中華人民共和國香港特別行政區政府總部食物及衞生局
Food and Health Bureau, Government Secretariat
The Government of the Hong Kong Special Administrative Region
The People's Republic of China

本局檔號 Our Ref : FHB/H/16/102/1
來函檔號 Your Ref :
電　　話 Tel : 3509 8913
圖文傳真 Fax : 2102 2431

4 December 2012

Ms Elyssa WONG
Clerk to Panel on Health Services
Legislative Council
Legislative Council Complex
1 Legislative Council Road
Hong Kong

Dear Ms WONG,

Legislative Council Panel on Health Services
Enhancements to the Elderly Health Care Voucher Pilot Scheme

We refer to your letter dated 29 November 2012.

At the meeting of the LegCo Panel on Health Services held on 19 November 2012, Members discussed the proposed enhancements to the Elderly Health Care Voucher Pilot Scheme (the Pilot Scheme) vide LC Paper No. CB(2)191/12-13(03), and requested the Administration to provide the following supplementary information –

(a) financial implications of lowering the eligible age for Elderly Health Care Vouchers to 60 or 65;

(b) the respective breakdown by health professions and by reasons of visit of the reimbursement claims under the Pilot Scheme in the past three years; and

(c) report of the Interim Review of the Pilot Scheme.

The information relevant to items (a) and (b) above is set out at ***Appendices A and B*** respectively.

As for item (c), we briefed the Panel on Health Services on 14 March 2011 on the findings of the interim review vide LC Paper No. CB(2)1220/10-11(04). The full report of the interim review is also available from the Pilot Scheme's dedicated website (www.hcv.gov.hk/eng/resources_corner.htm). A copy of the Executive Summary of the report is reproduced at ***Appendix C***.

Yours sincerely,

(Vivian CHEUNG)
for Secretary for Food and Health

Appendix A

Elderly Health Care Vouchers
Financial Implications of Lowering Age Eligibility

Table A - Estimated Expenditure for the Scheme in 2013 and 2018
(based on the existing eligible age of 70)

	2013	2018
Population Projections[1]	Aged 70 or above	Aged 70 or above
	723 500	835 600
(A) Maximum expenditure for providing $1,000 for each eligible elder based on elderly population projection ($m)	723.5	835.6
(B) Estimated take-up rate	70%	90%
(C) Adjusted requirement for participating voucher users [(A) x (B)] ($m)	506.5	752.0
(D) Estimated cash flow requirement based on utilisation rate of 67.5%[2] [(C) x 67.5%] ($m)	341.9	507.6

1 Hong Kong Population Projections 2012-2041 published by the Census and Statistics Department.

2 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%.

Table B - Estimated Expenditure for the Scheme in 2013 and 2018
(assuming lowering the eligible age from 70 to 65)

	2013	**2018**
Population Projections	Aged 65 or above	Aged 65 or above
	1 018 400	1 265 500
(A) Maximum expenditure for providing $1,000 for each eligible elder based on elderly population projection ($m)	1,018.4	1,265.5
(B) Estimated take-up rate	70%	90%
(C) Adjusted requirement for participating voucher users [(A) x (B)] ($m)	712.9	1,139.0
(D) Estimated cash flow requirement based on utilisation rate of 67.5% [(C) x 67.5%] ($m)	481.2	768.8

Table C - Estimated Expenditure for the Scheme in 2013 and 2018
(assuming lowering the eligible age from 70 to 60)

	2013	**2018**
Population Projections	Aged 60 or above	Aged 60 or above
	1 460 800	1 814 600
(A) Maximum expenditure for providing $1,000 for each eligible elder based on elderly population projection ($m)	1,460.8	1,814.6
(B) Estimated take-up rate	70%	90%
(C) Adjusted requirement for participating voucher users [(A) x (B)] ($m)	1,022.6	1,633.1
(D) Estimated cash flow requirement based on utilisation rate of 67.5% [(C) x 67.5%] ($m)	690.3	1,102.3

Appendix B

No. of Health Care Voucher Claim Transactions Broken Down by Health Professions and Reasons of Visit

