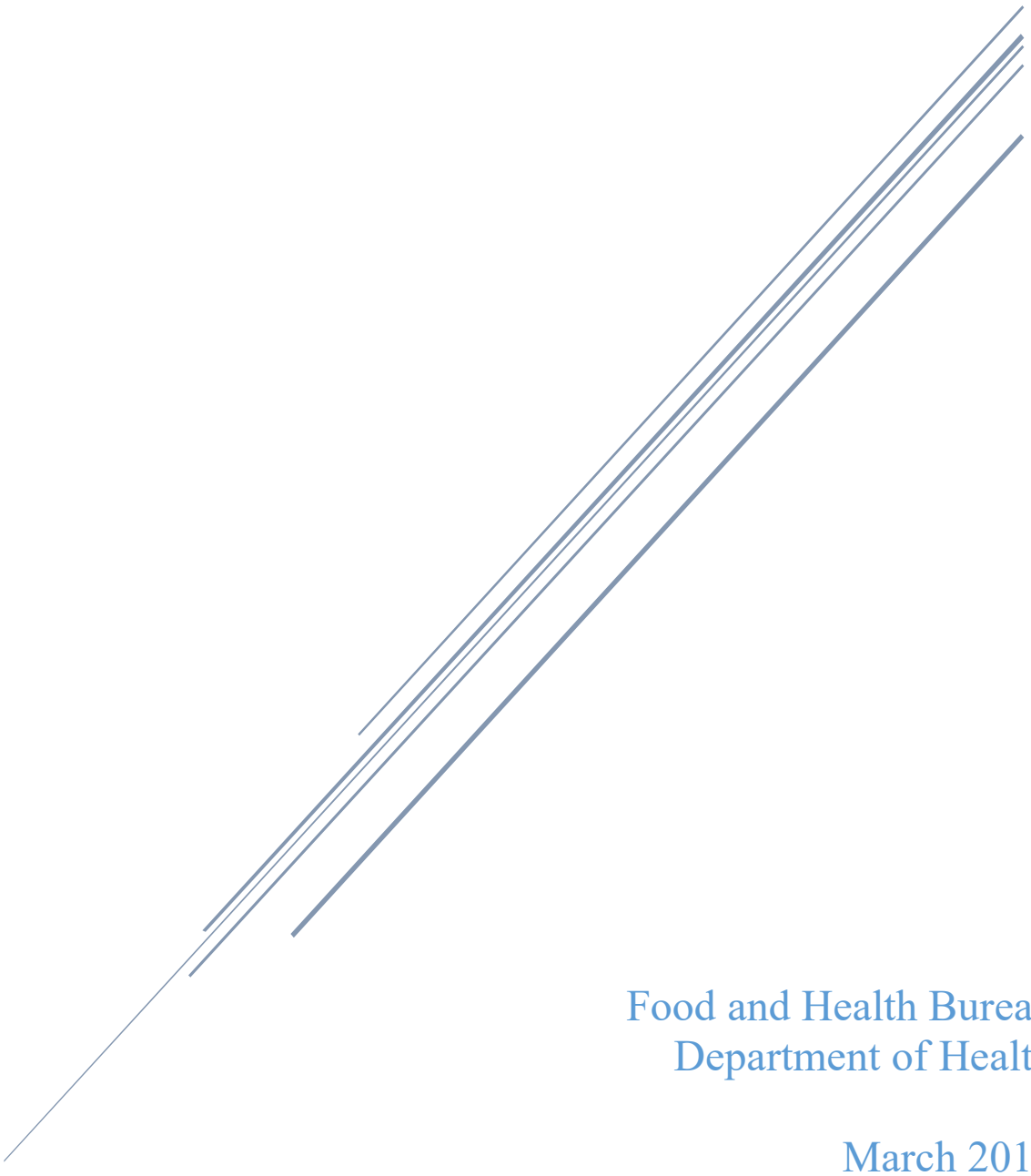
REPORT ON THE REVIEW OF THE ELDERLY HEALTH CARE VOUCHER SCHEME



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Department of Health

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CONTENT

I. BACKGROUND

The Elderly Health Care Voucher Scheme (the Scheme) was launched in 2009 as a pilot scheme and later converted into a recurrent programme in 2014. The Scheme aimed at providing additional choices for elders on top of the existing public primary care services with a view to enhancing the primary care services for the elders. The Scheme implements the "money follows the patient" concept to enable elderly people to choose within their neighbourhood private primary care services that best suit their health needs. By providing subsidies to the elders for choosing private primary care services in the community, it was expected that the Scheme could help promote the key ingredients of quality primary care, such as more utilisation of preventive healthcare services and continued relationship between the elders and their healthcare service providers. While the Scheme was not intended to reduce the existing public healthcare services, which elders could continue to access as necessary, it was expected that with the implementation of the Scheme, some elders could have better access to healthcare services and continuity of care from their chosen private service providers, thus reducing their reliance on public healthcare services and other members of the public in need of public primary care services could be benefited indirectly.

