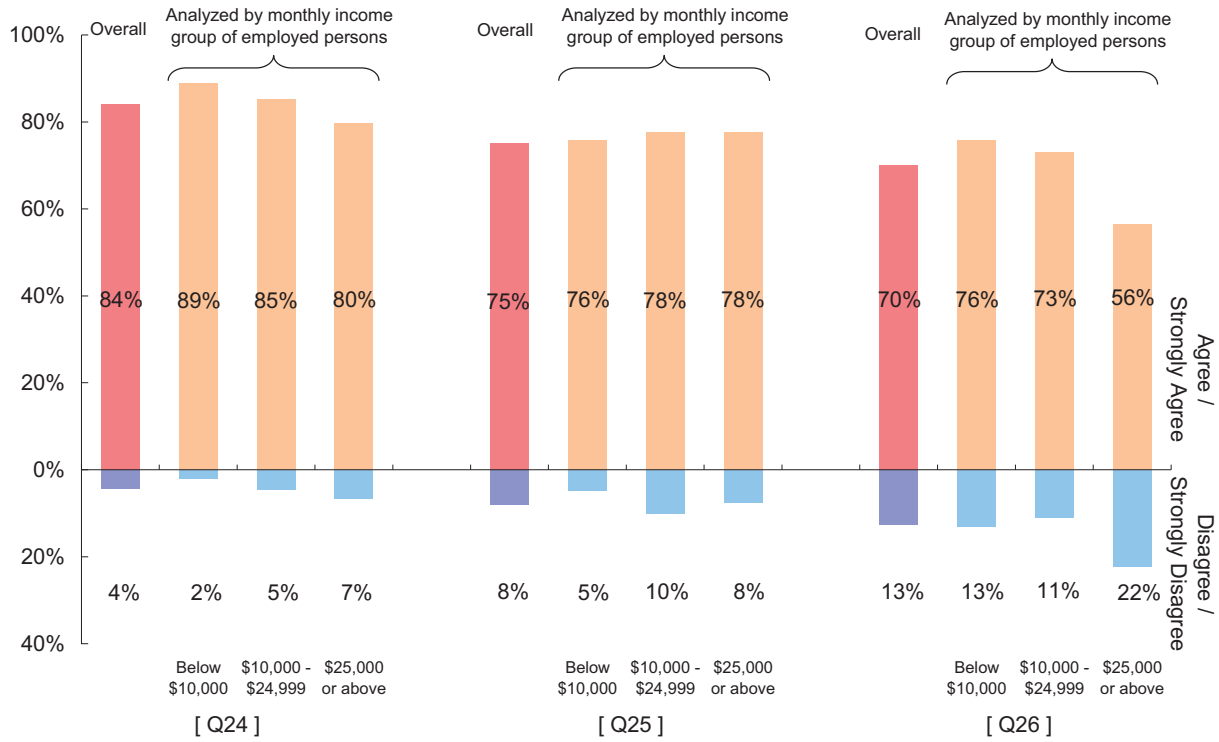
[Q20] To legislate for regulating the medical charges of private hospitals and medical practitioners

[Q21] The Government to provide health insurance if insurance companies could not provide healthcare insurance products that meet the requirements of the Health Protection Scheme

[Q22] The Government to provide private beds and healthcare services if private hospitals and medical practitioners could not provide sufficient healthcare services with packaged charging

[Q23] Do you agree that the Government should require the insured who have received incentives under the Health Protection Scheme to save for paying premium in their old age

Figure 5 Views on Public Subsidy for Different Groups of People to Join the Health Protection Scheme