Health professions	Year	Reasons of Visit				Total
		Preventive care	Management of acute episodic condition	Follow-up / Monitoring of long term conditions	Rehabilitative Care	
Medical Practitioner	2009	16,830	232,739	52,558	4,723	306,850
	2010	21,097	339,999	75,841	7,425	444,362
	2011	27,827	410,612	91,911	8,906	539,256
	Total	65,754	983,350	220,310	21,054	1,290,468
Chinese Medicine Practitioner	2009	5,311	5,173	19,723	1,651	31,858
	2010	7,167	6,258	32,802	1,292	47,519
	2011	8,716	5,532	41,828	1,816	57,892
	Total	21,194	16,963	94,353	4,759	137,269
Dentist	2009	1,748	3,097	405	2,083	7,333
	2010	2,087	3,752	330	2,894	9,063
	2011	3,053	5,343	428	3,894	12,718
	Total	6,888	12,192	1,163	8,871	29,114
Occupational Therapist	2009	1	0	0	30	31
	2010	1	0	0	14	15
	2011	0	0	2	94	96
	Total	2	0	2	138	142
Physiotherapist	2009	5	170	198	972	1,345
	2010	8	110	213	1,080	1,411
	2011	27	188	301	1,144	1,660
	Total	40	468	712	3,196	4,416
Medical Laboratory Technologist	2009	273	13	104	0	390
	2010	299	34	102	0	435
	2011	517	40	49	0	606
	Total	1,089	87	255	0	1,431
Radiographer	2009	100	59	94	71	324
	2010	67	134	252	101	554
	2011	192	186	238	21	637
	Total	359	379	584	193	1,515
Enrolled Nurse	2009	181	0	0	0	181
	2010	17	0	5	0	22
	2011	4	0	4	0	8
	Total	202	0	9	0	211
Registered Nurse	2009	234	3	24	18	279
	2010	203	10	27	33	273
	2011	122	8	54	22	206
	Total	559	21	105	73	758
Chiropractor	2009	7	67	28	181	283
	2010	6	61	9	117	193
	2011	2	82	21	159	264
	Total	15	210	58	457	740
	2009	***24,690*** ***(7.1%)***	***241,321*** ***(69.2%)***	***73,134*** ***(21.0%)***	***9,729*** ***(2.8%)***	***348,874*** ***(100%)***
	2010	***30,952*** ***(6.1%)***	***350,358*** ***(69.5%)***	***109,581*** ***(21.7%)***	***12,956*** ***(2.6%)***	***503,847*** ***(100%)***
	2011	***40,460*** ***(6.6%)***	***421,991*** ***(68.8%)***	***134,836*** ***(22.0%)***	***16,056*** ***(2.6%)***	***613,343*** ***(100%)***
	Total	***96,102*** ***(6.6%)***	***1,013,670*** ***(69.1%)***	***317,551*** ***(21.7%)***	***38,741*** ***(2.6%)***	***1,466,064*** ***(100%)***

Note: 2009 - Figures from 1 January 2009 to 31 December 2009

2010 - Figures from 1 January 2010 to 31 December 2010

2011 - Figures from 1 January 2011 to 31 December 2011

Figures may not add up to 100% due to rounding

No. of Claimed Health Care Vouchers Broken Down by Health Professions and Reasons of Visit

Health professions	Year	Reasons of Visit				Total
		Preventive care	Management of acute episodic condition	Follow-up / Monitoring of long term conditions	Rehabilitative Care	
Medical Practitioner	2009	40,734	510,475	137,472	8,973	697,654
	2010	59,360	858,664	229,377	16,293	1,163,694
	2011	87,655	1,144,128	297,574	21,407	1,550,764
	Total	187,749	2,513,267	664,423	46,673	3,412,112
Chinese Medicine Practitioner	2009	14,691	12,084	35,332	5,196	67,303
	2010	24,626	21,798	61,674	4,923	113,021
	2011	34,275	15,985	86,660	6,601	143,521
	Total	73,592	49,867	183,666	16,720	323,845
Dentist	2009	5,430	12,120	1,625	9,313	28,488
	2010	7,672	19,066	1,775	17,750	46,263
	2011	12,595	31,363	2,967	30,088	77,013
	Total	25,697	62,549	6,367	57,151	151,764
Occupational Therapist	2009	4	0	0	99	103
	2010	4	0	0	43	47
	2011	0	0	8	398	406
	Total	8	0	8	540	556
Physiotherapist	2009	12	438	517	2,442	3,409
	2010	21	390	755	3,043	4,209
	2011	119	719	1,142	3,524	5,504
	Total	152	1,547	2,414	9,009	13,122
Medical Laboratory Technologist	2009	1,042	45	399	0	1,486
	2010	1,494	114	543	0	2,151
	2011	2,943	132	209	0	3,284
	Total	5,479	291	1,151	0	6,921
Radiographer	2009	424	163	347	291	1,225
	2010	322	398	1,220	561	2,501
	2011	1,122	544	1,366	83	3,115
	Total	1,868	1,105	2,933	935	6,841
Enrolled Nurse	2009	610	0	0	0	610
	2010	26	0	5	0	31
	2011	4	0	4	0	8
	Total	640	0	9	0	649
Registered Nurse	2009	871	8	73	50	1,002
	2010	1,015	22	133	135	1,305
	2011	676	31	335	175	1,217
	Total	2,562	61	541	360	3,524
Chiropractor	2009	35	270	74	794	1,173
	2010	46	295	43	571	955
	2011	8	447	89	953	1,497
	Total	89	1,012	206	2,318	3,625
	2009	*63,853* *(8.0%)*	*535,603* *(66.7%)*	*175,839* *(21.9%)*	*27,158* *(3.4%)*	*802,453* *(100%)*
	2010	*94,586* *(7.1%)*	*900,747* *(67.5%)*	*295,525* *(22.2%)*	*43,319* *(3.2%)*	*1,334,177* *(100%)*
	2011	*139,397* *(7.8%)*	*1,193,349* *(66.8%)*	*390,354* *(21.9%)*	*63,229* *(3.5%)*	*1,786,329* *(100%)*
	Total	*297,836* *(7.6%)*	*2,629,699* *(67.0%)*	*861,718* *(22.0%)*	*133,706* *(3.4%)*	*3,922,959* *(100%)*

Note: 2009 - Figures from 1 January 2009 to 31 December 2009

2010 - Figures from 1 January 2010 to 31 December 2010

2011 - Figures from 1 January 2011 to 31 December 2011

Figures may not add up to 100% due to rounding

EXECUTIVE SUMMARY

The Elderly Health Care Voucher Pilot Scheme (the Scheme) has been in place for two years since its implementation in 2009. To assess the effectiveness of the Scheme in enhancing primary care for the elderly, the Government initiated an interim review in the second half of 2010. The operation of the Scheme and utilization of the vouchers were examined. The opinions and feedback of the elderly and healthcare service providers were collected. This executive summary highlights the major findings of the review, our evaluation of the extent to which the Scheme has achieved its objectives, and our recommendations on the way forward when the current pilot period ends on 31 December 2011.