2. The Government conducted an interim review in 2011 to examine the operation and utilisation of the pilot scheme so as to collect feedback from elders and healthcare service providers in order to evaluate the effectiveness of the Scheme and make recommendations on its way forward with the pilot period ended on 31 December 2011. In overall terms, the interim review showed that the Scheme made a start in establishing an effective and efficient mechanism for the provision of healthcare services with government subsidies through a form of public-private partnership. Meanwhile, the interim review also reminded us that it was no easy task to induce behavioural changes among the elders in seeking healthcare services. It showed that more efforts were required for the key notions of good primary care especially preventive care, as well as the concept of continuum of care to be more widely promoted and accepted among the elders and healthcare service providers. It also pointed to the need for further strengthening the Scheme operation including its supporting platform.

3. The Scheme has undergone various enhancements over the years, including the progressive increase in the annual voucher amount from the original $250 to the current $2,000, the increases in accumulation limit from the original $3,000 to the current $5,000, the change of the face value

of each voucher from $50 to $1 in 2014, the extension of the Scheme as a Pilot Scheme at the University of Hong Kong-Shenzhen Hospital (HKU-SZH) in 2015, and the lowering of the eligibility age from 70 to 65 in 2017.

4. In view that it had been some time since the interim review in 2011 and the regularisation of the Scheme in 2014, the Government considered it necessary to conduct a review so as to consolidate its experience on the administration of the Scheme, assess its impact on healthcare service utilisation, and gauge the views of stakeholders (i.e. elders and healthcare service providers), with a view to formulating recommendations for further enhancements.

II. OBJECTIVES, SCOPE AND METHODOLOGY OF THE REVIEW

5. The objective of this review is to address the following questions –

(a) Whether the Scheme has achieved its original objective, i.e. to provide additional choices for elders on top of the existing public primary care services with a view to enhancing the primary care services for the elders;

(b) Whether the Scheme has any impact on the elders' health seeking behaviour, i.e. use of preventive care services; and use of private healthcare vs. public healthcare services;

(c) How the Scheme should be positioned against the latest primary care development in Hong Kong; and

(d) What areas of improvement should be pursued in terms of Scheme design and operation.

6. The scope of the review covers 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 vouchers usage on primary healthcare services for the elderly (e.g. any change in health seeking behaviour of voucher recipients, the effectiveness of encouraging more frequent use of preventive care in primary care system, etc.);

(d) utilisation pattern of vouchers;

(e) operational arrangements of the Scheme, including the monitoring mechanism; and

(f) whether the intended objectives of the Scheme have been achieved.

7. The review was conducted in phases between 2015 and 2018. Owing to the different time frames under which the different stages of the review were carried out, results may contain data with different cut-off time points. In conducting the review, the Department of Health (DH) had collated and synthesised information generated from the following sources and considered the operational experience of the Scheme (a summary of the methodology of the various studies is provided at **Appendix**) –

(a) Data captured by the eHealth System (Subsidies)[1] (eHS(S))

(b) Studies conducted by the Jockey Club School of Public Health and Primary Care (JCSPHPC) of the Faculty of Medicine of the Chinese University of Hong Kong (CUHK) –
- A cross-sectional survey on 1 026 elders aged 70 or above conducted in 2010 [2];
- A longitudinal follow-up survey in 2016 of 326 elders who participated in the 2010 cross-sectional survey [3];
- A cross-sectional survey on 974 elders aged 70 or above conducted in 2016 [3];
- Focus group study and telephone interviews of 33 enrolled and non-enrolled healthcare service providers as well as administrators of medical groups [3]; and
- Analysis of linked administrative data from eHS(S) and Hospital Authority (HA) on 551 elders who participated in the 2016 cross-sectional survey and were born in or before 1939 (i.e. aged 70 or above in 2009) [4];

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[1] 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. It has been enhanced and expanded to incorporate vaccination subsidy schemes.

[2] A study conducted by JCSPHPC in 2010 which contributed to DH's interim review of the Scheme in 2010.

[3] These studies were conducted in collaboration with DH.

[4] The analysis was done by DH.

(c) Analysis of the voucher utilisation pattern for medical practitioner services from 2009 to 2017 of 10% (19 000) of randomly selected elders who had used vouchers in 2009 from the eHS(S); and

(d) A report on the use of vouchers by the elderly prepared by HKU-SZH [5].

III. KEY FINDINGS

(a) Scheme participation and utilisation

(i) Participation by healthcare professionals

8. Over the years, there has been a progressive increase in the number of healthcare service providers who have joined the Scheme (**Figure 1**). According to DH's statistics, as at end of 2018, a total of 7 941 healthcare service providers in Hong Kong were enrolled under the Scheme, providing services at 18 725 places of practice. The numbers of enrolled healthcare service providers (EHCPs) in 2015 - 2018 are provided in **Figure 2** while the distribution by healthcare profession in 2018 is presented in **Figure 3**.

