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Panel on Health Services

Updated background brief prepared by the Legislative Council Secretariat for the meeting on 19 November 2012

Elderly Health Care Voucher Pilot Scheme

Purpose

This paper gives an account of the past discussions by the Panel on Health Services ("the Panel") on the Elderly Health Care Voucher Pilot Scheme ("the Pilot Scheme").

Background

2. The Administration launched the Pilot Scheme in January 2009 for three years up to December 2011. The Pilot Scheme aimed to implement the "money follows patient" concept through providing health care vouchers to elderly people for the purchase of primary health care services in their own communities, thereby piloting a new model for subsidized primary care services in the future. The Pilot Scheme provided five health care vouchers of $50 each to elderly people aged 70 or above per year for three years up to December 2011. In 2010, the Administration conducted an interim review to assess the effectiveness of the Pilot Scheme. Having regard to the findings of the interim review, the Administration extended the Pilot Scheme for another three years from January 2012 to December 2014. It also increased the number of vouchers from five to 10 and the value of vouchers from $250 to $500 per year during the extended pilot period.

3. The operation of the Pilot Scheme remains the same in the extended pilot period. Vouchers unused each year can be retained and carried forward to the extended pilot period until 31 December 2014. Vouchers are issued and used through an electronic health care voucher system ("the eHealth System") for preventive care and curative services only. They cannot be used for the purchase of drugs at pharmacies or other medical items, nor can they be used for the payment of subsidized public health care services. Eligible elders can use the vouchers by showing their Hong Kong identity cards ("HKIDs") and undergoing a simple registration process at the practices of the participating private health care service providers.

Deliberations of the Panel

4. The Panel held four meetings between 2007 and 2011 to discuss the scope and implementation of the Pilot Scheme. The deliberations and concerns of members are summarized below.

Eligible age for receiving health care vouchers

5. Members were of the view that the scope of the Pilot Scheme should be extended to elderly people aged 65 or above, having regard to the fact that the eligible age for receiving the Old Age Allowance was 65 or above. They expressed disappointment at the Administration's proposal of maintaining the eligible age for health care vouchers at 70 or above in the extended pilot period. There was also a suggestion that the eligible age should be lowered to 60 which was the general retirement age in Hong Kong.

6. The Administration advised that as the implementation of the "money follows patient" concept through the Pilot Scheme was new, it was necessary to proceed with caution by confining the Pilot Scheme to a smaller scale and a smaller population group as a start. Overseas experience also showed that private health care providers might increase their fees and charges if the government provided substantial subsidies for private health care services on a large scale. In this connection, the Administration considered it prudent to continue the Pilot Scheme with the existing pool of eligible elderly and further test the effectiveness of the Pilot Scheme in the extended pilot scheme before recommending any changes to it.

Value and use of the health care vouchers

7. Members were generally of the view that the voucher value of $500 per year was still inadequate to enable the elderly to use private primary care services. They urged the Administration to provide the eligible elderly with 10 vouchers per year of $120-$150 each, which was the average consultation and medication fee charged by doctors in the private sector.

8. The Administration explained that the health care vouchers were not meant to provide full subsidy for seeking private health care services, but to provide partial subsidy with a view to promoting the concept of shared responsibility for health care among patients, particularly the concept of co-payment to ensure appropriate use of health care. A host of factors had been taken into consideration when setting the subsidy level at $500 per year. These factors included the average number of vouchers claimed per transaction, the amount elderly people were willing to co-pay, the prices charged by health care service providers and the emphasis elderly people put on preventive services. In the Administration's view, further extension on the coverage of the Pilot Scheme would require data support and be subject to the review of the effectiveness of the Pilot Scheme.

9. Given the limited voucher value, some members were of the view that the elderly should be provided with additional vouchers/subsidy to purchase physical checkup services or dental checkup services. The Administration advised that it attached great importance to strengthening preventive care for the elderly. For instance, a pilot project was launched in April 2011 to provide outreach primary dental care and oral health care services to elderly people in residential care homes and Day Care Centres for the Elderly.

10. Some members held the view that the Administration should consider removing the restriction on the use of health care vouchers to pay for health care services provided by public general out-patient clinics and for the purchase of drugs at pharmacies or other medical items.

11. The Panel passed a motion at its meeting on 14 April 2008, urging the Administration to provide health care vouchers to elderly people aged 65 or above, to increase the value of each voucher to at least $100, to expedite the

launching of the Pilot Scheme within 2008, to provide each senior citizen with at least 10 health care vouchers a year, and to adopt measures to prevent service providers from raising their fees opportunistically which would erode the subsidies provided to the elderly.

Scheme participation and utilization

12. Members were concerned about the number of private health care providers who would be eligible to participate in the Pilot Scheme. They suggested that the Administration should draw up a list of participating health care providers and their fee schedules to enable the elderly to identify the participating health care providers. The Administration advised that it was not possible for some participating providers to publicize their names as this might be in breach of their code of practice. Providers would be issued the Pilot Scheme logo to be displayed outside their practices for identification and they would be encouraged to increase the transparency of their fees and charges.

