For discussion **FCR(2012-13)58**
on 7 December 2012

ITEM FOR FINANCE COMMITTEE

HEAD 37 – DEPARTMENT OF HEALTH
Subhead 700 General non-recurrent
Item 887 Health Care Voucher Pilot Scheme

Members are invited to approve an increase in the annual amount of Elderly Health Care Voucher from $500 to $1,000 per eligible elder with effect from 1 January 2013.

PROBLEM

We need to enhance the Elderly Health Care Voucher Pilot Scheme (Pilot Scheme) to render it more effective in providing primary care services to elders in Hong Kong.

PROPOSAL

2. The Secretary for Food and Health proposes to enhance the Pilot Scheme by increasing the annual voucher amount from $500 to $1,000 per eligible elder with effect from 1 January 2013.

JUSTIFICATION

The Pilot Scheme

3. Following funding approval by the Finance Committee (FC), the Pilot Scheme was initially launched on 1 January 2009 for a period of three years to try out a new concept of enhancing the provision of primary care service for the elderly. It aims to supplement existing public healthcare services (e.g. General Out-patient and Specialist Out-patient Clinics) by providing financial incentive for elders to choose private healthcare services that best suit their needs, including preventive care. It is in addition to the existing public healthcare services,

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which will continue to be made available to elders after the introduction of Elderly Health Care Voucher. By encouraging elders to seek consultation and establish a closer relationship with private doctors who are familiar with their health conditions, it also helps promote the concept of family doctor.

4. Under the Pilot Scheme, an elder aged 70 or above holding a Hong Kong Identity Card is eligible to receive $250 each year in health care vouchers (in the form of vouchers of $50 each) - and $500 under the extended Pilot Scheme starting from 1 January 2012 - to subsidise their use of multi-disciplinary care services provided by various private healthcare professionals. They include medical practitioners, Chinese medicine practitioners, dentists, nurses, occupational therapists, physiotherapists, radiographers, medical laboratory technologists and chiropractors. Starting from 1 January 2012, this has also been expanded to include optometrists with Part I registration under the Supplementary Medical Professions Ordinance (Cap. 359) to facilitate the greater use of preventive care services concerning eye conditions by the elderly. The vouchers are not allowed to be used for purchase of drugs at pharmacies or medical items, or meeting the fees and charges for public healthcare services.

5. Health care vouchers are handled electronically through the eHealth System[1] developed for this purpose. To provide greater flexibility for eligible elders to choose the healthcare services that meet their needs, there is no limit on the number of vouchers that an elder may use for each visit to a participating healthcare service provider or on the type of services for which the voucher may be used. In addition, the Pilot Scheme allows voucher users to accumulate any unspent voucher amount up to the end of the first three-year pilot project period (i.e. a maximum of $750 ($250 x 3) if an elder has not spent any amount during the period from 1 January 2009 to 31 December 2011), and with the extension of the Pilot Scheme for three years, a maximum unspent voucher balance of $2,250 ($250 x 3 + $500 x 3) by the end of 2014.

6. As at the end of October 2012, over 3 500 healthcare service providers, including about 1 580 medical practitioners, have enrolled in the Pilot Scheme. About 460 000 elders (or about 64% of the eligible elders) have made use of the vouchers with about 2.3 million claim transactions at a cumulative expenditure of about $327.5 million (counting from the beginning of the first phase of the Pilot Scheme). The Pilot Scheme has provided incentive for the elderly to seek private healthcare services that best meet their needs.

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[1] The eHealth System was purposefully designed for the Pilot Scheme to provide an electronic platform on which participating healthcare service providers can manage the registration of eHealth accounts for the elderly and handle reimbursement of health care vouchers. It has become an efficient platform to facilitate the development of public-private partnership, and has been enhanced and expanded to incorporate the Elderly Vaccination Subsidy Scheme and the Childhood Influenza Vaccination Subsidy Scheme.

