For discussion **FCR(2011-12)31**
on 24 June 2011

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 commitment for the Elderly Health Care Voucher Pilot Scheme from $505.33 million by $1,032.60 million to $1,537.93 million under Head 37 Department of Health Subhead 700 General non-recurrent Item 887 Health Care Voucher Pilot Scheme for a further three-year pilot period until 31 December 2014.

PROBLEM

The current three-year Elderly Health Care Voucher Pilot Scheme (the Pilot Scheme) launched in 2009 will draw to a close by the end of 2011. We need additional funding to extend the Pilot Scheme for a further three-year period and to enhance it to render the Scheme more effective.

PROPOSAL

2. The Secretary for Food and Health proposes to increase the commitment for the Pilot Scheme to extend it for a further period of three years starting from 1 January 2012 and to increase the annual voucher amount from $250 to $500 per eligible elderly person in the extended pilot period.

/JUSTIFICATION …..

JUSTIFICATION

3. The Pilot Scheme, as approved by the Finance Committee (FC) on 20 June 2008, was launched on a pilot basis for a period of three years from 1 January 2009. Under the Pilot Scheme, each eligible elderly person aged 70 or above holding Hong Kong Identity Card or Certificate of Exemption is eligible to receive five health care vouchers worth $50 each per year during the three-year pilot period. Health care vouchers are designated for services provided by enrolled healthcare service providers in the non-public sector. The health services may be preventive, curative or rehabilitative in nature. The vouchers are provided in addition to (not a substitute of) the public medical services available to and accessible by all Hong Kong residents.

4. As foreshadowed in FCR(2008-09)33, the Administration conducted an interim review in the second half of 2010 to examine and review different aspects of the Pilot Scheme, including participation rate, voucher utilisation, service coverage, operational arrangements, stakeholder feedback and healthcare seeking patterns. The review findings are summarised at Enclosure 1. Having regard to the outcome of the interim review and other relevant considerations including feedback from the community, the Administration has drawn up a set of recommendations on the way forward of the Pilot Scheme, which are set out in paragraphs 5 to 8 below.

Encl. 1

Need for Extending the Pilot Scheme

5. We recommend that the Pilot Scheme be extended for a further trial period of three years, from 1 January 2012 to 31 December 2014. This is to allow further testing of the effectiveness of the Pilot Scheme, taking into account the recommended adjustments set out in paragraph 6 below. We would need further time to more thoroughly evaluate whether the stated policy objectives would be achieved, including enhancing primary healthcare services for the elderly by enabling them to choose private primary care in the community through the provision of partial subsidy, and whether there would be any behavioural changes on the part of the users and providers with the three-year extension. The proposed extension is in line with the strategies for the promotion and development of primary care as set out in the Strategy Document on Primary Care Development in Hong Kong and can tie in with the Primary Care Campaign now underway.

/**Proposed** ….

Proposed Enhancements to the Pilot Scheme

6. We recommend that the following measures be taken in conjunction with the proposed extension of the Pilot Scheme to enhance its operation and effectiveness –

(a) Increase the voucher amount per year in the extended three-year pilot period from $250 to $500, while retaining the dollar value of each voucher at $50. In other words, the number of vouchers given to each eligible elderly person will be increased to ten.

(b) Forge a closer collaboration with healthcare professionals to further promote the importance of primary care, both among elderly people and service providers, and to encourage utilisation and provision of such services, having regard to the reference framework to be developed for the elderly under the primary care development strategy. Apart from publicity and education, we will enhance efforts to promote protocol-based preventive services that the elderly could make use of voluntarily at affordable prices, in collaboration with interested and qualified healthcare service providers.

(c) Allow health care vouchers not yet used by eligible elderly people in the current Pilot Scheme, to be carried forward on a one-off basis into the extended three-year pilot period. All unused vouchers shall lapse on the expiry of the extended pilot period ending 31 December 2014.

