For discussion
on 16 November 2015

Legislative Council Panel on Health Services

Update on the Implementation of the Elderly Health Care Voucher Scheme

PURPOSE

This paper briefs Members on –

(a) the implementation of the Elderly Health Care Voucher (EHV) Scheme; and

(b) the proposal to seek a supplementary provision of $380.7 million under Head 37: Department of Health (DH) to meet the estimated expenditure for the EHV Scheme in 2015-16.

BACKGROUND

2. The EHV Scheme was launched on a pilot basis in 2009 to subsidise Hong Kong elders aged 70 or above to use primary care services provided by the private sector. They include services provided by medical practitioners, Chinese medicine practitioners, dentists, nurses, occupational therapists, physiotherapists, radiographers, medical laboratory technologists, chiropractors and optometrists with Part I registration under the Supplementary Medical Professions Ordinance (Cap. 359). To prevent abuse, the vouchers are not allowed to be used solely for the purchase of medical items, for the purchase of drugs at pharmacies, or meeting the fees and charges for public healthcare services. By giving elders a choice to use private healthcare services that best suit their needs, the Scheme also helps supplement the existing public healthcare services (e.g. General Outpatient Clinic services) and promote the concept of family doctor.

3. As at end-September 2015, over 5 100 healthcare service providers, including about 1 900 medical practitioners, 1 800 Chinese medicine practitioners and 600 dentists, have enrolled in the EHV Scheme. About 590 000 elders (or about 78% of the eligible elders) have made use of the vouchers and the cumulative expenditure is about $1,870.8 million. Details of the take-up rate and annual voucher expenditure are at **Annex**. The pilot project was converted to a regular programme in 2014.

4. According to the Hong Kong Population Projections 2015-2064 published by the Census and Statistics Department, the number of Hong Kong elders aged 70 or above is forecast to be about 760 000 in 2015 and increase to 1 507 000 and 2 000 800 by 2030 and 2041 respectively.

ENHANCEMENTS TO THE SCHEME

(A) Annual Voucher Amount

5. To allow elders greater room and flexibility in using private primary care services, the annual voucher amount was increased from the original $250 to $500 in 2012, to $1,000 in 2013, and to $2,000 per year in June 2014.

6. The EHV Scheme allows any unspent amount of the vouchers to be carried forward. There is no restriction on the number of years that an elder may carry forward the unspent voucher amount, subject to a financial cap on the cumulative amount of vouchers in the account which is intended primarily to encourage elders to make more frequent use of the vouchers for primary care services, both curative and preventive care. Following the increase of annual voucher amount to $2,000 in June 2014, the financial cap was revised upward from $3,000 to $4,000 for each eligible elder.

(B) Changing the Voucher Face Value from $50 to $1

7. When the pilot scheme was launched in 2009, the face value of each voucher was set at $50. Elders were hence required to make co-payment for the services received in using the vouchers unless the service charge was a multiple of $50. The face value of each voucher

was changed from $50 to $1 starting 1 July 2014 to provide elders with greater flexibility in using the vouchers.

(C) Pilot Scheme at the University of Hong Kong - Shenzhen Hospital (HKU-SZ Hospital)

8. To facilitate Hong Kong elders who reside regularly in Shenzhen to seek medical out-patient treatments locally without having to travel back to Hong Kong, especially for minor or routine treatments, a pilot scheme was launched on 6 October 2015 with the HKU-SZ Hospital to allow eligible Hong Kong elders to use their EHV to meet the fees for outpatient services (including preventive as well as curative and rehabilitative services) provided by the Hospital. It includes 14 Outpatient Medical Centers/ Medical Service Departments at the HKU-SZ Hospital which provide various healthcare services such as family medicine, dental care, Chinese medicine, health assessment and physiotherapy, etc.

(D) Monitoring and Evaluation

9. The DH has put in place measures and procedures for checking and auditing voucher claims on the EHV Scheme 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. Since the Scheme was launched in 2009, the DH has conducted checking of about 210 000 claim transactions which covers 90% of the enrolled healthcare service providers with claims made (representing about 2.5% of all claim transactions made). The checking has identified 121 anomalous cases involving 2 167 claims. After further investigation, these cases were found mostly related to errors in procedures or documentation. Using a risk-based approach, DH's checking targets at enrolled healthcare service providers who have made anomalous claims in the past and those who have unusual patterns of claims identified via alerts generated based on pre-set parameters in the eHealth System. The parameters are fine-tuned from time to time to increase the sensitivity of picking up potential anomalous claims.