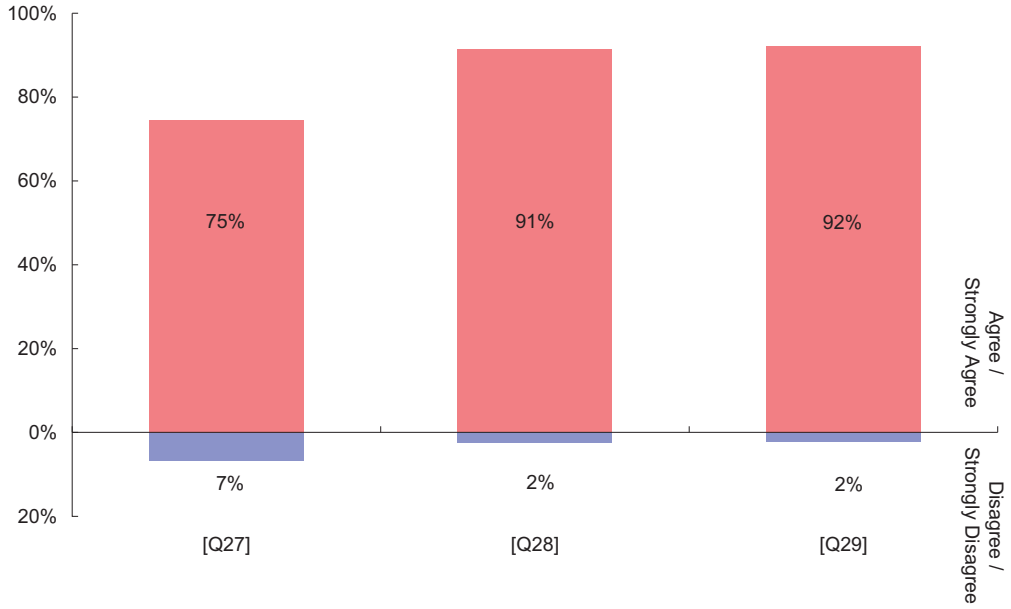
Do you agree that under the Health Protection Scheme, the Government should provide subsidy to the following groups of people?

[Q24] To subsidize the elderly subscribers on their premium, and the amount of subsidy to be provided in their old age should be proportional to the length of staying insured under the Scheme

[Q25] To subsidize the high-risk subscribers on their premium so that the premium of other subscribers would not be substantially increased arising from their participation

[Q26] To subsidize the first-time subscribers during the first few years

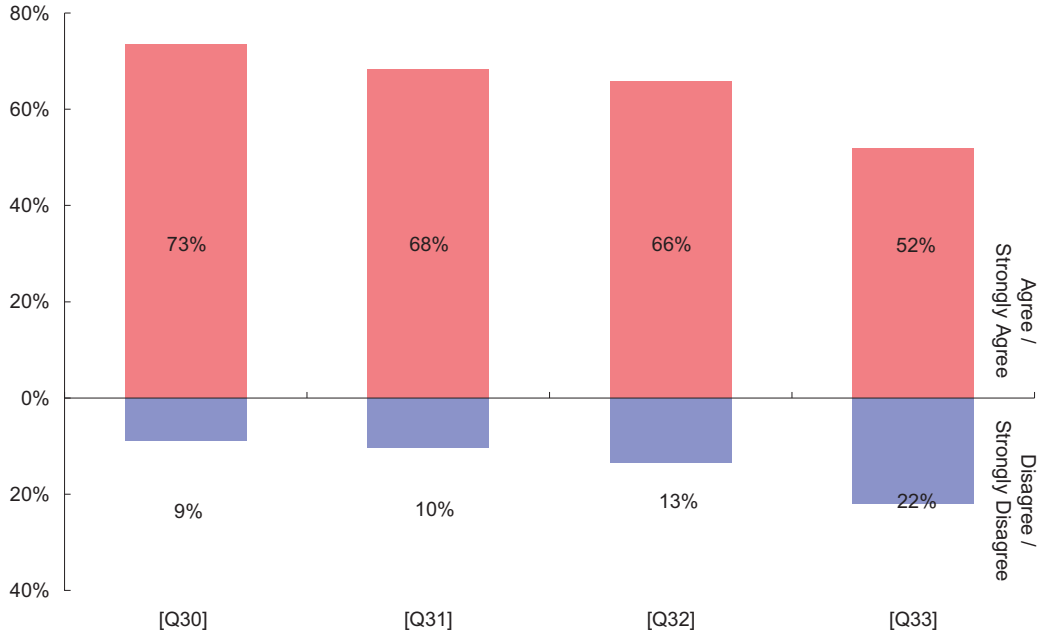
Figure 6 Views on Health Capacity and Manpower