Proposed enhancements

Increasing the annual voucher amount

7. Response from the elderly and the private healthcare service providers to the Pilot Scheme so far is generally positive. There have been calls from different quarters of the community to increase the voucher amount. In response to this, the Chief Executive made a pledge in his election manifesto to raise the voucher amount to $1,000 per year. The Administration further announced on 16 July 2012 our plan to increase the voucher amount with effect from 1 January 2013.

8. The proposed increase in voucher amount would help widen the choice of affordable healthcare services for the elderly particularly in preventive care and provide a greater incentive for them to use private healthcare services in their neighbourhood.

Long-term funding arrangements

9. The Pilot Scheme launched since 2009 has given us useful experience and feedback which is conducive to assessing the response of the elderly community, and fine-tuning the administrative arrangement for the long-term implementation of the Scheme. Having regard to the positive response to the Pilot Scheme, as well as its effectiveness on promoting private sector participation, and provision of more choice in healthcare services for the elderly, we plan to convert the voucher scheme into a recurrent support programme for the elderly. When the Scheme is run on a recurrent basis, we anticipate that more healthcare service providers will join and hence there will be more clinics and service providers, like Chinese medicine practitioners, accepting health care vouchers for elders to choose within their neighbourhood community.

10. The current Pilot Scheme allows voucher users to accumulate any unspent voucher amount during the pilot period i.e. a maximum of $2,250 (see paragraph 5 above). Once the Scheme has been converted into a recurrent funding programme, we will continue to allow the unspent part of the vouchers to be carried forward and accumulated by an eligible elder, subject to a ceiling of $3,000. There will be no restriction on the number of years that an elder may carry forward the unspent voucher amount but the cumulative total as at 1 January each year cannot exceed $3,000. By doing so, we can also encourage elders to make more frequent use of the vouchers for primary care services, not only for curative services but also preventive care support, including services provided by Chinese medicine practitioners, dentists, chiropractors, etc.

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Monitoring and evaluation

11. The Department of Health (DH) has put in place measures and procedures for checking and auditing voucher claims to ensure proper disbursement of public monies in handling reimbursements. These include routine checking, monitoring and investigation of aberrant patterns of transactions and, where necessary, investigation of complaints. By the end of October 2012, DH has conducted about 5 000 inspection visits, and checked over 89 000 reimbursement claims (or 3.9% of the transactions made). The checking covers 88.4% of the enrolled healthcare service providers with the claims made, and has identified 66 anomalous cases involving about 1 500 claims (or 1.7% of the checked claims). These cases were mostly related to minor errors in procedures or documentation. DH will continue to conduct post-claim checking and auditing to ensure proper use of public monies and, where necessary, take appropriate follow-up actions.

12. We have enhanced the data-capturing functions of the eHealth System since 1 January 2012 to step up monitoring over the use of health care vouchers, such as by requiring participating healthcare service providers to input the co-payment amount made by an elder for each consultation, in addition to the number of health care vouchers used. We will continue to monitor the operation of the Scheme, as well as feedback from elders and service providers, with a view to introducing improvements in different aspects, including service scope, eligibility, and administrative support for individual healthcare service providers (e.g. Chinese medicine practitioners) as appropriate.

Promotion and publicity

13. Subject to Members' approval of the above proposal, DH will inform the relevant professional bodies and healthcare service providers about the proposed enhancements and related arrangements. To further encourage utilisation and provision of primary healthcare services, DH will step up publicity to encourage more healthcare service providers to enroll in the Scheme and eligible elders to use the vouchers, in particular the use of vouchers for preventive care. Specifically, promotional activities will be launched in early 2013 which will include broadcasting television and radio announcements of public interest, distributing posters and leaflets through public clinics and hospitals, elderly centres, residential care homes for the elderly, etc. Poster campaign at malls of various public housing developments will also be launched.

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FINANCIAL IMPLICATIONS

14. As at the end of October 2012, the cumulative expenditure for voucher reimbursement amounted to $327.5 million. On the basis of the estimated total population of around 723 500 elders aged 70 or above, the maximum expenditure for providing vouchers at an annual value of $1,000 to all eligible elders is estimated to be $723.5 million for 2013 (i.e. doubling the maximum of $361.75 million for providing vouchers at an annual value of $500) which could be absorbed from within the unspent balance of the approved non-recurrent commitment ($1,210.43 million out of $1,537.93 million) for the Pilot Scheme.