Scheme Objectives

2. The Chief Executive announced in the 2007-08 Policy Address that the Government would launch a three-year pilot scheme in the 2008-09 financial year under which elderly people aged 70 or above would be given annually five health care vouchers worth $50 each to subsidise the primary healthcare services they purchase from the private sector. The Scheme was launched on 1 January 2009. It aims at providing partial subsidies for the elderly to receive private primary healthcare services in the community, as additional choices on top of the existing public primary healthcare services, with a view to enhancing primary healthcare services for the elderly. The Scheme implements the "money follows patient" concept on a trial basis, enabling elderly people to choose within their neighbourhood private primary healthcare services that best suit their needs.

3. By providing partial subsidies for the elderly to choose private primary healthcare in the community, it is expected that the Scheme could help promote key ingredients of good primary care among the elderly and healthcare service providers, including: continued relationship between the elderly and their healthcare providers, more provision and utilization of preventive healthcare services, and promotion of well-being among the elderly. With better access and a continuum of care from participating healthcare service providers, we expect that more elderly people would be able to choose private primary healthcare services close to their homes, and those elderly people who need to rely on public healthcare services might also benefit from

the less burdened public primary care services.

Scope and Methodology of the Interim Review

4. The interim review was conducted when the Scheme has been implemented for its first half of the pilot period. Efforts have been made to show the position up to 31 December 2010, save for situations where only data up to 31 October 2010 were available for analysis purposes.

5. The scope of the interim review covers the operation of the Scheme, participation in the Scheme, utilization of vouchers, and feedback on the Scheme in general and specific aspects. In particular, the interim review has covered the following aspects by –

(a) examining voucher utilization by the elderly and participation of healthcare service providers in the Scheme;

(b) collecting feedback from the elderly (both participating and non-participating) about the Scheme, including their awareness of the Scheme, means to get to know the Scheme, reasons for Scheme participation / non-participation, desirable subsidy amount, age eligibility, healthcare services coverage, service delivery and perception about change in service fees and choice of healthcare service after Scheme launch; and

(c) collecting feedback from healthcare service providers (both enrolled and non-enrolled) about the Scheme, including scheme operation, service delivery, barriers of non-participation and reasons for withdrawal.

6. Data collected for analysis and examination include statistical data captured in the database of the eHealth System and purposely collected data through structured questionnaires and focus group discussions. To this end, studies were conducted by the School of Public Health and Primary Care of Faculty of Medicine of the Chinese University of Hong Kong to collect feedback from the elderly and healthcare service providers, viz. the opinion survey, focus group discussions and the willingness-to-pay study.

Scheme Operation and Implementation

eHealth System

7. The Scheme is administered through an electronic platform, viz. the eHealth System. It is a web-based system on which voucher-based and subsidy schemes operate. There is no need to issue or carry vouchers in paper form as vouchers are issued and used through the electronic system. The eHealth System performs the following functions -

(a) managing information on healthcare service providers and enrolment;

(b) managing health care voucher accounts, including registering eligible elderly people under the Scheme, issuing vouchers, processing claims and recording usage;

(c) managing reimbursement of health care vouchers on a monthly basis; and

(d) monitoring the Scheme by producing statistical reports to facilitate planning and management of daily operation, and generating alert messages whenever an irregularity in the use of vouchers is detected to facilitate follow-up actions and investigations.

Use of Smart Identity Card Reader

8. To further streamline procedures and provide greater convenience to healthcare service providers, arrangements have been made in late 2010 to make use of the "card face data" function in the chips of the Smart Hong Kong Identity Card (HKID) for registration and authentication. It provides an alternative means to participating healthcare service providers to register persons eligible for vouchers and to access their accounts for claiming vouchers, obviating manual input and ensuring data accuracy.

Privacy Impact Assessment and Privacy Compliance Assessment

9. Measures to protect personal data privacy and to prevent abuse have been instigated prior to and during Scheme implementation. A Privacy Impact Assessment (PIA) and a Privacy Compliance Assessment (PCA) on the design and operational procedures of the Scheme (phase I) were conducted between July and December 2008 by Deloitte Touche Tohmatsu. This ensures that the eHealth System has built-in features to safeguard the security of personal data transferred and stored within it in compliance with the relevant legislation and government guidelines on protection of personal data privacy. Prior to full launch of Smart HKID deployment for eHealth account creation and voucher claims in October 2010, PIA and PCA on phase II of the eHealth System were conducted between April and July 2010.

Security Risk Assessment and Audit

10. In addition, the Department of Health (DH) engaged Computer and Technological Solutions Limited (C&T) to conduct Security Risk Assessments of phase I and II of the eHealth System in May 2008 and June 2010 respectively. The current security risk level of eHealth System was found satisfactory, and complied with the Government's IT Security Policy and Security Regulations.