Do you agree with the Government on increasing the following three items in order to support the implementation of the Health Protection Scheme?

[Q27] Hospital beds in private hospitals
[Q28] Overall manpower of doctors
[Q29] Overall manpower of nurses

Figure 7 Views on Widening Sources of Manpower

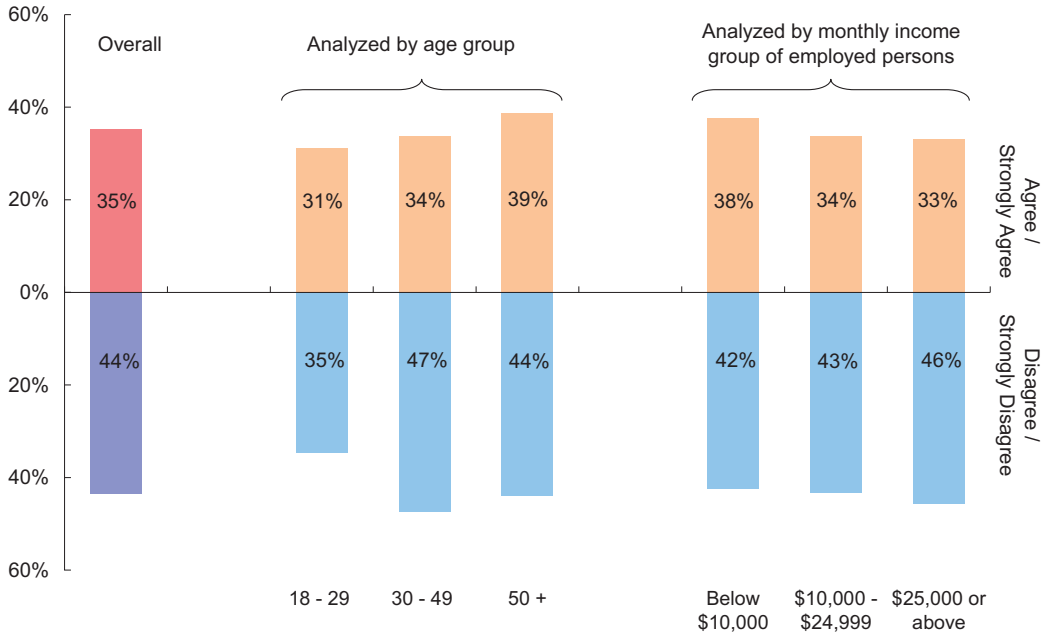


[Q30] Do you agree that the Government should allow specialist doctors from places outside Hong Kong, through accreditation, to practise in Hong Kong in order to increase the manpower of doctors?

Do you agree that the Government should allow the following types of people, after passing the accreditation requirements, to practise in hospitals in Hong Kong in order to increase the manpower of doctors?

