For discussion
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Legislative Council Panel on Health Services
Review on the Elderly Health Care Voucher Scheme

PURPOSE

This paper briefs Members on the findings of the latest review on the Elderly Health Care Voucher Scheme (the Scheme) conducted by the Department of Health (DH) and invites Members' views on the Government's proposed enhancement measures to refine the Scheme's operation.

BACKGROUND

2. The Scheme, launched on a pilot basis in January 2009 and regularised in January 2014, aimed at providing financial incentives for elders to choose private healthcare services in their local communities that best suit their health needs. It is meant to help enhance primary healthcare for the elderly and provide them with additional healthcare choices. Elders can then have better access to care and a continuity of care from their chosen providers.

3. Currently, the Scheme subsidises eligible Hong Kong elders aged 65 or above with an annual voucher amount of $2,000 to use private primary healthcare services provided by 10 types of healthcare professionals, viz. medical practitioners, Chinese medicine practitioners, dentists, nurses, physiotherapists, occupational therapists, radiographers, medical laboratory technologists, chiropractors and optometrists with Part I registration under the Supplementary Medical Professions Ordinance (Cap. 359). The accumulation limit of vouchers is $5,000. As at end-2018, over 7 900 healthcare service providers had enrolled. Close to 1.2 million elders, accounting for about 94% of the eligible population, had made use of the vouchers.

4. The Scheme has seen a number of enhancements over the years. The annual voucher amount has been progressively increased from the initial $250 to the current $2,000. Since July 2014, the face value of each voucher has been lowered from $50 to $1 to allow greater flexibility in use. In October 2015, a Pilot Scheme was launched to allow eligible elders to use the vouchers to pay for designated outpatient services at the University of Hong Kong – Shenzhen Hospital (HKU-SZH). In July 2017, the eligibility age was lowered from 70 to 65. In June 2018, an additional one-off $1,000 voucher amount was provided under the Scheme and the accumulation limit was raised to $5,000. As announced in the 2019-20 Budget, the Government proposes that an additional one-off $1,000 voucher amount be made available and the accumulation limit be further raised to $8,000 in 2019. The measures will be implemented as soon as practicable after the passage of the Appropriation Bill.

THE REVIEW

5. DH has recently completed a review on the Scheme. During the process, DH made reference to and synthesised information from various sources, including studies conducted in collaboration with the Chinese University of Hong Kong's Jockey Club School of Public Health and Primary Care[1], data extracted from the eHealth System (Subsidies) (eHS(S))[2], and a report issued by HKU-SZH on the use of vouchers under the Pilot Scheme there. The review assessed the following major areas –

(a) knowledge and attitudes of elders towards the Scheme;
(b) views of elders and healthcare professionals on the Scheme;
(c) impact of voucher usage on primary healthcare services for the elderly;
(d) utilisation pattern of vouchers;

[1] Including a cross-sectional survey on 1 026 elders aged 70 or above conducted in 2010, a longitudinal follow-up survey in 2016 of 326 elders who participated in the 2010 cross-sectional survey, a cross-sectional survey on 974 elders aged 70 or above conducted in 2016, and a focus group study and telephone interviews of 33 enrolled and non-enrolled healthcare service providers as well as administrators of medical groups.

[2] The eHS(S) was designed for the Scheme in 2008, providing an electronic platform for supporting its operation. The system is used for the enrolment of elders and healthcare service providers, processing and reimbursement of voucher claims, recording of voucher usage, generation of statistical reports, etc.

(e) operational arrangements of the Scheme; and

(f) whether the intended objectives as set out in paragraph 2 above have been achieved.

A summary of the findings of the review and our proposed follow-up measures are set out in the ensuing paragraphs.

6. The key findings of the review are as follows –

(a) **Scheme participation and utilisation** – An increase in participation by both elders and healthcare service providers was observed over the years. The percentage of elders who had used vouchers rose progressively from 28% in 2009 to 94% in 2018, with a corresponding increase in the annual amount of vouchers claimed from $40 million to $2.8 billion. As regards healthcare service providers, the participation rate[3] increased from 14% in 2014 to 20% in 2017. As of end-2018, a total of 7 941 healthcare service providers in Hong Kong had enrolled under the Scheme, providing services at 18 725 places of practice.