(d) Improve the operation of the Pilot Scheme and step up monitoring over the use of health care vouchers by enhancing the data-capturing functions of the eHealth System in the following aspects –

(i) Diagnosis information: enhance the "reason of visit" arrangements in the system to allow multiple entries of reasons. We will also explore the feasibility for participating healthcare service providers to input more specific information on the healthcare services provided to voucher users, such as requiring participating medical practitioners to provide more specific clinical diagnosis; and

(ii) Co-payment: require participating healthcare service providers to input the co-payment made by an elderly person for each consultation involving the use of health care voucher(s).

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(e) Add optometrists with Part I registration[1] under the Supplementary Medical Professions Ordinance (Cap. 359) to the Pilot Scheme with effect from 1 January 2012 when the extended pilot period commences, subject to the requirement that vouchers should only be used for provision of healthcare services and must not be used to cover the purchase of equipment and optical appliances such as spectacles.

7. Apart from the above, we do not recommend any change to other rules of the Pilot Scheme. Specifically, we will continue to maintain the existing age eligibility for health care vouchers, i.e. aged 70 or above. We will also keep the current rules on the use of vouchers, i.e. usable for private healthcare services, but not for purchase of drugs at pharmacies, purchase of medical items, or public healthcare services, etc. We will also retain the current flexibility in using health care vouchers subject to eligibility, i.e. no limit on the number of vouchers that may be used for each episode of healthcare services, no restriction on the type of healthcare services or providers for which each voucher may be used, and no limit on the amount of vouchers to be used for different types of healthcare services or providers.

8. In view of the findings of the interim review, the Administration considers it prudent to adopt the proposed increase in the amount of vouchers while keeping the other rules of the Pilot Scheme unchanged. This will enable the effects of the Pilot Scheme to be more thoroughly and accurately evaluated, especially on the impact of vouchers on primary healthcare behaviours and costs. This would also help ensure appropriate use of public funds in subsidising private healthcare services.

Implementation and Review

9. Subject to Members' approval, we will increase the voucher amount for eligible elderly persons to $500 each per year under the extended Pilot Scheme. We will also allow the unspent part of the existing vouchers ($250 each per year from 2009 to 2011) to be carried forward into the extended pilot period. The inclusion of Part I optometrists into the Pilot Scheme, the arrangement for recording multiple reasons of visit, and the requirement for participating healthcare professionals to provide co-payment information will also be implemented from 1 January 2012.

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[1] Optometrists with Part I registration can provide comprehensive care services. For registrants in other parts (Parts II, III and IV) of the Register, there are restrictions on practice. As at May 2011, among the 2 000 registered optometrists, 742 optometrists are with Part I registration.

10. As regards the input of more specific diagnosis information, we will explore the feasibility of doing so and, if so, when and how it should be implemented having regard to the readiness and availability of the necessary IT infrastructure and diagnosis data standards.

11. We will initiate a further comprehensive review of the extended Pilot Scheme after the enhancement measures have been put into operation and complete the review within the extended trial period.

FINANCIAL IMPLICATIONS

12. According to the projections of the Hong Kong elderly population by the Census and Statistical Department, the number of elderly people aged 70 or above in Hong Kong in 2012 will be about 688 400. Based on these projections, we propose to include an additional non-recurrent provision of $1,032.6 million for providing health care vouchers at $500 annually to every eligible person making valid claims from 2012 to 2014. The cash flow requirement is estimated to be $344.2 million annually.

13. Within the approved commitment of $505.33 million in the current Pilot Scheme for providing vouchers at $250 each year for every eligible person making valid claims, the actual expenditures incurred up to 2010-11 are tabulated at Enclosure 2.

Encl. 2

14. Administration of the Pilot Scheme for the extended pilot period will require time-limited staff and other resources. The resource requirements in 2011-12 will be absorbed within existing provisions and those for the remainder of the extended pilot period will be reflected in the Estimates of the relevant years.

15. As regards a related information technology system for health care vouchers, the commitment approved[2] for the current Pilot Scheme will continue to be utilised in the extended pilot period.

/**PUBLIC** …..