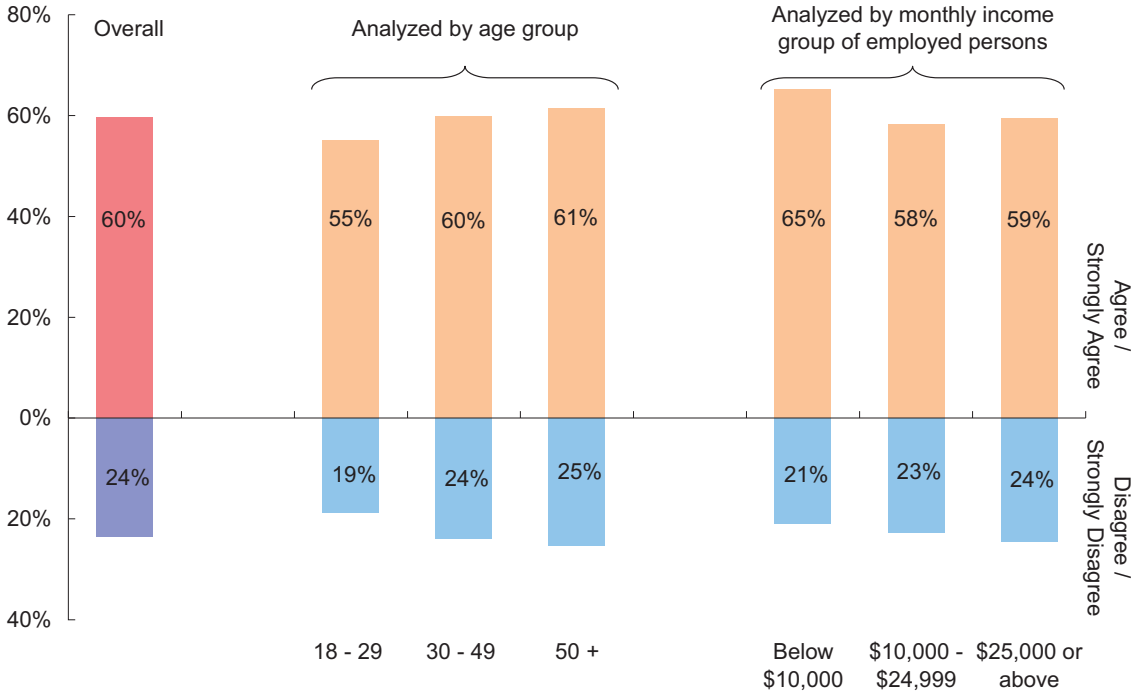
[Q31] Hong Kong residents who had acquired overseas specialist qualification
[Q32] Specialist doctors from places other than the mainland of China
[Q33] Specialist doctors from the mainland of China

Figure 8 Views on Increasing Tax to Fund Public Healthcare



[Q34] Do you agree that the Government should increase tax as a means to increase public health funding to ensure adequate resources for providing the public healthcare services?

Figure 9 Views on Increasing User Fees of Public Healthcare Services



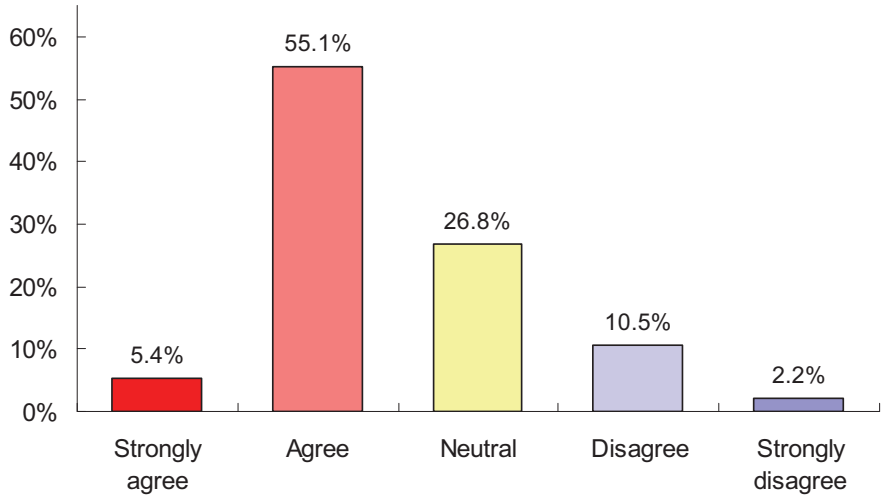
[Q35] Do you agree that the Government should increase the user fees for the public healthcare services and use the money to subsidize the low-income families, disadvantaged groups and people with severe illness?