(b) **Awareness and understanding** – An increase in elders' awareness of the Scheme was observed (from 71% in 2010 to 99% in 2016). Despite the enhancements introduced to the Scheme throughout the years (such as increases in annual voucher amount and accumulation limit), elders were found to have a good understanding of the Scheme. There was an increase in the percentage of elders who knew the annual voucher amount (74% in 2010 vs. 81% in 2016). However, the percentage of elders who knew that vouchers could not be used for, for example, inpatient services was still low (42% in 2010 vs. 44% in 2016).

(c) **Attitude** – The attitude towards the Scheme became more positive. Between 2010 and 2016, a higher percentage of elders considered the Scheme convenient to use (67% vs. 95%). More elders were satisfied with the sufficiency of information on the Scheme available to them (47% vs. 76%). In 2016, the majority (72%) of elders considered the coverage of healthcare

[3] The participation rate is the percentage of healthcare service providers who have joined the Scheme out of the total potential healthcare service providers eligible to join. The latter excludes those who are practising in the public sector or are economically inactive.

services by the Scheme sufficient.

(d) **Utilisation pattern** – The percentage of elders who agreed that the Scheme had encouraged them to seek private primary healthcare services doubled from 32% in 2010 to 66% when the same group of elders were surveyed again in 2016. In 2016, of the elders who claimed that the Scheme had encouraged them to use private primary healthcare, 90% said the vouchers encouraged them to use acute episodic care services, while 42% claimed the vouchers encouraged them to seek more preventive care services. A modestly increasing trend was observed for the annual percentage of elders who had used the vouchers on preventive healthcare services (from 9% in 2010 to 36% in 2017). A slight increase was noted for follow-up/monitoring of long term conditions (from 26% in 2010 to 36% in 2017).

(e) **Voucher value** – In 2016, slightly less than half (44%) of the surveyed elders considered the voucher amount appropriate. Some healthcare service providers thought the price difference between the public and private sectors was too big to incentivise patients to change their health-seeking behaviour with the use of vouchers in the long run.

(f) **Impact on public services** – The Scheme encouraged dual use of public and private healthcare services. In 2016, when asked about their usual source of healthcare before and after they started using vouchers, elders who "usually attended both public and private services" increased from 49% to 61%. Those who "usually attended public services" and "usually attended private services" dropped from 24% to 16% and from 22% to 19% respectively. Among a cohort of 551 elders followed through from 2009 to 2015, an increase in overall utilisation of outpatient healthcare services was noted, with the increase more significant for utilisation of private services (via voucher usage) than of public services. This showed that although the use of vouchers might not have any immediate impact on public healthcare service utilisation, it nonetheless provided additional support to elders on top of the existing public services.