13. Members noted with concern that as at end 2010, only 57% of the eligible elderly population had registered with the Pilot Scheme and only 45% had made voucher claims. Some members were of the view that the low enrolment rate of medical practitioners in the Pilot Scheme was the main reason for the low take-up rate of the Pilot Scheme. There was also concern about the withdrawal of participating health care service providers. Members urged the Administration to step up its efforts in encouraging the participation of health care service providers, especially those practised in the New Territories.

14. According to the Administration, among the some 4 200 economically active medical practitioners in the private sector, 1 431 had enrolled in the Pilot Scheme with practices located in every district. Although a total of 202 health care service providers had withdrawn from the Pilot Scheme as at end 2010, there was still an increase in the number of participating health care service providers in the first two years of the first pilot period. The Administration further advised that in the light of the problems encountered during the first pilot period, efforts had been made to streamline the operation details, including the provision of a Smart Identity Card Reader to participating health care service providers for easy access and retrieval of users' personal particulars for voucher claims.

15. Concern was also raised over the low participation rate of Chinese medicine practitioners in the Pilot Scheme which stood at only 13%. Members were advised that apart from the lack of computer facilities to access the eHealth System, some Chinese medicine practitioners indicated that their consultation fees were already very low and they did not intend to accept the health care vouchers.

16. Considering the low registration and take-up rates of the Pilot Scheme, some members suggested that consideration could be given to allowing eligible elderly people to redeem the health care vouchers if they could provide receipts for payment of fees charged by private health care service providers, instead of requiring the service providers to enrol in the Pilot Scheme. This could address the shortcoming of the Pilot Scheme whereby elderly people tended not to use the vouchers if the medical practitioners whom they usually visited did not enrol in the Pilot Scheme.

17. According to the Administration, experience of overseas places revealed that this arrangement would entail increase of service volume and high administrative cost, but could not ascertain benefits to patients. In the Administration's view, the enrolment of private health care service providers in the Pilot Scheme was necessary to facilitate the collection of information on the health care services provided by the enrolees to their voucher users so as to ensure proper use of public money.

Monitoring of the Pilot Scheme

18. Members expressed concern on the measures taken to protect the privacy of the personal data stored in the eHealth System. The Administration stressed that protection of patient data privacy was of paramount importance in developing the Pilot Scheme. Information stored in the eHealth System, including the diagnosis information, could only be accessed by the patient and the service provider concerned. A Privacy Impact Assessment and a Privacy Compliance Assessment on the design and operational procedures of the Pilot Scheme had also been conducted prior to the implementation of the Pilot Scheme.

19. Noting three proven cases of abuse of the Pilot Scheme by enrolled health care service providers, members expressed concern about the measures put in

place to prevent fraud and abuse. The Administration advised that the concerned health care service providers had been disqualified from the Pilot Scheme and they were requested to return the funds disbursed for the concerned claims. The Department of Health ("DH") had also issued reminders to all enrolled health care service providers on proper procedures and documentation of voucher claims. DH would also conduct random inspections on the health care providers and carry out investigations on complaints and suspected cases as and when necessary.

Financial implication

20. Members noted that a sum of $30 million would be provided to the Hospital Authority for the development and maintenance of the eHealth System during the first pilot period. An amount of $38 million had also been earmarked by the Food and Health Bureau and DH to cover the additional non-recurrent staff cost and operational expenditure arising from the implementation of the Pilot Scheme. Some members were of the view that such money should be better spent on extending the scope of the Pilot Scheme to benefit more elderly people and increasing the value of the vouchers.

21. The Administration advised that $20 million out of the $30 million earmarked for the eHealth System was the capital cost for developing the IT system which could be used to support similar initiatives in the future. Regarding the staff cost and operational expenditure, they would be strictly controlled and kept within 10% of the total expenditure of the Pilot Scheme.

22. The Finance Committee ("FC") approved on 20 June 2008 a new commitment of $535.33 million in total for the implementation of the Pilot Scheme and developing and installing the eHealth System and for its operation and maintenance during the first pilot period. On 24 June 2011, FC further approved an additional funding of $1,032.6 million to extend the Pilot Scheme for a further three-year pilot period until 31 December 2014.

Recent development

23. To better address the pressing needs of the community, the Chief Executive has since mid-July 2012 announced a series of policy initiatives to address livelihood issues, including a one-fold increase in the value of health care vouchers from $500 to $1,000 per year. It is estimated that about 700 000 senior citizens aged 70 or above will be benefited from the proposal. The Administration aims at briefing the Panel on the details of the proposal in November 2012 and seeking FC's funding approval in December 2012. Subject to the approval of FC, the target implementation date of the proposal is 1 January 2013.

Relevant papers

24. A list of the relevant papers on the Legislative Council website is in the **Appendix**.

Council Business Division 2
Legislative Council Secretariat
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Appendix

Relevant papers on the Elderly Health Care Voucher Pilot Scheme

Committee	Date of meeting	Paper
Panel on Health Services	12.10.2007 (Item I)	Agenda Minutes
Panel on Health Services	12.11.2007 (Item IV)	Agenda Minutes
Panel on Health Services	14.4.2008 (Item IV)	Agenda Minutes
Panel on Health Services	14.3.2011 (Item V)	Agenda Minutes CB(2)1538/10-11(01)

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