Post-claim checking and Auditing

11. As at 31 December 2010, a total of 852,721 claim transactions involving 2,136,630 vouchers were processed for reimbursement and a total of about $106 million have been reimbursed to enrolled healthcare service providers. To ensure proper disbursement of funding for voucher claims, DH has put in place a mechanism for checking and auditing voucher claims. It involves (a) routine checking, (b) monitoring and investigation of aberrant patterns of transactions, and (c) investigation of complaints. By end December 2010, a total of 1,711 inspection visits were conducted, having 30,241 claims checked which represents 4% of claim transactions made. The checking covers 77% of enrolled healthcare service providers with claims made. The post-claim checking and auditing revealed 25 cases of wrong claims, representing 4% of the checked claims. These claims involved errors in procedures or documentation. So far, two medical practitioners and one Chinese medicine practitioner have been delisted from the Scheme.

12. In mid 2008, the Corruption Prevention Department of the Independent Commission Against Corruption offered corruption prevention advice to DH on the administration of the Scheme prior to its launch. Also, to ascertain whether there are potential risks to regularity, propriety or financial control in the management of the Scheme and its operational mechanism, the Audit Commission conducted a risk audit of the Scheme in 2009-10. DH has taken into account their suggestions and observations in fine-tuning the modus operandi of the Scheme.

Statistics on Scheme Participation and Utilization

Healthcare service providers: distribution of places of practice

13. As at 31 December 2010, there are a total of 2,736 healthcare service providers enrolled in the Scheme, involving 3,438 places of practice. Among them, 39.6% (1,363) are in Kowloon, 23.4% (803) Hong Kong Island, 19.8% (681) the New Territories West, 16.0% (549) the New Territories East and 1.2% (42) Islands district. Of the 18 districts, Yau Tsim Mong district (549) has the highest number of places of practice.

Healthcare service providers: Enrolment and participation rate

14. Nine categories of healthcare professional who are registered in Hong Kong are eligible to participate in the Scheme. They are medical practitioners, Chinese medicine practitioners, dentists, chiropractors, registered and enrolled nurses, physiotherapists, occupational therapists, radiographers and medical laboratory technologists. Medical practitioners account for the highest percentage of enrolled healthcare service providers (52.3%) (1,431), followed by Chinese medicine practitioners (27.9%) (762) and dentists (8.7%) (239).

15. We estimate that the participation of medical practitioners, which formed the majority of the enrolled healthcare services providers, is about 34.1% of the potential pool of medical practitioners actively providing healthcare services in the private sector. The participation rate is on par with other public-private partnership schemes launched by the Government (e.g. vaccination subsidy schemes). Participation among other eligible health

professions is relatively lower, at 16.1% for dentists and 12.5% for Chinese medicine practitioners.

Elderly people joining the Scheme and claiming vouchers

16. As at 31 December 2010, a total of 385,657 eHealth accounts (representing 57% of eligible elderly people) were created and 300,292 eHealth accounts made voucher claims (representing 45% of eligible elderly people). The number of eligible elderly people who have registered with the Scheme has increased from 42% in end 2009 to 57% in end 2010. The number of eligible elderly people who have registered with the Scheme and made voucher claims has increased from 29% to 45% over the same period. By the end of the second year of the pilot period, 131,801 elderly people, or 34% of elderly people who have registered with the Scheme (some 20% of the eligible elderly people), used up the vouchers they were entitled to by then.

Claim transactions made: distribution among health professions, vouchers claim pattern and usage

17. With regard to the distribution of claim transactions among the different professions, the majority (88.1%) (751,212 out of 852,721) of the claim transactions are made by medical practitioners. Chinese medicine practitioners (9.3%) (79,377) and dentists (1.9%) (16,396) rank second and third in terms of utilization of vouchers. In terms of number of vouchers claimed, medical practitioners constitute the largest proportion (87.1%) (1,861,348 out of 2,136,630 vouchers), followed by Chinese medicine practitioners (8.4%) (180,324) and dentists (3.5%) (74,751).

18. Among the nine health professions, dentists have the highest average number of voucher claimed per transaction (4.56 vouchers per transaction) whereas the two lowest are medical practitioners (2.48 vouchers per transaction) and Chinese medicine practitioners (2.27 vouchers per transaction). The median of vouchers claimed per transaction for dentists is 4.75 whereas for medical practitioners and Chinese medicine practitioners are 2.77 and 2.43 respectively.

19. For distribution of claims by reason of visit, a high proportion of claim transactions (69.4%) are made for management of acute episodic conditions.

Follow-up / monitoring of long term conditions account for 21.4%. Only 6.5% and 2.7% of the claim transactions are made for preventive healthcare service and rehabilitative care respectively.

20. In terms of the number of vouchers used during each transaction, the most common pattern (40.4%) is the use of two vouchers ($50 x 2), followed by three vouchers ($50 x 3) (21.8%) and one voucher ($50 x 1) (21.1%). No information on additional charges above the vouchers claimed is available as healthcare providers are currently not required to supply such information.

21. The eHealth statistics reveal that there are 25% eHealth accounts with claim transactions involving two or more medical practitioners. 75% of eHealth accounts with more than one claim transaction involved only one medical practitioner. Most of the elderly tend to stay with the same medical practitioner when using vouchers.

Opinion Survey and Willingness-to-pay Study

22. To gauge the views and opinions of the elderly and healthcare service providers about the Scheme, an opinion survey and four focus group discussions were conducted between January and June 2010. In order to further assess the willingness to pay for private primary healthcare services among the elderly and to examine the level of subsidy that would incentivize the elderly to change their healthcare seeking behaviour for private primary healthcare services, a willingness-to-pay study was conducted in June and July 2010. These studies were undertaken by the School of Public Health and Primary Care of Faculty of Medicine of the Chinese University of Hong Kong.