9. The participation rate [6] of healthcare service providers increased from 14% as at end-2014[7] to 20% as at end-2017. As at end of 2017, optometrists (Part I) had the highest participation rate (78%) among all the healthcare professions, followed by dentists (49%) and medical practitioners (45%) (**Table 1**).

[5] 《香港大學深圳醫院長者醫療券使用情況調查報告》，香港大學深圳醫院，二零一八年十月。

[6] 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.

[7] The Scheme was converted into a recurrent programme in 2014.

Figure 1 Total number of EHCPs in Hong Kong, 2009 - 2018

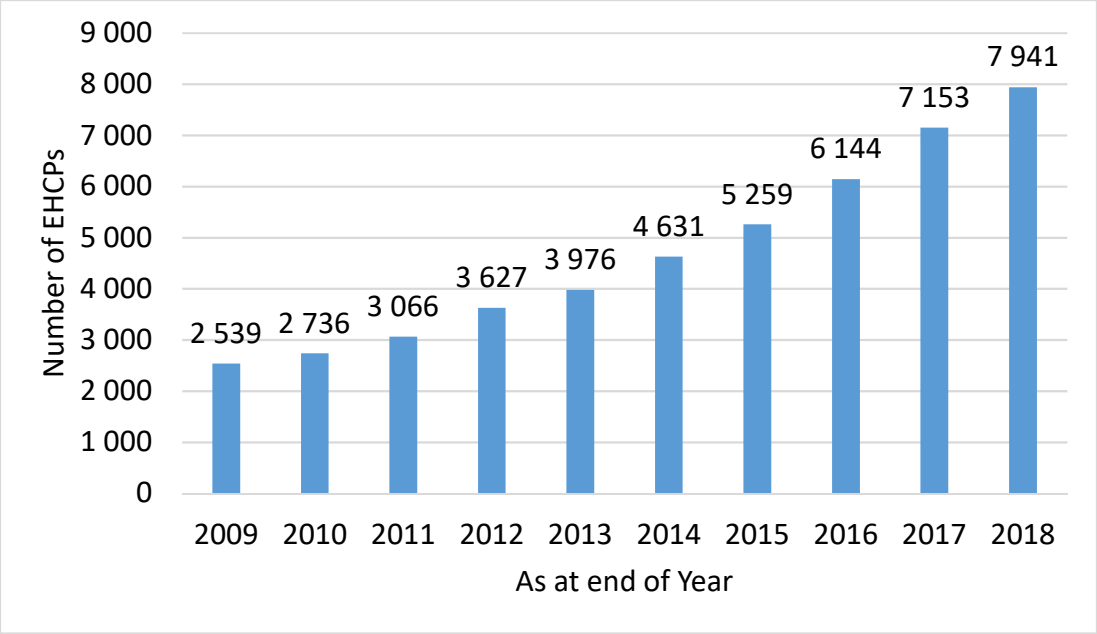


Figure 2 Numbers of EHCPs in Hong Kong by healthcare profession, 2015 - 2018

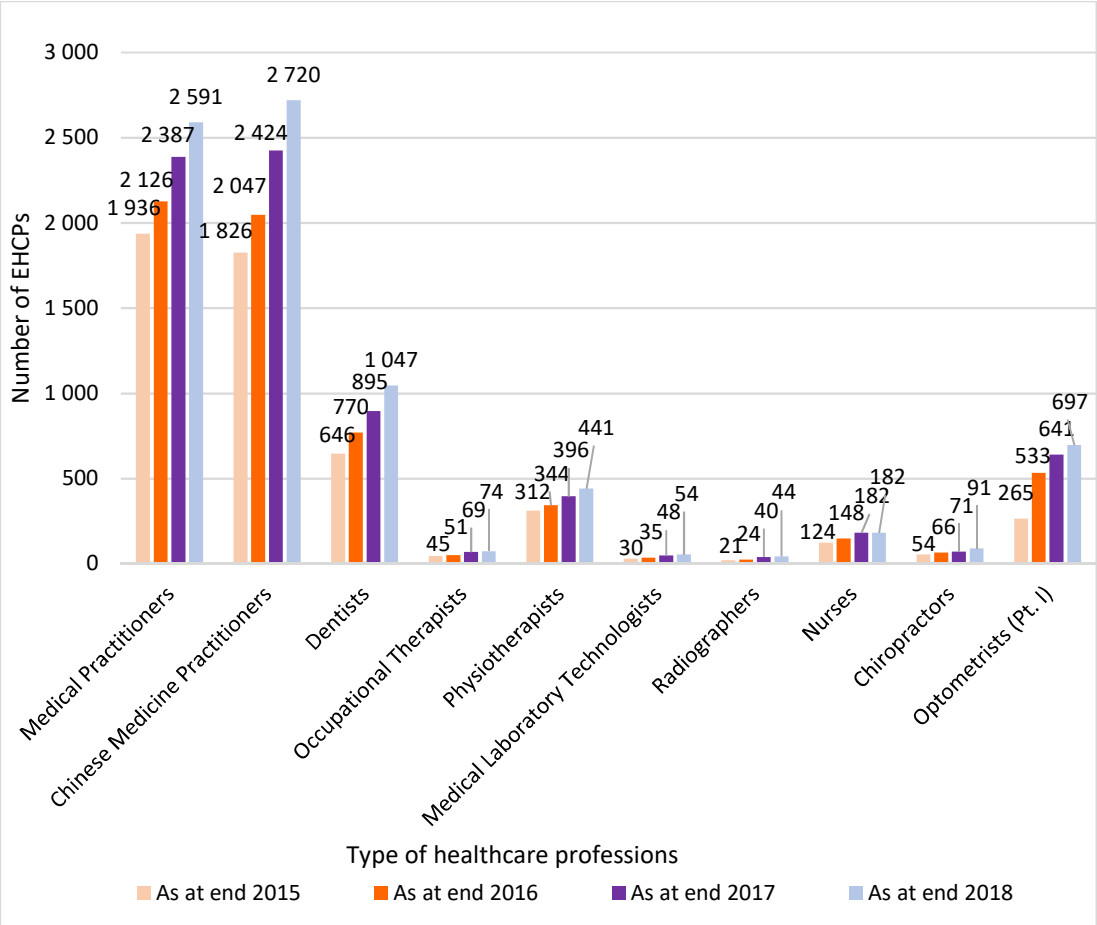


Figure 3 Distribution of EHCPs in Hong Kong by healthcare profession, 2018

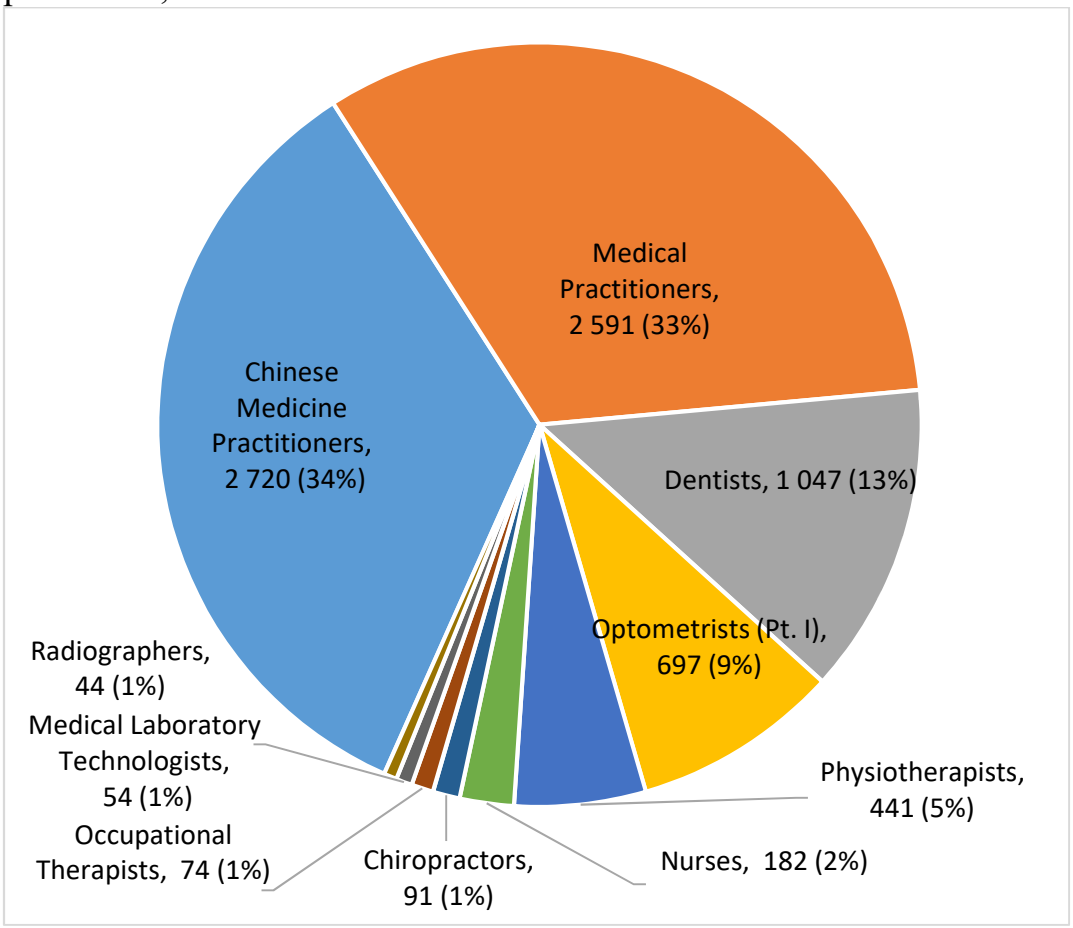


Table 1 Participation rate of healthcare service providers in Hong Kong, 2014 - 2017