APPENDIX G SURVEY 2A – SUMMARY OF KEY FINDINGS
MEDICAL STAKEHOLDERS' OPINION RESEARCH ON HEALTH PROTECTION SCHEME

The Food and Health Bureau commissioned the School of Public Health and Primary Care, the Chinese University of Hong Kong in December 2010 to conduct a study to collect and analyze the views of stakeholders from the medical sector on the proposed Health Protection Scheme (HPS) and its related measures as set out in the healthcare reform second stage consultation document. Both quantitative method, a postal survey (Survey 2A), and qualitative method, focus group discussions (Focus Group 2B), were adopted in the study. This appendix presents some key findings of the postal survey (1,100 completed questionnaires received). For more details about study findings and methodology, please see the full reports of the postal survey and focus group study on the healthcare reform second stage website (http://www.MyHealthMyChoice.gov.hk).

A. HPS Objectives

Figure 1 Agreement/disagreement rates on the objectives of HPS

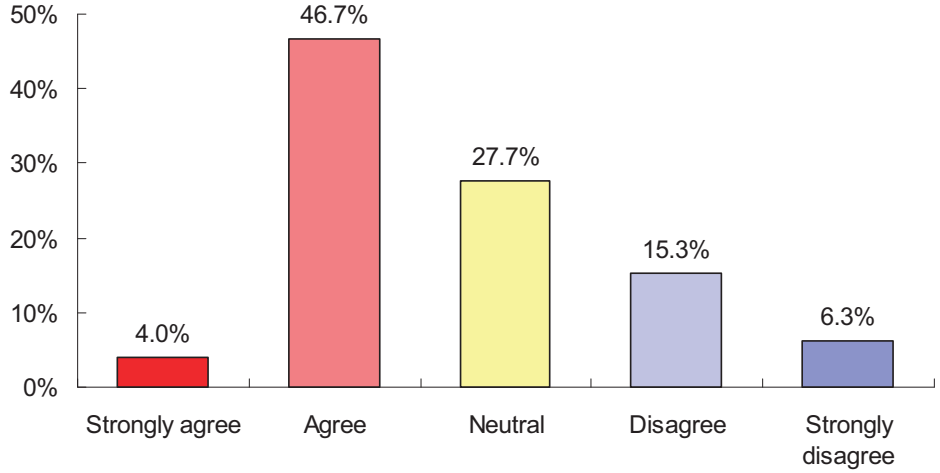


Q: Do you agree with the objectives of HPS as stated in the enclosed material?