Opinion survey

23. A total of 1,026 elderly people were recruited from public parks, General Out-patient Clinics of Hospital Authority, Elderly Health Centres of the Department of Health and private general practitioners' clinics. They included participants and non-participants of the Scheme. 70% of the elderly said that they were aware of the Scheme. 35% said that they had actually used the vouchers.

Reasons for using vouchers

24. The survey reveals that elderly people who are used to seeing private doctors are more ready and prepared than those relying on the public healthcare system to register and make use of health care vouchers. Comparison is made on use of vouchers for subpopulations according to the type of doctors they usually visit. 24% of the elderly who usually visited public doctors had made use of their vouchers. For those who usually visited private general practitioners' clinics, 49% of them had made use of their vouchers during consultation. Comparison is also made for two sub-groups, viz. voucher users and non-voucher users. For those who had made use of vouchers, comparatively speaking, more elderly people were used to seeing private doctors (27.5% usually visited private doctors, 49.4% visited both private and public doctors, and only 23.0% usually visited public doctors). For those who had never made use of vouchers, many of them were used to seeing public doctors (43.2% usually visited public doctors, 40.2% visited both private and public doctors, and only 16.6% usually visited private doctors). The trigger for the use of vouchers was to make good use of the subsidy given by the Government (36%), followed by shorter waiting time (33%), and recommendation from friends, doctors and nurses (18%).

25. For those who were aware of the Scheme but had never used their vouchers (328), the reasons for not using vouchers included the healthcare professionals whom they usually visited had not enrolled in the Scheme (24%), the elderly were used to seeing public doctors (24%), the elderly were healthy and did not have to consult healthcare professionals (23%), and they could not find an enrolled healthcare professional nearby (22%).

Scheme awareness

26. Some 71% of the interviewed elderly were aware of the Scheme. Television advertisement (58%) was the key source of information, followed by press and magazines (23%), and enrolled healthcare service providers (20%). Among those elderly people who were aware of the Scheme, 47% of the respondents felt the information provided to them was very, quite or fairly sufficient. Among the 31% of elderly people who felt that the information was insufficient, 53% would like to learn more on how to use the vouchers and 43% would like to know the channels where they could obtain the list of

enrolled healthcare professionals.

Scheme scope: subsidy amount

27. Of the 1,026 elderly people who participated in the survey, 17% (35% were voucher users) of them considered the annual subsidy amount of $250 was enough. 68% (39% were voucher users) of them considered the subsidy amount of $250 per annum was not enough. Among those who considered the amount was not enough, 36% preferred a subsidy amount of $300-$500 and 32% preferred a subsidy amount of $501-$1,000.

Scheme scope: age eligibility

28. A total of 233 elderly people aged 60-69 were interviewed during the survey. The majority of the respondents (74%) thought that the age eligibility should be lowered. Among them, 70% suggested lowering the age to 65 years old.

Scheme scope: health service coverage

29. Of the 1,020 elderly people who answered the question on coverage of health services, 24% of elderly people thought that the coverage of health services was insufficient. Among those who provided suggestions to enhance the service coverage (173), 63% suggested adding public clinics and 28% suggested adding optometrist to the list of participating healthcare professionals.

Scheme delivery

30. Elderly people's satisfaction of the Scheme was assessed by asking whether they considered the Scheme useful or convenient to use. Some 65% of interviewed elderly people (including both voucher users and non-voucher users) considered the Scheme useful. Among the 359 voucher users, 79% considered the Scheme useful.

31. In addition, the elderly were also asked on whether they considered the vouchers were convenient to use. Some 64% of the interviewees (including both voucher users and non-voucher users) considered the

vouchers were convenient to use. Among the 359 voucher users, 80% considered the vouchers convenient to use.

Scheme impact: choice of healthcare services after Scheme launch

32. Of 1,026 elderly people who participated in the survey, one third (32%) said that the Scheme encouraged them to use private primary care service more than before. Some 66% of the elderly considered that the Scheme did not change their behaviour in seeking private primary healthcare services. Major reasons for no change of health seeking behaviour included "used to seeing public doctors (26%)" and "the subsidy amount was too little (24%)".

Scheme impact: change in service fees after Scheme launch

33. In the survey, the elderly were asked whether, from a perception point of view, the consultation fees in general had increased subsequent to the launch of the Scheme. 45% did not perceive any increase in consultation fees. 42% reported that they did not know whether the Scheme had led to any increase in consultation fees. 14% perceived that the consultation fees increased as a result of the Scheme.

Willingness-to-pay study

34. To assess the elderly's willingness-to-pay, their sensitivity towards subsidy amount and health seeking behaviour, the Willingness-to-pay (WTP) Study was conducted between June and July 2010 among 1,164 elderly people aged 60 or above.

Willingness-to-pay and co-pay

35. The elderly were asked what was the maximum amount they were willing to pay for a visit to see a private medical practitioner for different conditions, and what was the maximum additional amount they were willing to co-pay if the Government provided subsidy for them to seek care in the private sector. The results show that their willingness to pay (WTP) and the amounts they were willing to co-pay for private primary care services varied by type of diseases and services.