10. In response to the comments and recommendations in the Director of Audit's Report No. 63, the DH has established a mechanism to regularly compile and analyse the statistics on the major and minor

errors/ omissions identified in consent forms so as to facilitate timely feedback of common problems identified to the enrolled healthcare service providers to help them improve their compliance with the Scheme requirements. The inspection strategy and monitoring protocols will be further reviewed as part of the comprehensive review of the EHV Scheme to be undertaken, see paragraph 11 below. It is envisaged that the DH will fine-tune the risk-based approach vis-à-vis the increase in the number of EHV users and service providers and the complaints and feedback received.

11. DH is currently conducting a comprehensive review of the EHV scheme, covering the following major areas –

(a) knowledge and attitudes of elders on EHV;

(b) views of elders and healthcare professionals about the EHV Scheme;

(c) impact of vouchers on primary care services for the elderly (e.g. any change in health-seeking behavior of voucher recipients, the effectiveness of encouraging more frequent use of preventive care in primary care system, etc.);

(d) utilization pattern of vouchers; and

(e) operational arrangements for the Scheme, including the monitoring mechanism.

Apart from analyzing the EHV statistics and comments and suggestions received over the years, the DH will collaborate with the Chinese University of Hong Kong (CUHK)'s Jockey Club School of Public Health and Primary Care in undertaking this review. For example, CUHK will seek to identify the facilitators and barriers for private healthcare service providers to join the EHV Scheme through collection of their opinion.

2015-16 Supplementary Provision for EHV Scheme

12. A provision of $811 million was approved under Head 37: DH in the 2015-16 Draft Estimates to meet voucher expenditure, which represents an increase of 16% over the 2014-15 Revised Estimates of $700 million. The actual voucher expenditure for the first half of

2015-16 (i.e. up to September 2015) is $419.9 million, or 51.8% of annual provision, as compared with 33% of annual provision for the same period in 2014-15. The higher than anticipated expenditure is likely due to the doubling of annual voucher amount since mid-2014, the enhancement measures introduced in the scheme and DH's efforts in promoting the EHV Scheme via different channels such as television and radio announcements of public interest, and advertisements in the public transport system; all of these factors contributed to elders' increased willingness to use EHV. We anticipate that the current trend will continue and the monthly voucher expenditure will be even higher in the winter season, as in previous years. In addition, we anticipate that more elders will make use of their vouchers in the last quarter of 2015 to ensure that the financial cap of $4,000 will not be exceeded when their unspent vouchers are carried forward to 2016.

13. Against the above, we propose to increase the 2015-16 provision under Head 37 from $811 million by $380.7 million to $1,191.7 million. We will also adjust the expenditure projections for the EHV Scheme in 2016-17 and beyond on the same basis in preparing the 2016-17 Estimates. Subject to Members' views, we plan to seek approval of the Finance Committee of the Legislative Council for the supplementary provision required in 2015-16 to meet the anticipated expenditure as soon as possible.

ADVICE SOUGHT

14. Members are invited to note the implementation of the EHV Scheme and give their views on the proposal for seeking supplementary provision to meet the estimated voucher expenditure in 2015-16.

Food and Health Bureau
Department of Health
November 2015

Annex

Take-up Rate and Annual Expenditure of the Elderly Health Care Voucher Scheme

	2009	**2010**	**2011**	**2012**	**2013**	**2014**	**2015 (Jan – Sep)**
Number of claim transactions	349 000	504 000	613 000	937 000	1 470 000	2 222 000	2 078 000
Voucher expenditure (in $ million)	36.0	65.7	87.9	158.6	298.5	554.8	669.3
(a) Number of elders who had made use of vouchers	186 000	286 000	358 000	424 000	488 000	551 000	590 000
(b) Number of eligible elders (aged 70 or above)	671 000	688 000	707 000	714 000	724 000	737 000	760 000
(c) Percentage of eligible elders who had made use of vouchers (i.e. scheme take-up rate) [(c) = (a)/(b) x 100%]	28%	42%	51%	59%	67%	75%	78%
Number of participating service providers	2 539	2 736	3 066	3 627	3 976	4 631	5 165

Actual Voucher Expenditure
(as at 30 September 2015)

Calendar Year	Actual Expenditure ($ million)	Financial Year	Actual Expenditure ($ million)
		2008-09 (Jan-Mar 2009 only)	6.6
2009	36.0	2009-10	49.0
2010	65.7	2010-11	72.0
2011	87.9	2011-12	104.1
2012	158.6	2012-13	196.0
2013	298.5	2013-14	341.0
2014	554.8	2014-15	682.2
2015 *(up to 30 Sep 2015)*	669.3	2015-16 *(up to 30 Sep 2015)*	419.9
Total	**1,870.8**	Total	**1,870.8**