B. Diagnosis-related groups (DRG)-Based Charging

(i) Feasibility of DRG-based charging

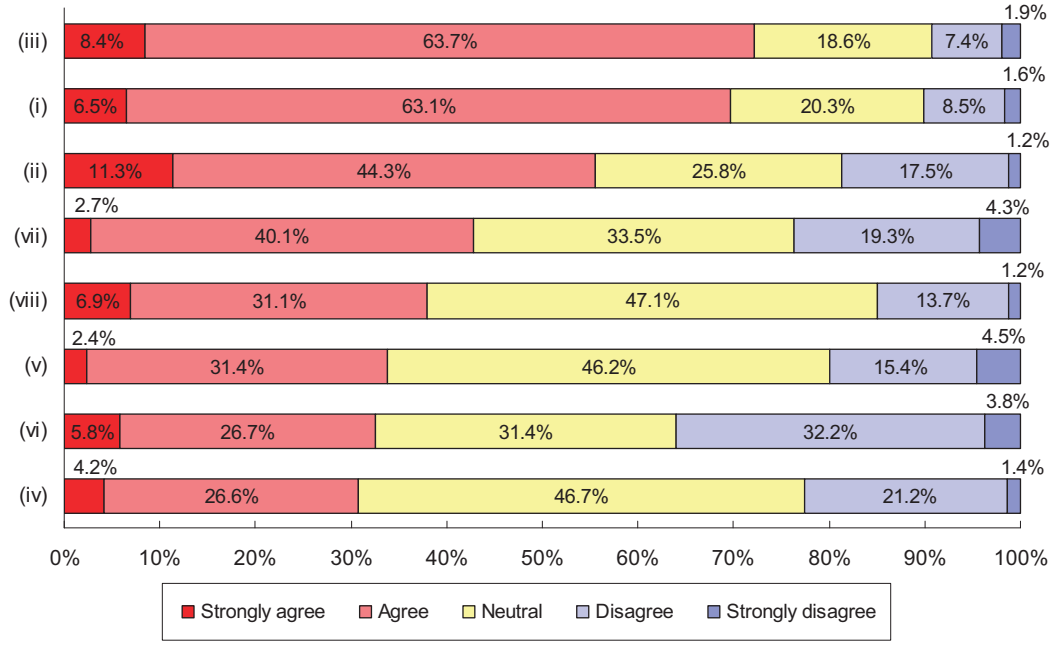
Figure 2 Agreement/disagreement rates on feasibility for healthcare providers to set their charges for common treatment or procedures based on DRG



Q: Do you agree that it is feasible for healthcare service providers to set their charges for common treatment or procedures based on DRG as described in the enclosed material?

(ii) Possible impacts of DRG-based charging

Figure 3 Agreement/disagreement rates on the possible impacts of DRG-based charging