15. As regards the longer-term funding arrangements, starting from 2014, the voucher expenditure will be included in the Estimates of the relevant years. Assuming a progressive increase in take-up rate[2] from 70% in 2013 to 90% in 2017 and onwards, and utilisation rate[3] of 67.5% as in the Pilot Scheme, the maximum expenditure and estimated cash flow requirement for providing annual vouchers at $1,000 for all eligible elders are as follows –

	2013	**2014**	**2015**	**2016**	**2017**	**2018**
(A) Maximum expenditure for providing $1,000 for each eligible elder based on elderly population projection ($m)	723.5	737.0	750.8	767.3	799.8	835.6
(B) Estimated take-up rate	70%	75%	80%	85%	90%	90%
(C) Adjusted requirement for participating voucher users [(A) x (B)] ($m)	506.5	552.8	600.6	652.2	719.8	752.0
(D) Estimated cash flow requirement based on utilisation rate of 67.5% [(C) x 67.5%] ($m)	341.9	373.1	405.4	440.2	485.9	507.6

The actual annual expenditure will depend on the take-up and utilisation rates which are expected to increase as the vouchers become more popular as a result of enhanced publicity and promotion over the years.

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[2] Referring to the percentage of eligible elders who will participate in the Scheme and use vouchers. As mentioned in paragraph 6 above, the take-up rate as at the end of October 2012 is about 64%.

[3] Referring to the percentage of vouchers claimed by participating elders out of their voucher entitlement. The utilisation rate for the first three-year pilot period (i.e. January 2009 to December 2011) is 67.5%.

16. On staffing, DH has established a dedicated Health Care Voucher Unit since 2008 to oversee the administration and implementation of the Pilot Scheme. The Unit comprises seven civil service non-directorate posts and ten non-civil service contract staff positions at a total cost of $7.2 million in 2012-13. We estimate that the same level of manpower resources will be required after the Pilot Scheme is converted into a recurrent programme.

PUBLIC CONSULTATION

17. We consulted the Panel on Health Services on 19 November 2012. Panel Members indicated support for the proposal to be submitted to FC. Panel Members also suggested the Administration to consider lowering the eligible age from 70 to 65 to enable more people to benefit from the Scheme. The Administration will need to assess the longer-term financial sustainability of the Scheme, the response of the eligible people and the participation rate after the proposed increase of the annual voucher amount and the Pilot Scheme has been converted to a recurrent support programme.

18. Panel Members also asked the Administration to consider measures to enable more healthcare service providers to join the Scheme so as to facilitate and enable more eligible elderly to use the vouchers. The Administration undertook to do more publicity and provide more support and facilitation to encourage more service providers such as Chinese medicine practitioners to participate in the Scheme. Noting the findings from an interim review completed in 2011, a few Members suggested that the Administration should conduct a more in-depth assessment of the Scheme's effectiveness e.g. how the vouchers alter the healthcare seeking behaviour of the elderly. We will initiate a further review of the Scheme after the enhancement measures have been implemented and sufficient experience has been accumulated.

BACKGROUND

19. On 20 June 2008, Members approved a non-recurrent commitment of $505.33 million vide FCR(2008-09)33 for launching the Pilot Scheme as a three-year programme, under which elderly people aged 70 or above would be given annually health care vouchers of $250. In addition, Members approved a commitment of $30 million for the development and maintenance of the eHealth System. On 24 June 2011, Members approved vide FCR(2011-12)31 an increase in the commitment by $1,032.6 million for extending the Pilot Scheme for three years up to the end of 2014. The annual voucher amount for an eligible elder was also increased from $250 to $500.

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20. According to the Hong Kong Population Projections 2012-2041 published by the Census and Statistics Department, the number of elders aged 70 or above is forecast to be about 723 500 in 2013 and increase to 967 500 by 2021 and 2 036 100 by 2041.

Food and Health Bureau
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