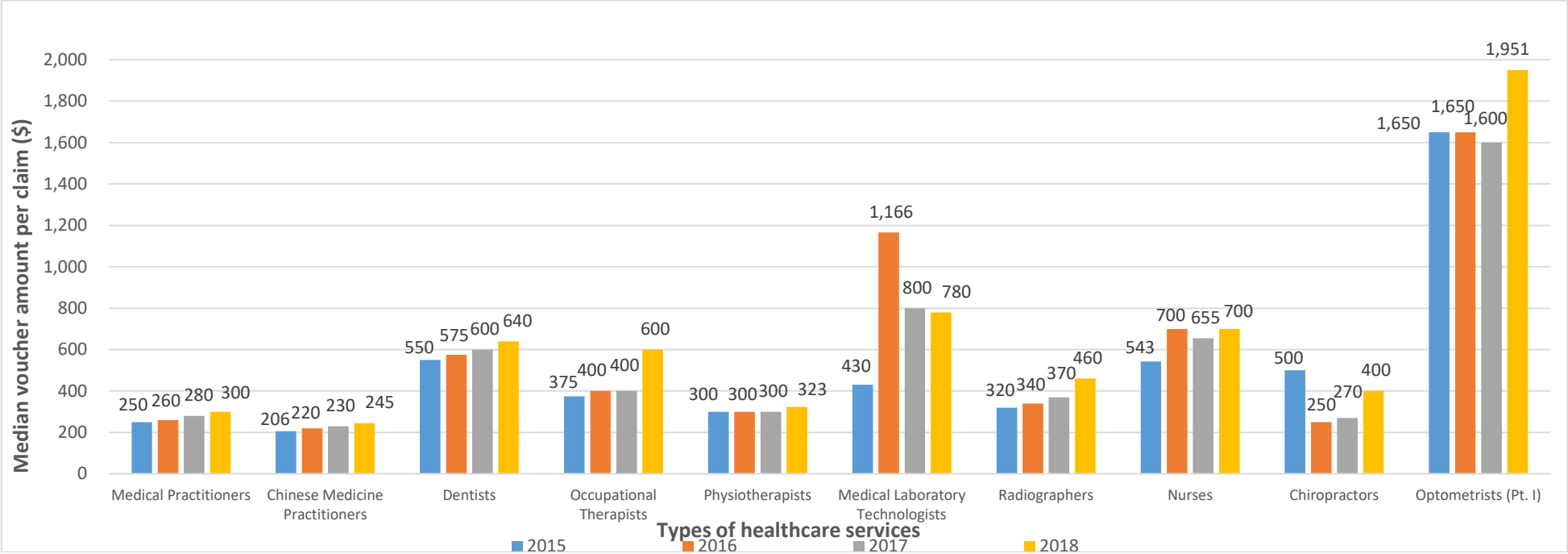
(g) **Voucher use** – The three figures below provide the (1) number of healthcare professionals enrolled in the Scheme, their total voucher amount claimed and number of voucher claim transactions in 2017 and 2018, (2) median voucher amount per

claim by types of healthcare services from 2015 to 2018, and (3) number of voucher claims exceeding $4,000 per claim by types of healthcare services between 8 June 2018 (when the accumulation limit was raised to $5,000) and 31 December 2018.

Figure 1: Number of healthcare professionals enrolled in the Scheme, their total voucher amount claimed and number of voucher claim transactions in 2017 and 2018

	2017			2018		
	No. of healthcare professionals enrolled at year-end	**Voucher amount claimed ($'000)**	**No. of voucher claim transactions**	**No. of healthcare professionals enrolled at year-end**	**Voucher amount claimed ($'000)**	**No. of voucher claim transactions**
Medical Practitioners	2 387 *(33%)*	774,088 *(51.7%)*	2 218 938 *(63.8%)*	2 591 *(33%)*	1,154,745 *(41.2%)*	2 917 895 *(56.4%)*
Chinese Medicine Practitioners	2 424 *(34%)*	256,563 *(17.1%)*	860 927 *(24.7%)*	2 720 *(34%)*	533,136 *(19.0%)*	1 502 140 *(29.0%)*
Dentists	895 *(12%)*	144,331 *(9.6%)*	168 738 *(4.8%)*	1 047 *(13%)*	287,044 *(10.3%)*	294 950 *(5.7%)*
Occupational Therapists	69 *(1%)*	2,506 *(0.2%)*	2 217 *(0.1%)*	74 *(1%)*	5,681 *(0.2%)*	3 515 *(0.1%)*
Physiotherapists	396 *(5%)*	8,344 *(0.6%)*	25 076 *(0.7%)*	441 *(5%)*	16,452 *(0.6%)*	40 874 *(0.8%)*
Medical Laboratory Technologists	48 *(1%)*	11,256 *(0.7%)*	12 044 *(0.3%)*	54 *(1%)*	17,808 *(0.6%)*	18 662 *(0.4%)*
Radiographers	40 *(1%)*	5,447 *(0.4%)*	8 935 *(0.3%)*	44 *(1%)*	13,400 *(0.5%)*	16 785 *(0.3%)*
Nurses	182 *(3%)*	5,122 *(0.3%)*	5 079 *(0.1%)*	182 *(2%)*	7,447 *(0.3%)*	6 523 *(0.1%)*
Chiropractors	71 *(1%)*	2,303 *(0.1%)*	5 346 *(0.2%)*	91 *(1%)*	5,225 *(0.2%)*	10 743 *(0.2%)*
Optometrists (Part I)	641 *(9%)*	288,582 *(19.3%)*	173 279 *(5.0%)*	697 (9%)	759,750 *(27.1%)*	359 343 *(7.0%)*
Sub-total (Hong Kong):	**7 153** *(100%)*	**1,498,542** *(100.0%)*	**3 480 579** *(100.0%)*	**7 941** *(100%)*	**2,800,688** *(100.0%)*	**5 171 430** *(100.0%)*
HKU-SZH (joining on hospital basis)	-	1,855	6 755	-	3,492	11 418
Total:	**7 153**	**1,500,397**	**3 487 334**	**7 941**	**2,804,180**	**5 182 848**