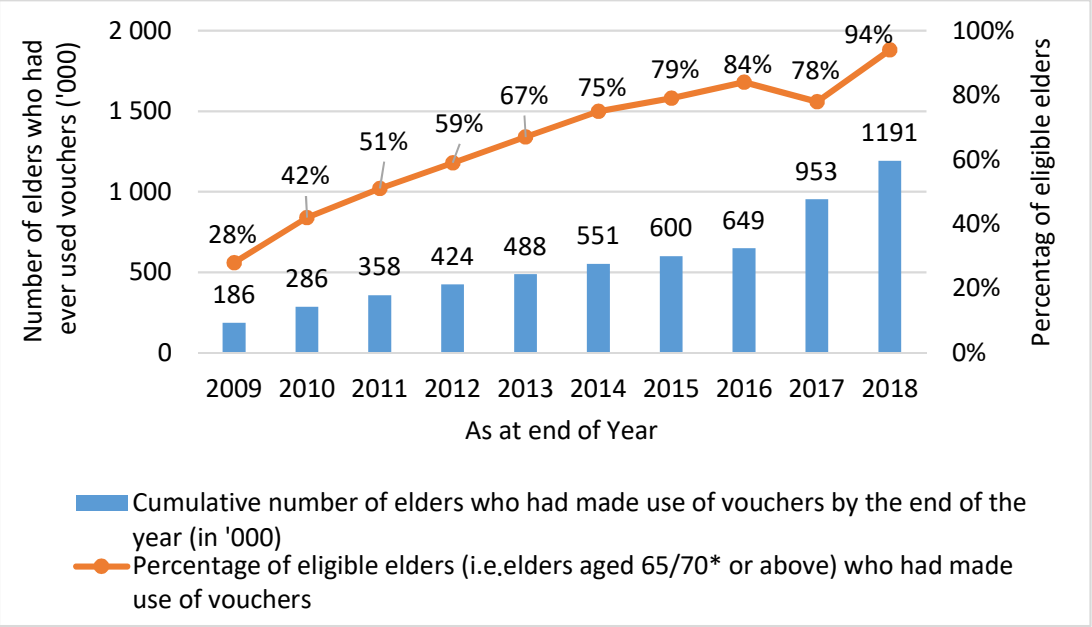
As at end of year	Participation rate of healthcare service providers*			
	2014	2015	2016	2017
Medical Practitioners	36%	39%	42%	45%
Chinese Medicine Practitioners	26%	30%	32%	38%
Dentists	33%	38%	44%	49%
Occupational Therapists	6%	6%	6%	7%
Physiotherapists	23%	22%	22%	24%
Medical Laboratory Technologists	3%	3%	3%	5%
Radiographers	3%	2%	3%	5%
Nurses	1%	1%	1%	1%
Chiropractors	31%	32%	36%	37%
Optometrists (Part I)	25%	34%	67%	78%
Overall	14%	16%	17%	20%

**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, e.g. not practising in Hong Kong.*

(ii) Participation by elders

10. There was a progressive increase in the percentage of elders who had ever used vouchers (Figure 4) from 28% in end of 2009 to 94% in end of 2018. Over 1.19 million elders had ever used vouchers under the Scheme by end-2018.

Figure 4 Cumulative number and percentage of eligible elders who had ever used vouchers under the Scheme, 2009 - 2018

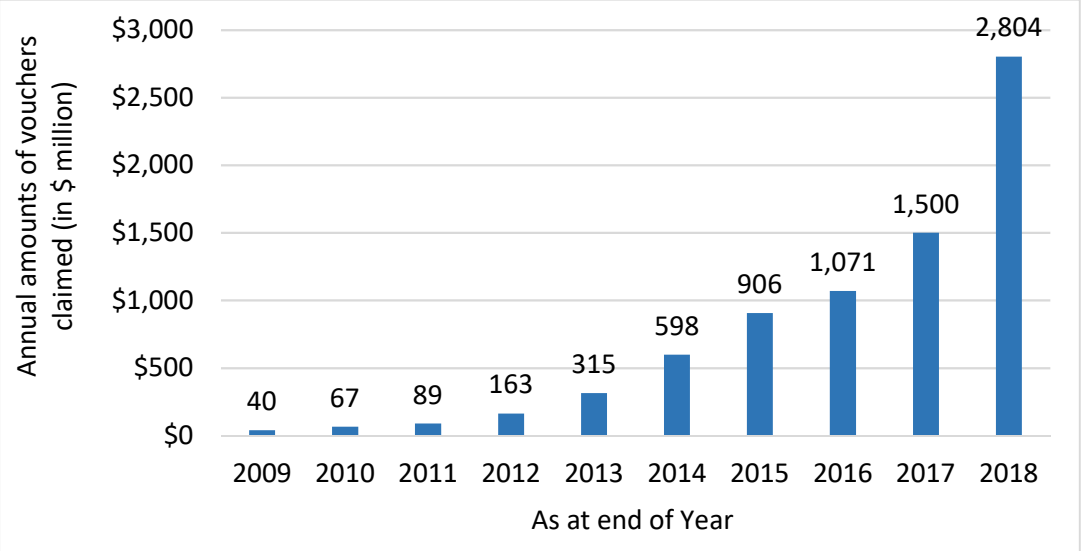


Note: The eligibility age for the Scheme was lowered from 70 to 65 on 1 July 2017.