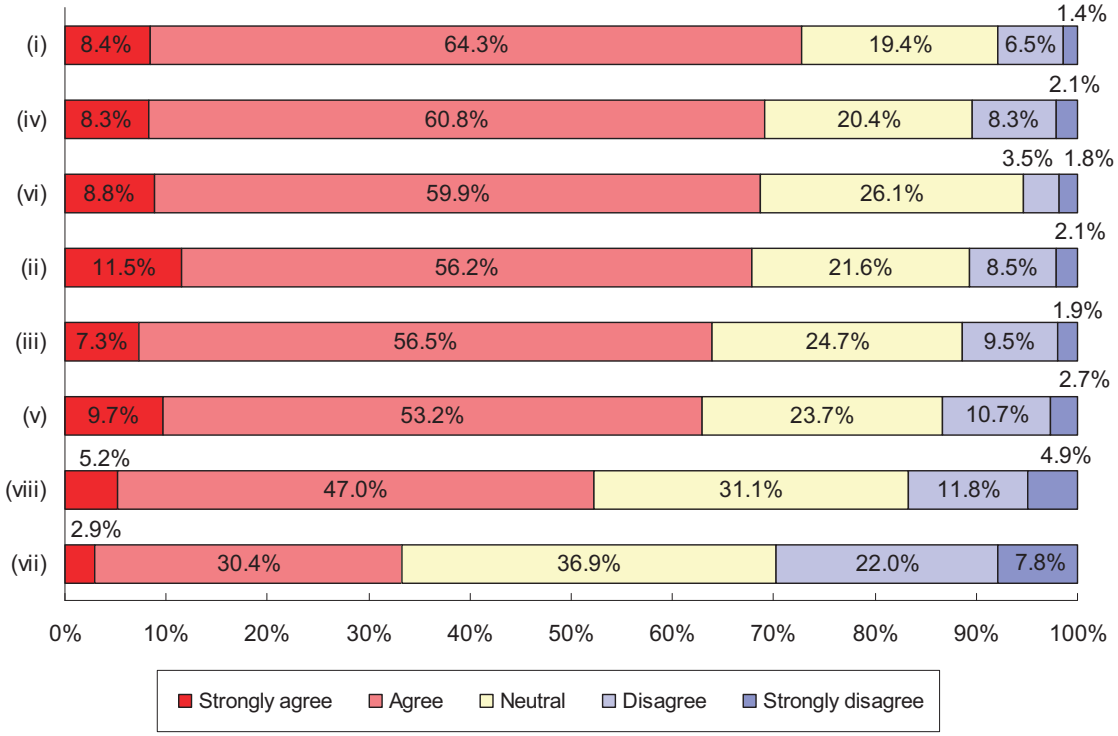


Q: Do you agree that DRG-based charging would lead to the following?

(i) Increase certainty of private healthcare charges
(ii) Reduce professional autonomy of private doctors
(iii) Increase price transparency and competitiveness of clinical practice in the private healthcare sector
(iv) Reduce the income of private healthcare providers
(v) Facilitate the development of team-based care in line with global best practice
(vi) Compromise the quality of care that private doctors are able to provide for patients
(vii) Reduce claim disputes and associated administrative burden to private healthcare providers
(viii) Reduce the bargaining power of private doctors with admission rights versus that of private hospitals

C. Regulatory Measures

Figure 4 Agreement/disagreement rates on regulatory measures which the Government may take to enhance transparency, increase competition and ensure quality of private healthcare services

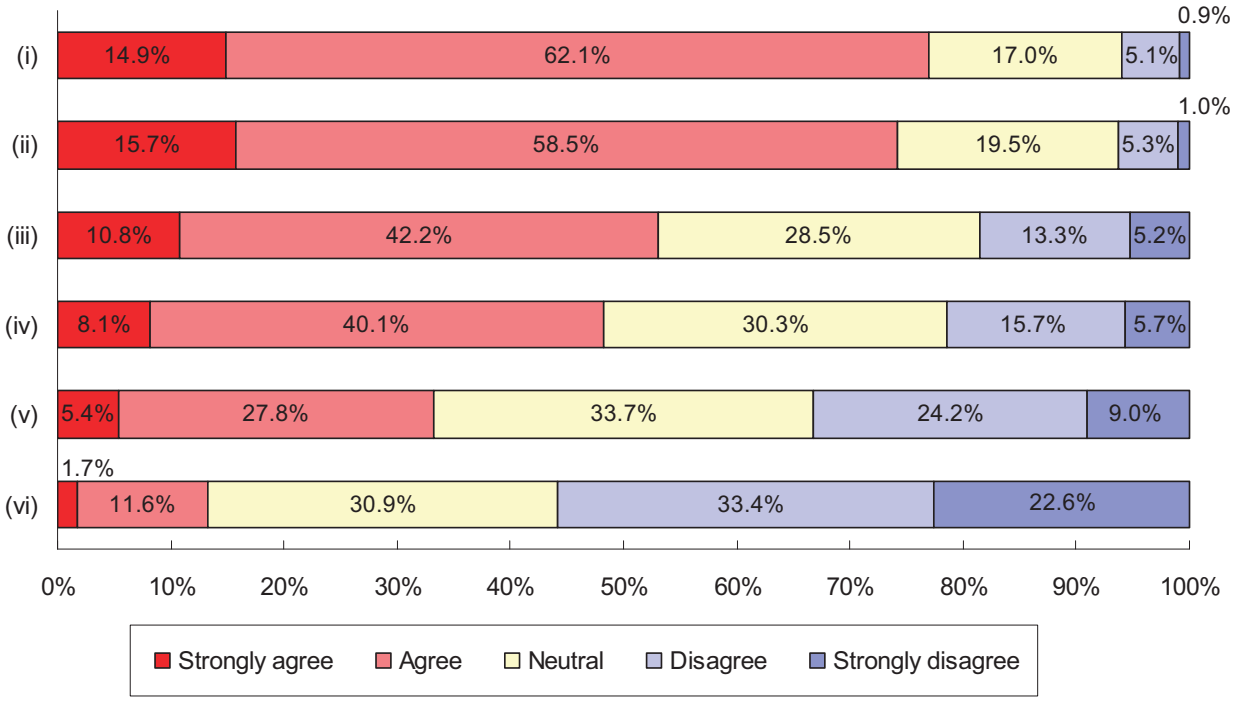


Q: Do you agree with the following regulatory measures which the Government may take to enhance transparency, increase competition and ensure quality of private healthcare services?