[2] FC approved on 20 June 2008 under FCR(2008-09)33 the creation of a capital account commitment item of $30 million under Head 140 Government Secretariat: Food and Health Bureau (Health Branch) Subhead 882, i.e. Item 886 Hospital Authority – Information Technology System for Health Care Vouchers for developing and installing the eHealth System and for its operation and maintenance. As at end-March 2011, it recorded a balance of $9.41 million.

PUBLIC CONSULTATION

16. We consulted the Legislative Council Panel on Health Services on 14 March 2011. Members of the Panel supported the proposed Pilot Scheme extension and enhancement. Some Members expressed the view that the annual amount of voucher should be further increased to $1,000 per eligible elderly and the eligible age should be lowered to 65. However, we consider it prudent to confine the extended Pilot Scheme to the proposed enhancements at this juncture so that the Pilot Scheme can be further evaluated and to ensure the appropriate use of public funds.

BACKGROUND

17. In the 2007-08 Policy Address, the Chief Executive announced that the Government would launch a three-year pilot scheme under which all elderly people aged 70 or above would be given annually five health care vouchers worth $50 each. By providing partial subsidies, the Pilot Scheme aims at encouraging the elderly to seek private primary healthcare services in their neighbourhood so as to enhance primary care services for them for the betterment of their health and well-being. It is an addition to the existing public healthcare services available to the elderly, which will continue with no reduction following the implementation of the Pilot Scheme. With the approval of the FC on 20 June 2008 (FCR(2008-09)33), the Pilot Scheme was launched on a pilot basis for a period of three years from 1 January 2009.

Food and Health Bureau
June 2011

Summary of Interim Review on Elderly Health Care Voucher Pilot Scheme

The interim review was conducted on the basis of the statistical data captured in the eHealth System[1], and feedback by elderly people and healthcare service providers collated through questionnaires and focus group discussions conducted by the School of Public Health and Primary Care of the Faculty of Medicine of the Chinese University of Hong Kong (CUHK medical school). The full report of the interim review can be accessed through the Health Care Voucher website (www.hcv.gov.hk/eng/resources_corner.htm). The review findings are summarised below.

(1) Scheme Awareness and Participation

2. The findings of the interim review show that the majority of the elderly are aware of the Pilot Scheme. The opinion survey conducted by CUHK medical school indicates that over 70% of its interviewees were aware of the Pilot Scheme and, among them, 54% had a good understanding of what the Pilot Scheme entailed. As at end 2010, 57% of the eligible elderly population have opened eHealth accounts, and 45% have made voucher claims[2]. The registration and take-up rates are in general higher than other public-private partnership healthcare projects.

(2) Satisfaction with the Pilot Scheme

3. CUHK medical school's opinion survey reveals that the majority of its interviewees (64%), comprising both voucher users and non-users, perceived that health care vouchers were convenient to use, and 65% of interviewed elderly people considered the Pilot Scheme useful. For those interviewees who had made use of vouchers, 80% agreed that the vouchers were convenient to use, and 79% considered the Pilot Scheme useful. For those who had never used vouchers, the main reasons were that they usually visited public doctors and the healthcare service providers whom they usually visited had not enrolled in the Pilot Scheme.

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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. As at May 2011, the eHealth System administered over 580 000 user accounts and 3 200 healthcare service providers for all schemes.

2 The registration and usage rates have further increased since then. As at 31 May 2011, 429 239 eHealth accounts were created, representing 63% of the eligible elderly population. Among them, 345 698 have made voucher claims, accounting for 51% of the eligible elderly population. A total of 1 197 533 claim transactions were recorded, involving 3 122 396 claimed vouchers.

(3) Impact on Healthcare Seeking Behaviour

4. According to CUHK medical school's opinion survey, 66% of its interviewees considered that the availability of health care vouchers did not change their healthcare seeking behaviour. Only 32% of the interviewees said that the Pilot Scheme encouraged them to use private healthcare service more often. The survey also shows that elderly people who are used to seeking private healthcare services are more likely and ready than those who are users of public healthcare services to register and make use of health care vouchers.