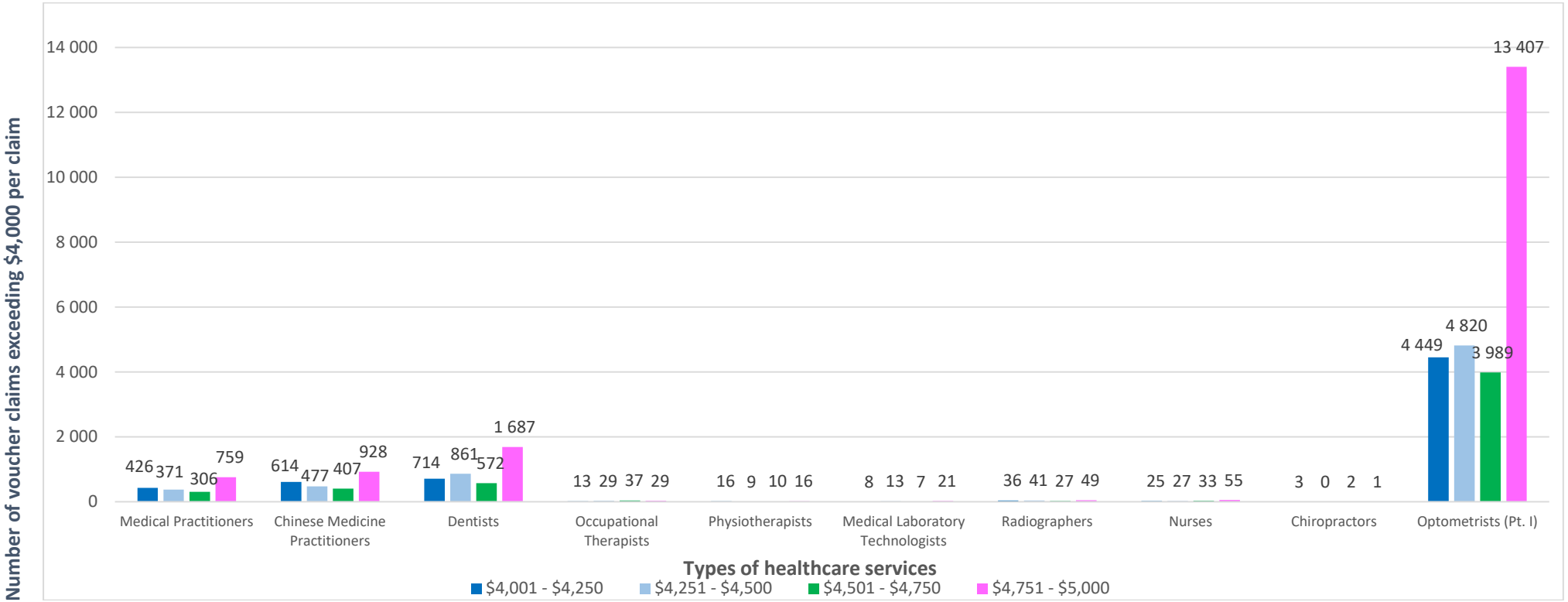
Figure 2: Median voucher amount per claim by types of healthcare services, 2015 – 2018 (Note)



