For discussion
on 19 November 2012

Legislative Council Panel on Health Services

Enhancements to the Elderly Health Care Voucher Pilot Scheme

PURPOSE

This paper seeks Members' views on the proposed enhancements to the Elderly Health Care Voucher Pilot Scheme (Pilot Scheme).

BACKGROUND

2. Following approval of the Finance Committee (FC) in June 2008 for a non-recurrent commitment of $505.33 million, the Pilot Scheme was launched on 1 January 2009 as a three-year project 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. 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.

3. In June 2011, FC approved an increase in the commitment by $1,032.6 million for extending the Pilot Scheme for three years up to end-2014. The annual voucher amount for an individual eligible elder was also increased from $250 to $500.

4. 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.

SCHEME OPERATION

5. 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 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.

6. To facilitate administration and control as well as to promote the use of information technology in healthcare management, all health care vouchers are handled electronically through the eHealth System[1] developed for this purpose. An eligible elder needs only to make a simple registration and open a voucher account through any healthcare service provider who has participated in the Pilot Scheme. Elder can then use the voucher to settle payment to the service provider (and other participating service providers) and check the voucher balance.

7. Healthcare service providers who wish to participate in the Pilot Scheme are required to first register with the Department of Health (DH) through the electronic platform of the eHealth System. Upon registration, they are given a Scheme logo and are required to display it at their premises for easy identification by elders. They will also be given a username, password and security token for accessing the eHealth System, helping first-time voucher users to register, checking the voucher balance of elders, submitting information to DH on consultation/treatment provided, deducting vouchers against service payment, and obtaining monthly statements and individual transaction records. Service providers are reimbursed of the vouchers deducted on a

[1] The eHealth System was purposefully designed for the Pilot Scheme in 2008, providing 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.

monthly basis. 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 end-2014.

8. As at end-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 relatively high take-up rate has demonstrated that the Pilot Scheme has provided incentive for the elderly to seek private healthcare services that best meet their needs, which will in turn help lessen the burden on the public healthcare sector.

PROPOSED ENHANCEMENTS

(A) Increasing the annual voucher amount

9. The Pilot Scheme has proved to be well received by the elderly and the private healthcare service providers. 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 starting from 1 January 2013.

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

(B) Long-term funding arrangements

11. The Pilot Scheme launched since 2009 has given us useful experience and feedback in assessing the response of the elderly community and fine-tuning the administration arrangement for the long-term implementation of the scheme. Having regard to the positive response to the Pilot Scheme and that it can promote private sector participation as well as provide the elderly with more choice in healthcare services, we plan to convert the voucher scheme from a pilot project into a recurrent support programme for the elderly.

12. 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 7 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 including both curative and preventive care.

MONITORING AND EVALUATION

13. DH has put in place procedures for checking and auditing voucher claims to ensure proper disbursement of public monies for voucher reimbursement. This includes routine checking, monitoring and investigation of aberrant patterns of transactions, and where necessary investigation of complaints. By end-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 of 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 such post-claim checking and auditing to ensure proper use of public monies and where necessary, take appropriate actions.

14. 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 e.g. requiring participating healthcare service

providers to input the co-payment made by an elder for each consultation, in addition to the number of health care vouchers used. We will continue to monitor the scheme operation and feedback from elders and service providers and introduce improvements as appropriate.

PROMOTION AND PUBLICITY

15. Subject to FC's approval, 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. Specifically, promotional activities will be launched in early 2013 which will include broadcasting television and radio announcements of public interests, 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.

FINANCIAL AND STAFFING IMPLICATIONS

16. As at end-October 2012, the cumulative expenditure for voucher reimbursement amounted to $327.5 million. We estimate that after increasing the annual voucher amount from $500 to $1,000 per eligible elder, an additional funding of $361.75 million is required in 2013, which could be absorbed from within the approved non-recurrent commitment for the Pilot Scheme.

17. As regards the long-term funding arrangements, taking into account the take-up rate of elders and the utilisation rate of vouchers under the Pilot Scheme, as well as the ageing population, the annual cash flow requirement is estimated to be about $370 million in 2014-15, which is expected to increase to around $500 million by 2018-19. Starting from 2014, the voucher expenditure will be reflected in the Estimates of the relevant years.

18. 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. We estimate that the same level of manpower resources will be required after the Pilot Scheme is converted into a recurrent programme at an annual estimated cost of $7.2 million.

19. Subject to views of Members, we will seek approval from the FC later this year on the proposed increase in the annual voucher amount to $1,000 per eligible elder with effect from 1 January 2013 under the existing non-recurrent commitment. We will also inform the FC of the long-term funding arrangements for the scheme as set out in paragraphs 11 and 12 above.

ADVICE SOUGHT

20. Members are invited to give their views on the proposed enhancements to the Pilot Scheme as set out in this paper.

Food and Health Bureau
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