36. The average WTP amounts for general health conditions and acute condition were within the current price range in private sector. However, the WTP amounts for chronic condition and preventive care such as health check and dental check fell below the price range in private sector. For chronic conditions (47%) and dental check (54%), almost half of the respondents were unwilling to pay for private healthcare service (WTP=$0). For health check, 36% of respondents were unwilling to pay for such service (WTP=$0). 32% out of the total respondents were willing to pay an amount within or above the price range for health check in private sector, and another 32% willing to pay an amount below the market price range for health check. The elderly in general were more willing to pay for acute episodic condition. 76% of elderly were willing to pay for such services, including 65% willing to pay an amount within or above the price range in private sector and 11% willing to pay an amount below market price range. The main reasons for being unwilling to pay for private healthcare service were "used to seeing public doctors" and "private healthcare services were too expensive".

37. The elderly were also asked on the maximum amount they were willing to pay for service managing minor illness and chronic illness, if the Government provided them with different level of subsidy. It is noted that more than half of the elderly were willing to co-pay the same amount despite different amounts of subsidies potentially provided by the Government.

Subsidy

38. The elderly were asked the lowest amount of Government subsidy that would encourage them (i) to see a private medical practitioner among those who have been consulting public doctors for different diseases, (ii) to have a health check regularly in the private sector among those who had not done so, and (iii) to have dental check in the private sector. The findings reveal that the subsidy requested varies by type of diseases and services. By and large, the elderly requested more subsidy for chronic conditions, health checks and dental check. In other words, the elderly were more willing to pay for management of acute episodic diseases than chronic conditions and preventive care.

Conclusion and Recommendations

39. The interim review brings to light points worth noting regarding the Scheme over the past two years through its initial operation, and at the same time identifies areas requiring further attention. It deepens our understanding of the behaviour of elderly people and healthcare service providers in the use of health care vouchers and in seeking and providing healthcare services. Its findings provide us with a foundation for making observations and recommendations to improve the Scheme with a view to achieving the objectives of enhancing the health of the elderly. It also enables us to identify potential pitfalls in public-private partnership that provide useful inputs to the design of any other public-private partnership schemes for delivering healthcare.

40. In overall terms, the review shows that the Scheme, while might not have been able to readily achieve all the objectives it was intended for, has made a start in establishing an effective and efficient mechanism for the provision of healthcare services with government subsidies through public-private partnership. Meanwhile, the interim review also reminds us that it is no easy task to induce behavioural changes among the elderly in seeking and among the providers in providing healthcare services. It shows that more efforts are required for the key notions of good primary healthcare especially preventive care, as well as the concept of continuum of care to be more widely promoted and accepted among elderly population and healthcare providers. It also points to the need for the Scheme operation including its supporting platform to be further strengthened.

Key Observations on the Scheme

(i) Scheme awareness and participation

41. The findings of the interim review show that the Scheme has made a good start in raising the awareness of the elderly to primary healthcare and widening the choices of healthcare services to the elderly. The high awareness of the elderly of the Scheme (over 70%) signifies that the Scheme has gradually taken root in the community. This provides a good basis for furthering the objectives of the pilot to enhance primary care for the elderly and also for the promotion of other public-private partnership schemes in

healthcare.

42. The participation rate of the elderly (57% eligible elderly people registered in the Scheme and 45% eligible elderly people have actually used vouchers as at 31 December 2010) is noticeably higher than other public-private partnership schemes, signifying that the scheme has been able to attract the attention of the elderly. However, given that one of the main reasons for not using vouchers is that the elderly are used to seeking public healthcare, and that these elderly are less likely to seek private healthcare, more effort would be needed to encourage participation among the elderly.

43. The participation rate of healthcare professionals (34% for medical practitioners) has been on par with other public-private partnership schemes and geographically distributed across the territory, providing a large number of choices for the elderly. However, given that one of the main reasons for not using voucher is that the provider usually seen by the elderly has not enrolled in the Scheme, there appears room for further improvement in promotion efforts and participation rate among healthcare providers especially medical practitioners.

(ii) Satisfaction with the Scheme

44. Convenience and user-friendliness are the two guiding principles in designing and fine-tuning the eHealth System on which the Scheme runs and operates. In the survey about the general perception of the Scheme of both the voucher users and non-voucher users, a majority (64%) perceived that the vouchers were convenient to use and 65% of interviewed elderly people considered the Scheme useful. Among those who actually used the vouchers, 80% of them agreed that the vouchers were convenient to use and 79% of them considered the Scheme useful. It shows that the Scheme has been designed along the right track, and has provided a sound basis for the further development of public-private partnership in healthcare and subsidization schemes aiming at enhancing primary healthcare.

45. The operation of the Scheme had encountered various teething problems at the initial phase of the Scheme, mostly concerning the use of the electronic platform and the procedures for making claims. These have soon been identified and addressed through the concerted efforts of parties

concerned, and the operation details of the Scheme have been streamlined significantly since. Improvements on this front are recognized by elderly users, as evidenced by the favourable response they gave in the opinion survey concerning convenience of using vouchers. The use of vouchers in electronic form through the eHealth System has helped promote familiarization of e-transaction among the elderly population and healthcare providers. Some healthcare service providers, nevertheless, consider the eHealth System can further be improved its user-friendliness in the light of clinical operation.