Source: Population figure adopted from the Hong Kong Population Projections, Census and Statistics Department

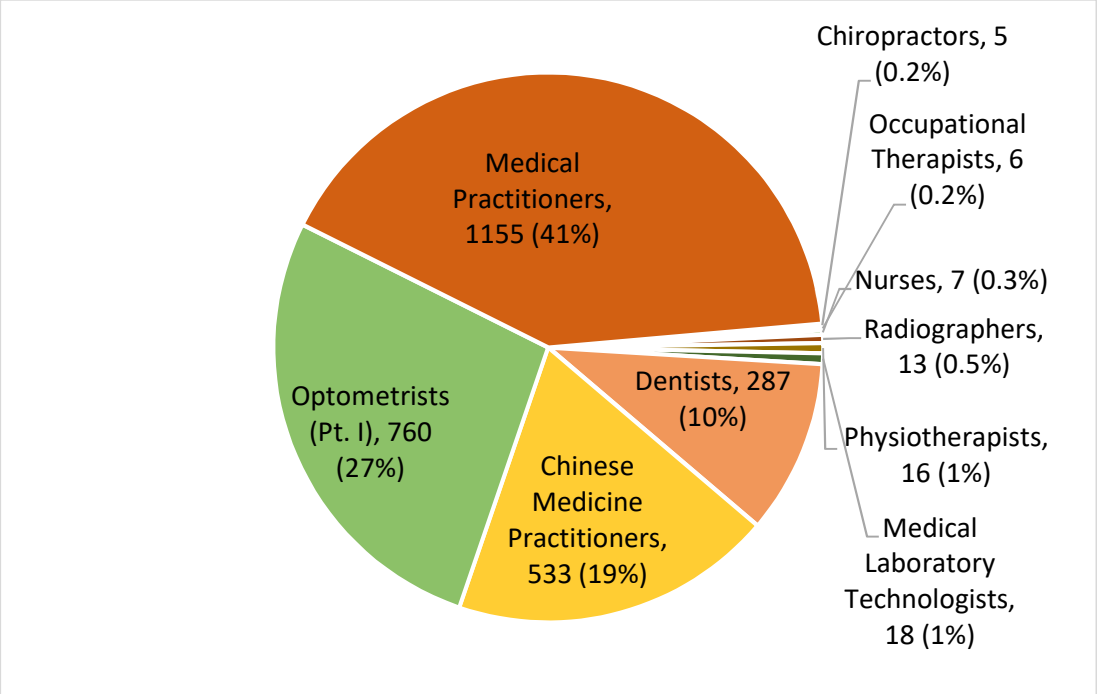
11. The annual amount of vouchers claimed also increased from $40 million to $2,804 million during the corresponding period (**Figure 5**), with medical practitioners' claim amount ranking the highest (41%), followed by optometrists' (Part I) (27%) and Chinese medicine practitioners' (19%) in 2018 (**Figure 6**).

Figure 5 Annual amount of vouchers claimed, 2009 - 2018



Note: The amount of vouchers claimed included the claims made by HKU-SZH

Figure 6 Distribution of voucher amount claimed (in $ million) by types of healthcare services in Hong Kong, 2018



12. The above statistics show that over the years, participation by both healthcare service providers and elders under the Scheme has increased significantly, possibly due to various Scheme enhancement measures and increased publicity.

(b) Scheme awareness and understanding

13. The cross-sectional surveys in 2010 and 2016 showed that there was an increased awareness among elders of the Scheme from 71% in 2010 to 99% in 2016. Whilst television advertisements remained the most effective publicity channel, promotion by healthcare professionals and word of mouth from family members/ relatives/ friends have become the second and third commonest ways to reach the elderly population (**Table 2**).