Note:

1. The above only reflects the amount of fees settled by vouchers and does not include any out-of-pocket payment (i.e. co-payment) made by elders for each consultation, if any.
2. The above statistical data are compiled based on the actual voucher claims made by the healthcare service providers and should not be interpreted as fees recommended by the Government. The amount of healthcare service fees can be affected by various factors, such as the individual elder's health condition, the complexity of the case, and the healthcare treatment/management options involved.
3. The eligibility age for the Scheme has been lowered from 70 to 65 since 1 July 2017.
4. On 8 June 2018, each eligible elder was provided with an additional voucher amount of $1,000 on a one-off basis, and the accumulation limit of vouchers was increased to $5,000 as a regular measure.

Figure 3: Number of voucher claims exceeding $4,000 per claim by types of healthcare services (8 June – 31 December 2018)



Note:

1. On 8 June 2018, each eligible elder was provided with an additional voucher amount of $1,000 on a one-off basis, and the accumulation limit of vouchers was increased to $5,000 as a regular measure.

(h) **The Pilot Scheme at HKU-SZH –** The Pilot Scheme was well-received, with 92% of the 384 elders surveyed being satisfied with the services received at HKU-SZH paid for by vouchers under the Pilot Scheme. The most common reason quoted by elders (73%) for choosing to patronise HKU-SZH was the "Hong Kong's management model" adopted by the hospital.

Overall speaking, we consider that the Scheme has been well received by the elderly users, as seen from utilisation, knowledge and attitude. It has also provided an added choice on top of the existing public healthcare services.

PROPOSED ENHANCEMENT MEASURES

Scheme Principles

7. Although the Scheme has been well-received, there remains room for improvement. Enhancement measures developed for the Scheme should be targeted and designed to serve the Government's healthcare visions and policies, with emphasis on promoting primary healthcare and reinforcing the different levels of prevention. We have adhered to the following key principles when considering possible enhancement measures –

(a) **Vouchers should not be used for inpatient services, day surgery procedures or insurance premiums** – The policy intent of the Scheme is to assist elders to use private **primary** healthcare services. As such, we will continue not to allow vouchers to be used for inpatient services, day surgery procedures or insurance premiums so that the Scheme can continue to serve its primary objectives.

(b) **Vouchers should not be used for services provided by the Hospital Authority (HA) or DH** – The Scheme has been designed to offer additional healthcare choices **outside** the public system. As HA and DH services are already heavily subsidised, vouchers should normally not be allowed to be used for their services.

(c) **Vouchers should not be used for sole purchase of products** – The Scheme is designed to be used only when the healthcare service providers, who are to be held individually and

professionally accountable, see a need for the medication and/or medical products, etc., to be prescribed **after consultation**. To ensure that vouchers are actually used on the elderly patients and to curb potential abuse, sole purchase of products with vouchers should continue to be disallowed under the Scheme.

Enhancement Measures

8. In alignment with the above key principles and taking into consideration the review findings, the following enhancement measures are proposed –

(a) Allowing the use of vouchers at District Health Centres (DHCs)

9. The setting up of DHCs, as announced in the Policy Address 2017, is a landmark effort to enhance primary healthcare in Hong Kong. DHCs will be set up in every district in Hong Kong, with the DHC in Kwai Tsing District slated for opening in around Q3 this year. The elderly population will stand to benefit from the protocol-driven DHC system which will put greater emphasis on early detection and prevention of illnesses and better management of chronic diseases through provision of a host of subsidised services by network healthcare providers. As a matter of policy, we will allow the use of vouchers in all DHCs. As such, the Scheme and DHCs can complement each other in promoting primary healthcare among the elderly.