46. After the initial phase, the operation of the Scheme including its claims mechanism and eHealth System has been smooth and efficient, as indicated by the low number of support requests or complaints from users, the high compliance with pledged performance targets for claims processing, and the effective monitoring of the operation of the Scheme and claims pattern. The eHealth System established and refined enables us to implement and further test the concept of "money follows patient", and has also benefited other public-private partnership schemes (e.g. the vaccination subsidy schemes) in providing a highly efficient platform for providing small amount of government subsidies for healthcare services that are high in volume.

47. The Scheme had also established a network of healthcare providers in the community who are mostly involved in the provision of primary healthcare services to the elderly as well as the population at large. The engagement of these providers through various public-private partnership schemes in delivery healthcare services, including the Elderly Health Care Voucher Pilot Scheme, is instrumental to the implementation of our primary care development strategy and development of primary health care services in the community, as the private sector provides the majority of primary health care services available to the population. In this regard, the Scheme has taken a major step in the direction of establishing a public-private partnership model and platform that is necessary to enable change of healthcare seeking and providing behaviour among users and providers.

(iii) Impact on healthcare seeking behaviour

48. Broadly speaking, the Scheme has so far failed to induce any

noticeable behavioural change on the part of both users and providers of primary healthcare services, during the first two years of the pilot period. In particular, there is no evidence so far that the Scheme has brought about any noticeable changes in the healthcare seeking behaviour among the elderly, or resulted in an increase in the utilization and provision of preventive care service. The review indicated that inertia of the elderly already seeking care in the public sector, participation of healthcare providers that the elderly usually see, and the relatively lower willingness-to-pay for preventive care are main factors impeding the desired changes.

49. The fact that only about 6.5% of health care vouchers claimed went towards preventive service (with about 70% for episodic care) shows that most elderly people give preventive services a low priority when it comes to healthcare spending decision. The Willingness-to-pay Study also shows that the elderly are less willing to pay for preventive care than episodic care. This is a conception that has taken root among the elderly, and takes time and the concerted efforts of all – Government, healthcare service providers, the media, etc – to gradually induce a cultural change that puts more value and emphasis on preventive care.

50. It appears from the review that these behavioural changes are not easy to induce, even with the aid of health care vouchers. The review showed that elderly people who are used to seeing private doctors are more ready and prepared than those relying on the public healthcare system to register and make use of health care vouchers. On the other hand, those elderly who are accustomed to seeking healthcare in the public system are only marginally motivated to seek private primary care services on account of the subsidies provided by the vouchers. Most elderly people tend to follow their usual healthcare-seeking pattern despite the availability of health care vouchers.

51. On the other hand, the review showed encouraging signs that the elderly do tend to stay with the same healthcare provider they use vouchers for especially in the case of medical practitioner. This is conducive to the development of continuous doctor-patient relationship and the concept of family doctor providing comprehensive care to them. With the right design and incentive, it is still possible for the Scheme to initiate the desired behavioural changes essential to the development of comprehensive and

holistic primary healthcare. However, further and more in-depth monitoring and analysis would be needed to assess the effects of the Scheme on such changes.

(iv) Price and subsidy for healthcare services

52. The review indicates that subsidy, price and co-payment required for healthcare services are important factors to be considered in affecting the elderly's healthcare seeking behaviour. As the Willingness-to-pay Study shows, the elderly in general are more willing to pay for curative care, with the average falling within the price range for private curative healthcare. This may also be one of the reasons for the voucher use concentrating on curative care. On the other hand, the elderly are relatively much less willing to pay for preventive and chronic disease care. This suggests that price and subsidy level are key indicators to be monitored.

53. The launch of the Scheme aims at providing partial subsidies for the elderly to receive private primary care services in the community with a view to enhancing primary healthcare services for the elderly and promoting well-being among them. The launch of the Scheme is also expected to introduce the concept of co-payment among the elderly in seeking healthcare services. We note that in most instances when vouchers are used, the elderly people concerned also meet part of their consultation fees out of their own pocket. In this respect, the concept of co-payment is realized. However, as revealed by the Willingness-to-pay Study, there is only limited incentive for the elderly to co-pay more (in absolute terms) when the voucher amount is increased. The relatively lower willingness to co-pay for preventive care than curative care and the concentration of voucher use on curative care also makes it difficult to assess the effect of subsidy on co-payment.

54. Since the current Scheme does not require providers to provide more specific information on healthcare services provided and additional co-payment charged over vouchers, we cannot ascertain with certainty if the actual co-payment charged for specific healthcare services are within affordable range of the elderly, or if the co-payment charged for specific services are beyond the willingness-to-pay of the elderly. The sampling survey suggests no significant degree of perceived increase in service fees, though a small but not insignificant proportion of elderly people did report

perceived increase in service fees due to the use of vouchers. However, given the sampling size and also lack of benchmark for comparison, we cannot conclude with certainty how co-payment level has played a role in influencing the healthcare seeking behaviour of the elderly, and if increasing the subsidy level might help change such behaviour.

55. The above observations suggest that any increase in subsidy level through higher voucher amount should be carefully calibrated to address the intention to influence the desired healthcare behavioural changes and the need to promote appropriate co-payment for healthcare service utilization. This is necessary to ensure that public monies are properly spent while suitably addressing the objectives of the Scheme and the needs and concerns of the elderly. The above also suggest that the monitoring and assessment of price and subsidy level for different healthcare services should be strengthened, so that the effect of government subsidy through the vouchers on healthcare seeking and providing behaviour could be better evaluated.