Table 2 Channels in knowing about the Scheme

Channels in knowing about the Scheme	Number (%) of respondents	
	2010 Cross-sectional Survey (n=725)	2016 Cross-sectional Survey (n=966)
Television advertisements	419 (58%)	406 (42%)
Healthcare professionals	144 (20%)	303 (31%)
Word of mouth from family/ relatives/ friends	71 (10%)	202 (21%)
Elderly Centre	70 (10%)	145 (15%)
Newspaper/ magazines	170 (23%)	113 (12%)
Radio advertisements	122 (17%)	56 (6%)
Poster/ leaflet	Not Applicable	32 (3%)
Internet	Not Applicable	3 (0.3%)

Note:

1. *Respondents were allowed to choose more than one answer in this question.*
2. *Six respondents did not reply to this question in the 2010 survey while one respondent did not reply in the 2016 survey.*

14. Despite changes made to the Scheme throughout the years (such as the annual voucher amount and accumulation limit), elders were found to have a very good understanding of the Scheme, except for the restriction on in-patient services and the extension of the Scheme to HKU-SZH as a Pilot Scheme (**Table 3**). The latter was probably due to the fact that the Pilot Scheme had only been launched for a short time (around one year) when the survey was conducted in 2016. There was an increase in the percentage of elders who knew the annual voucher amount (74% in 2010 vs 81% in 2016) and a more modest increase in the percentage of elders who knew vouchers could not be used for in-patient services (42% in 2010 vs 44% in 2016) but the percentage was still low. Nevertheless, the results suggested that future publicity activities should focus more on these aspects. Similarly, focus group discussion found that healthcare service providers had a high awareness of the Scheme including changes of annual voucher amount and face value of each voucher.

Table 3 Respondents' understanding on the Scheme

Questions on knowledge	Number (%) of respondents (n=967)	
1. Current amount of voucher per elder per year	782	(81%)
2. Current accumulation limit	718	(74%)
3. Face value of each voucher	562	(58%)
4. How to check voucher balance	791	(82%)
5. Vouchers could not be used for in-patient services	430	(44%)
6. Vouchers could not be used to purchase herbal medicines/ medication/ medical equipment without consultation provided by healthcare professionals	695	(72%)
7. Vouchers could not be used to purchase medicines for family	835	(86%)
8. Vouchers could be used in Mainland China (in HKU-SZH)	29	(3%)

Note: For questions 4 and 7, one respondent did not give a response.

15. Overall speaking, the findings showed that the enhanced publicity and promotion strategies by the Government might have raised overall awareness of elders on the Scheme. However, efforts in educating elders on areas such as the rules of the Scheme would continue to be needed.

(c) Views on Scheme operation

(i) Elders' perspective

16. The surveys showed that elders had positive attitudes towards the Scheme. The longitudinal follow-up survey of 2016 revealed a notable increase in the percentage of elders who agreed that the Scheme was convenient to use (from 67% in 2010 to 95% in 2016). The cross-sectional surveys also showed that more elders were satisfied with the sufficiency of information on the Scheme available to them (47% in 2010 vs 76% in 2016). Among the 16% of elders who opined that the information related to the Scheme was insufficient in 2016, 70% wanted more information on the EHCPs, 28% wanted more information on how to use vouchers, and 15% wanted more information on how to check voucher balance.

17. Currently, upon deduction of vouchers from elders' voucher accounts, the EHCPs would provide the elders with a "Notice on use of Health Care Voucher" indicating the name of the EHCP concerned, the

date of visit, the voucher amount available for use before the visit, the amount claimed for the visit, and the voucher balance after the visit. Moreover, elders could check (or with the help of family members or carers) the voucher balance by accessing the website <www.hcv.gov.hk> or calling 2838 0511.

18. Future publicity efforts should focus more on the practical aspects of the Scheme to facilitate elders to use vouchers with ease.

19. It was noted that the majority of elders (82%) reported that they knew the method(s) to check voucher balance, and the two commonest methods that they could name were through the "Notice on Use Health Care Voucher" (67%) and asking the attending healthcare professionals (47%). However, only 1% and 3% mentioned the method of checking voucher balance via the telephone hotline and the website respectively. More effort is therefore required to promote these two methods for checking voucher balance. On the other hand, the low percentage of elders mentioning the website as a method for checking the voucher balance was not surprising, given the relatively lower internet penetration rate among Hong Kong elders aged 65 or above (51%) compared to the overall usage rate of 89% among persons aged 10 and above. Nevertheless, the former rate had almost quadrupled compared to that five years ago [8]. As internet usage continues to become more popular among elders, development of information technology (IT) tools and applications, e.g. a patient portal for accessing voucher transaction records, may be a timely enhancement measure to pursue for the Scheme.

(ii) Healthcare service providers' perspective

20. The healthcare service providers participating in the focus group had a high awareness of the changes of annual voucher amount (from $250 to $2,000) and the face value of each voucher (from $50 to $1). Most of them also welcomed the changes made to the Scheme throughout the years and agreed that elders could benefit more from the Scheme, in particular the decrease of face value of each voucher to $1.

21. For internet accessibility, most participants who were already equipped with computer before joining the Scheme commented that the set-up process for the system was fairly easy and smooth, with some occasional hiccups in login and data input into the Scheme's electronic

[8] Statistical Highlights - Digital Inclusion in Hong Kong. Research Office, Legislative Council Secretariat. https://www.legco.gov.hk/research-publications/english/1718issh26-digital-inclusion-in-hong-kong-20180604-e.pdf (accessed on 14 February 2019)

platform, the eHS(S), during the peak hours. Some healthcare service providers also mentioned problems in the use of the Smart ID card reader.