(b) Empowering elders to make the informed choices and use vouchers wisely

10. DH's review found that while elders had high general awareness of the Scheme, some were still unclear about the Scheme's operation, such as how to check voucher balance and how to find the right healthcare service provider. As such, some elders may not be spending their vouchers in ways that can best meet their healthcare needs or may even be using their vouchers on unnecessary healthcare services and products. To address this problem, DH will strengthen its efforts in promoting better use of vouchers through proactively reaching out to elders, in addition to the current publicity efforts. The 18 Visiting Health Teams of DH will be mobilised to conduct health talks to promote the concept of primary healthcare and educate elders on the wise and proper use of vouchers through easy-to-understand illustrations. The message that vouchers can be spent on preventive care, management of chronic diseases and prevention and control of non-communicable

diseases will be strengthened and further publicised. Furthermore, DH will continue to regularly update key statistics on the Scheme and voucher usage, which have been uploaded to the Scheme's and DH's websites since April 2018, to help both elders and the general public better understand the Scheme.

11. Elders can now check their voucher balances via the Scheme's website and an Interactive Voice Response System at 2838 0511. We will further enhance the above functions in around mid-2019 so that elders may also check the amount of vouchers to be disbursed to their accounts and the amount of vouchers expected to be forfeited due to the accumulation limit being exceeded on 1 January of the coming year. We believe this can help elders better manage their voucher balances and plan ahead. Furthermore, for greater convenience and improved transparency, we will introduce a new function for easy checking of voucher balances and transaction history via the Patient Portal of the Electronic Health Record Sharing System, which is a mobile app being developed. We expect the function can be made available in the second half of 2020.

(c) Stepping up monitoring efforts

12. All along, DH has put in place measures and procedures for checking and auditing voucher claims to ensure proper disbursement of public monies in handling reimbursements to enrolled healthcare service providers. These include routine checking, monitoring and investigation of aberrant patterns of transactions and investigation of complaints. Using a risk-based approach, DH's checking targets healthcare service providers who had records of non-compliance with the Scheme rules and those who displayed unusual patterns of voucher claims. Since launch of the Scheme in 2009 until end-2018, DH had checked some 358 000 claim transactions (representing about 2% of all claim transactions) under the above monitoring mechanism. The checking had identified some 3 950 anomalous claims (representing around 1% of all claims checked and amounting to some $1.96 million in claim amounts). Any suspected fraud, criminal element or violation of professional code of practice uncovered during DH's monitoring and investigation activities will be referred to the Police and/or the relevant statutory regulatory body as appropriate. Healthcare service providers suspected to have engaged in serious malpractices or misconduct will be disqualified from the Scheme.

13. With an increasing number of complaints and media reports about cases of suspected misuse of vouchers, the Scheme's monitoring system has been strengthened. The system now includes graded levels

of actions against healthcare service providers who have breached the terms and conditions of the Scheme Agreement, including issuance of advisory and warning letters and recovery of the relevant amounts of voucher payment. In addition, the detection of aberrant claim transaction patterns in eHS(S) has been enhanced for identifying cases for targeted inspection visits. A new clause has also been added to the Scheme Agreement for temporary suspension of a healthcare service provider's account pending the investigation outcome of suspected non-compliance and irregularities. New directives are promulgated to enrolled healthcare service providers from time to time to address potential misuse of vouchers.

14. Apart from the above, DH regularly issues to healthcare service providers guidelines to remind them of the requirements of the Scheme, which include not imposing different levels of fees based on whether vouchers are used or not, enhancing the transparency of service charges as far as possible, explaining the charges to elders at their request before providing service, and allowing elders to choose from different healthcare treatment/management options which may have different service charges. We will seek to enhance the hotline for receiving and handling complaints and enquiries from the public.