(i) Improve collection, collation and dissemination of statistics and data associated with patient care and outcomes
(ii) Require hospital accreditation as a licensing condition of private hospitals
(iii) In line with global practice, require peer review or clinical audits of healthcare services to be undertaken by clinicians
(iv) Collect and publish price and services statistics of private healthcare services
(v) Publish costs of equivalent public healthcare services alongside prices of private healthcare services for comparison
(vi) Establish a statutory mechanism for health insurance claims arbitration
(vii) Enhance lay representation on the Medical Council
(viii) Establish a statutory Medical Ombudsman for handling medical complaints, disputes and incidents

D. Infrastructure and Manpower

Figure 5 Agreement/disagreement rates on measures which the Government may take to enhance supply of private healthcare services



Q: Do you agree with the following measures which the Government may take to enhance supply of private healthcare services?

(i) Increase number of beds in existing private hospitals
(ii) Increase number of private hospitals
(iii) Increase local doctor training quota
(iv) Attract qualified specialists who are Hong Kong residents and trained outside Hong Kong to practise in Hong Kong
(v) Attract qualified specialists trained outside Hong Kong (except Mainland China) to practise in Hong Kong
(vi) Attract qualified specialists trained in Mainland China to practise in Hong Kong

APPENDIX H SURVEY 3A – SUMMARY OF KEY FINDINGS
CONSUMER MARKET RESEARCH ON THE HEALTH PROTECTION SCHEME

The Food and Health Bureau commissioned Consumer Search Hong Kong Limited to conduct a Consumer Market Research on the Health Protection Scheme (HPS) in order to collect and analyze the views of consumers on the design of the proposed HPS as set out in the healthcare reform second stage consultation document. Both quantitative method, a telephone survey (Survey 3A), and qualitative method, focus group discussions (Focus Group 3B), were adopted in the study. This appendix presents some key findings of the telephone survey (a random sample of 2,000 persons were successfully interviewed). For more details about study findings and methodology, please see the full reports of the telephone survey and focus group study on the healthcare reform second stage website (http://www.MyHealthMyChoice.gov.hk).

Table: Ranking in preference towards selected key features of the HPS

	Features	% of respondents viewing the feature attractive or very attractive	% of respondents viewing the feature unattractive or very unattractive
1	Guaranteed acceptance of enrolment and renewal for life	64.3%	13.6%
2	Barrier-free portability	61.2%	14.6%
3	Coverage of pre-existing medical conditions subject to waiting period	56.0%	15.1%
4	Acceptance of high-risk individuals to be financed by premium loading at a maximum of 200% and a High-Risk Pool industry reinsurance mechanism	53.4%	16.9%
5	DRG-based packaged charging as the basis of setting insurance benefit levels	52.7%	13.8%
6	No-claim discount for premiums (up to 30%)	47.9%	18.3%
7	Greater transparency for premium adjustment by requiring insurers to report all costs, claims and expenses	47.3%	15.0%
8	Establishment of a Government regulated health insurance claims arbitration mechanism	45.2%	17.3%
9	Standardized health insurance policy terms and definitions	43.2%	18.5%
10	Acceptance of old-age enrolees above 65 without cap on premium loading in the first year of HPS implementation	39.6%	25.6%

Health Protection Scheme

Published by the Food and Health Bureau
Printed by the Government Logistics Department
Hong Kong Special Administrative Region Government