5. Usage statistics captured in the eHealth System show that preventive services are accorded a low priority in the voucher-spending decision of the elderly. Over 69% of the claim transactions went towards episodic care, about 21% for management of chronic diseases, about 7% for preventive care, and about 3% for rehabilitative care.

6. Broadly speaking, the Pilot Scheme could not induce any noticeable behavioural changes on the part of both users and providers of primary healthcare services during the first two years of the pilot period. There is no evidence so far that the Pilot Scheme has brought about any noticeable changes in the healthcare seeking behaviour among the elderly, or resulted in an increase in the utilisation and provision of preventive care services. This suggests that behavioural changes are not easy to induce, even with the aid of health care vouchers.

(4) Price and Subsidy for Healthcare Services

7. Statistics on the pattern of voucher claims indicate that in the majority of cases, elderly people made out-of-pocket payment on their own. The study conducted by CUHK medical school indicates that the healthcare seeking behaviour of the elderly is influenced by a combination of factors, including the level of government subsidy, the prices charged by healthcare service providers and the amount of co-payment that they are willing to make.

8. On the willingness of the elderly to make co-payment, CUHK medical school's study shows that they are relatively much less willing to pay for preventive services than curative ones. There is also limited incentive for the elderly to co-pay more even if the voucher amount is increased. This suggests that an increase in subsidy level through higher voucher amount may not be able to incentivise the elderly to seek preventive services. On episodic care, the amount that elderly people are willing to pay is more or less on par with the range of charges for private healthcare services. This suggests that government subsidy might not have a significant impact on the behaviour of elderly people in seeking episodic care.

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9. The findings of the review suggest that more in-depth evaluation of the level of government subsidy, prices charged by healthcare service providers and the amount of co-payment that elderly people are willing to make is required so as to better assess how these three factors would affect the provision and utilisation of primary care services.

(5) Coverage of Healthcare Service Providers

10. Nine categories of healthcare professionals are eligible to enrol in the Pilot Scheme[3]. In terms of participation rate, we estimate that about 34% of economically active medical practitioners in the private sector[4] have enrolled in the Pilot Scheme, followed by dentists (16%) and Chinese medicine practitioners (13%). There are enrolled healthcare service providers in every district, with relatively more in Kowloon and the Hong Kong Island. The participation rate of medical practitioners is on par with other public-private partnership schemes.

11. In the opinion survey conducted by CUHK medical school, interviewees were requested to provide suggestions to enhance the coverage of healthcare services. 28% of the interviewees suggested that Optometrists, who are currently outside the Pilot Scheme, should be included. In this connection, we note that optometrists with Part I registration under the Supplementary Medical Professions Ordinance (Cap. 359) are qualified to provide certain preventive care services such as providing visual acuity examination to patients suffering from cataract and diabetes.

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[3] As at end 2010, there were a total of 2 736 enrolees, with medical practitioners (totalling 1 431) making up the majority (52.3% of all enrolees), followed by Chinese medicine practitioners (762) (27.9%), dentists (239) (8.7%), physiotherapists (189) (6.9%), registered nurses (39) (1.4%) and enrolled nurses (6) (0.2%), occupational therapists (19) (0.7%), chiropractors (18) (0.7%), medical laboratory technologists (17) (0.6%), and radiographers (16) (0.6%).

[4] We estimate that there are about 4 200 economically active medical practitioners in the private sector having regard to the number of registered medical practitioners and the projection made from the 2009 Health Manpower Survey on Doctors.

Enclosure 2 to FCR(2011-12)31

The Actual Expenditures Incurred since Scheme Launch (as at 31 March 2011)

	2008-09 (in $'000)	2009-10 (in $'000)	2010-11 (in $'000)	Total (in $'000)
Expenditure on voucher claims reimbursement	6,600	49,000	72,000	127,600*

* The expenditure on vouchers is less than the amount of vouchers claimed because vouchers are reimbursed in arrears on a monthly basis.