(d) Tackling over concentration of voucher use

15. The review found a disproportionate number of claims with exceptionally high amounts made by optometrists under the Scheme over the past few years. It was noted that while optometrists only accounted for about 9% (697) of all the enrolled healthcare service providers in Hong Kong (7 941) as at end-2018, their voucher claims accounted for about 27% (about $760 million) of the total claims of $2.8 billion in 2018. This latter percentage has increased over the years, from about 4% in 2015 to about 12% in 2016 and about 19% in 2017. The median amount per claim by optometrists has also been high by comparison over the past few years. Between 2015 and 2018, the figure for optometrists ranges from $1,600 to $1,951, while the range is $250 to $300 for medical practitioners, $206 to $245 for Chinese medicine practitioners, and $550 to $640 for dentists. Between 8 June 2018 (when the accumulation limit was raised to $5,000) and end-2018, among all the 35 294 claims of more than $4,000, optometrists accounted for about 76% (26 665).

16. We are concerned that the situation will undermine the Scheme's effectiveness in promoting the use of a variety of private primary healthcare services by elders. This over-concentration of voucher use on

a particular type of service may render the elders not having vouchers for other types of services that they may need.

17. In order that vouchers for each eligible elder can be used on a mix of primary healthcare services, we intend to introduce a cap on the amount of vouchers that can be spent on optometry services. The cap will be set at a level of **$2,000 every two years,** representing **50%** of the voucher amount disbursed over a two-year period, or **25%** of the new cumulative limit of $8,000. The cap will allow an elder the flexibility to use optometry services whilst preserving a decent balance for use on other primary healthcare services.

18. We had initially considered setting the cap at $1,000 every two years, by drawing reference from a range of market rates for eye checks and rates for the provision of glasses under a welfare scheme. Having consulted patient groups and other stakeholders, we appreciate concerns that, at a cap of $1,000 every two years, the co-payment requirement for some elders may be higher. We also heed the concerns of relevant professional bodies that, inter alia, a cap at $1,000, may be unacceptably low. We agree that on balance we can draw reference instead from the 2018 median claim amount for optometry service ($1,951) and have thus proposed a cap at $2,000 every two years.

19. Our plan is to implement the cap in Q2 2019, together with the Budget measures. If aberrant claiming patterns are also observed in other types of healthcare services in future, we will not rule out the possibility of imposing conditions on these as well.

(e) Regularisation of the Pilot Scheme at HKU-SZH

20. To provide one more service point for Hong Kong elders to use vouchers and facilitate those who reside in the Mainland or places near Shenzhen to seek medical treatment in Shenzhen, the Government has launched the Pilot Scheme at HKU-SZH since October 2015. Eligible Hong Kong elders can use vouchers to pay for the fees of outpatient services provided by designated clinics/departments of HKU-SZH[4]. As at end-2018, about 3 400 elders had used the vouchers at HKU-SZH,

[4] Vouchers can be used for the outpatient services (including preventive care services as well as curative and rehabilitative services as in Hong Kong) provided by the following Outpatient Medical Centres/Medical Service Departments of the HKU-SZH: Family Medicine Clinic, Health Assessment and Management Centre, Accident and Emergency Department, Orthopaedic Clinic, Ophthalmology Clinic, Dental Clinic, Chinese Medicine Clinic, Medicine Clinic, Gynaecology Clinic, Surgery Clinic, Rehabilitation Clinic, Physiotherapy Department, Department of Medical Imaging, Department of Clinical Microbiology and Infection Control and Department of Pathology.

involving a total accumulated claim amount of over HK$7.3 million. In view of the positive experience revealed in the review, we propose that the Pilot Scheme be regularised.

(f) Streamlining enrolment procedures for healthcare service providers

21. With a view to facilitating participation of healthcare service providers under the Scheme, the existing enrolment procedures will be streamlined as appropriate. As a first step, DH has set up a portal page on the website of the Centre for Health Protection that lists all the Public-Private Partnership (PPP) Programmes (including the Scheme) administered by DH with links to the relevant background information, enrolment procedures, etc. Healthcare service providers can consider which PPP Programme(s) to join more easily. Besides, with the Government's plan to launch e-ID in 2020, the feasibility of allowing full online enrolment into the Scheme will also be explored.

ADVICE SOUGHT

22. Members are invited to note the findings of DH's review and give views on our proposed enhancement measures.

Food and Health Bureau
Department of Health
March 2019