(v) Coverage of healthcare service *providers*

56. Optometrists are not currently included as eligible healthcare providers under the Scheme. We note that some elderly people (28% of the elderly as revealed in the opinion survey) have expressed the wish for including Optometrists under the Scheme so that healthcare services provided by them could also be met through health care vouchers. We also note in particular that Optometrists with Part I registration under the Supplementary Medical Professions Ordinance (Cap. 359) are qualified to provide certain preventive care services concerning eye conditions, for example, to conduct visual acuity examination for patients suffering from cataract and diabetes. Their inclusion may thus help facilitate the greater use of preventive care by the elderly.

Recommendations

57. Having regard to the findings of the interim review, we recommend that **the Scheme be extended for another pilot period of three years, from 1 January 2012 to 31 December 2014**, when the current pilot period ends on 31 December 2011. This is to allow further testing the effectiveness of the Scheme in furthering the policy objectives to enhance the primary health care

for the elderly and to enable them to choose private primary health care in their neighbourhood, through providing partial subsidies to the elderly through health care vouchers.

58. The proposed extension of the pilot period of the Scheme is in keeping 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 to be launched in Q2 2011. In particular, the extended Scheme will allow a longer period to assess the effectiveness of using vouchers to promote good primary care among the elderly and healthcare providers, including: continued relationship between the elderly and their healthcare providers, more provision and utilization of preventive healthcare services, and the concept of continuum of care and well-being among the elderly and their healthcare providers.

59. In this regard, on the basis of the findings of the interim review, we recommend that the following specific measures be taken in conjunction with the extension of the Scheme for the further three year pilot period -

(a) Increase the voucher amount per year for the next three-year pilot period (from 1 January 2012 to 31 December 2014) from $250 to $500, while keeping the dollar value of each voucher the same as before (i.e. $50 each). The number of vouchers given to each eligible elderly person will be increased to ten. In this connection, we note that there are demands for increasing the voucher amount from the elderly and different quarters of the community. We also note that an increased voucher amount would help better assess the effectiveness of the Scheme in achieving its policy objectives. On the other hand, we need to carefully consider whether and, if so, to what extent an increase in voucher amount would affect the healthcare seeking behaviour among the elderly, the prices to be charged by healthcare service providers, the amount elderly people are willing to co-pay and the emphasis elderly people put on preventive services. We consider that the recommendation to increase the voucher amount per year to $500 strikes a right balance, and ensures that public monies are properly spent.

(b) There is a need to forge closer collaboration with healthcare professionals to further promote the importance of primary care, both among elderly people and service providers, and to encourage utilization 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, in partnership with interested and qualified healthcare service providers, a voluntary, protocol-based elderly health check programme at affordable prices for elderly people. Elderly people aged 70 or above could meet the payment, partly or wholly, through health care vouchers. The health check programme will be modeled on the established practices and service protocol of the Elderly Health Centres under the Department of Health.

(c) Allow, on a one-off basis on account of extension of the three-year further pilot period, the unspent balance of health care vouchers under the current pilot period (ending 31 December 2011) to be carried forward into the next pilot period (from 1 January 2012 to 31 December 2014). This is to allow a fuller assessment of the effectiveness of the Scheme and the utilization of health care vouchers in the next pilot period. Given the significant financial liability arising from accumulation of vouchers, all unused vouchers should lapse on the expiry of the extended pilot period ending 31 December 2014, irrespective of whether the voucher scheme will continue or otherwise.

(d) Improve upon the operation of the 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 two aspects –

(i) Diagnosis information: we would explore the feasibility for participating healthcare service providers to input more specific information on the healthcare services provided to voucher users. For example, participating medical

practitioners would be required to provide more specific clinical diagnosis, rather than the broad indication under the current "reason of visit" arrangement, for their voucher users so as to better enable the Administration to assess and monitor the healthcare services provided to the elderly; and

(ii) Co-payment: participating healthcare service providers would be required to input the co-payment made by an elderly person for each consultation involving the use of health care voucher(s). Coupled with (i), this will allow the price and subsidy level for specific healthcare services to be better monitored, and the impact of vouchers on healthcare services be better assessed.

(e) Add optometrists with Part I registration under the Supplementary Medical Professions Ordinance (Cap. 359) to the Scheme with effect from the next pilot period, i.e. 1 January 2012, 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 (e.g. spectacles).

60. Apart from the above, we do not recommend making any changes to other rules of the Scheme. Specifically, we will, in the further three-year pilot period, continue to –

(a) Maintain the existing age eligibility, i.e. aged 70 or above. In view that the effectiveness of the voucher model in changing healthcare seeking behaviour has yet to be fully ascertained, we consider it prudent to continue the pilot scheme with the existing pool of eligible elderly and further assess the impact of the Scheme on healthcare utilization and price. Given the proposed increase in voucher amount, maintaining the pool of eligible elderly would also help minimize the risk of price inflation of private healthcare services due to increased government subsidy.

(b) Keep the current rules on the use of health care 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). Given the objective of the Scheme to enhance primary healthcare for the elderly through public-private partnership and in view of concerns over double-subsidy using public money, we maintain the view that vouchers should only be used for private services, but not for medical items or public healthcare.

(c) Retain the current flexibility in using health care vouchers (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). This is to allow the voucher model to be further and more fully assessed on its effectiveness to enhance and incentivize various primary healthcare services. However, restrictions or limitations may need to be imposed eventually in the light of further review of the Scheme especially voucher utilization over the extended pilot period.