22. Solo practitioners commented that Scheme enrolment procedures were complex and related administrative work caused stress and inconvenience to them. The issue was less of a problem for practitioners under group practices who would delegate related administrative work to front-desk staff. One healthcare service provider suggested aligning the registration for all Government's Public Private Partnership (PPP) programmes such that it could be more hassle-free for those who are interested in the Scheme and have already joined other PPP programmes administered by DH to join the Scheme (and vice versa).

23. As regards whether the eHS(S) should capture more detailed information about the reasons for visit upon submission of voucher claims by EHCPs, some healthcare service providers were concerned about the administrative workload as well as the infringement of patient privacy if too much information was to be disclosed.

24. In sum, to be in line with the Government's drive to pursue wider adoption of information and communications technology and development of e-Government initiatives, more efforts should be made to further enhance the IT platform for the Scheme with a view to streamlining enrolment and operational procedures.

(d) Views on scope and design of the Scheme

25. According to the cross-sectional survey in 2016, the majority (72%) of elders considered the coverage of healthcare services by the Scheme sufficient. For the 17% who considered it insufficient, they suggested expanding the coverage to allow the use of vouchers for in-patient services and surgical fees, purchase of medical products/ devices without consultation, and public healthcare services. Besides, the percentages of elders who considered the coverage of healthcare services sufficient increased from 45% in 2010 to 86% in 2016 as revealed by the longitudinal follow-up surveys.

26. In terms of further enhancements gearing towards encouraging more use of vouchers for preventive care or management of chronic diseases, 69% of elders disagreed with reserving a portion of vouchers for preventive services while 24% of them agreed. The remaining (7%) said that they did not know. While some healthcare service providers

suggested designating a separate voucher for preventive care services such as screening programmes, most disagreed with changing the terms of voucher usage by splitting the annual voucher amount for different purposes such as body check and acute treatment, for fear that this would confuse elders, limit elders' choices for using the healthcare services that best suit their needs, disincentivise healthcare service providers, and encourage some healthcare service providers to perform unnecessary treatments just to use up the money in the elders' voucher accounts.

27. The above results illustrated that the balance between the Scheme's objectives to allow flexibility of voucher use with emphasis on patient choice and to promote primary preventive care could be delicate. While relaxing the Scheme's scope to allow purchase of medical products and use of vouchers on surgical procedures would provide more flexibility in voucher usage and align with the "money follows the patient" concept, untargeted spending of vouchers may not be conducive to the aim of promoting preventive care services. On the other hand, designating vouchers for specific purposes (e.g. preventive care or chronic disease management) would help channel resources to targeted objectives but would inevitably restrict choice and flexibility. Thus, any changes to the Scheme's design and scope should be carefully considered, balancing the benefits and risks of each option against the long term plan for the Scheme and its future position in the overall plan on primary care development.

(e) Views on voucher amount and service fees

28. The Government's interim review in 2010 indicated that the subsidy amount and price for healthcare services were important factors to be considered in affecting the elders' healthcare seeking behaviour. Indeed, the survey findings and eHS(S) data showed that the increase in voucher amount was associated with a significant increase in voucher usage.

29. Regarding the current annual voucher amount, the majority of healthcare service providers in the focus group discussions thought that $2,000 was not enough, especially for elders in need of chronic disease management. Although the Government had increased the annual voucher amount progressively from $250 in 2009 to $2,000 in 2014, many service providers considered the amount insufficient and suggested an increase. Some also believed that the price difference between the public and private healthcare sectors was too big for the Scheme to incentivise elders to change their health seeking behaviour in the long run. As for

elders, slightly less than half (44%) of those who responded to the question in the 2016 cross-sectional survey considered the subsidy amount of $2,000 per year appropriate while 46% considered it insufficient and 10% answered "don't know". Slightly more than half (55%) agreed that the accumulation limit of $4,000 was appropriate, while 35% considered it too low and 10% answered "don't know". According to the longitudinal survey, the percentage of elders who agreed that the subsidy amount was appropriate increased from 20% to 98%.

30. As for service fees, the 2016 cross-sectional survey found that 50% of elders did not experience any increase in the service fees when they used vouchers for the same kind of services provided by the same healthcare service provider. This finding is comparable to the finding from the interim review in 2010 where 45% of elders did not perceive any increase in consultation fees in general subsequent to the launch of the Scheme. The corresponding figures for those who replied that there was an increase in fees in the 2016 and 2010 surveys were 26% and 14% respectively. The rest of the respondents (24% and 42% respectively) replied that they did not know.

31. On the other hand, there were mixed views among healthcare service providers on whether the Scheme had led to inflated service charges and potentially encouraged abuse of vouchers. Some thought that the Scheme had caused increase in demand on private healthcare services which could lead to increase in service charges. Healthcare service providers also had mixed views on the proposal of requiring EHCPs to increase transparency of service charges. Some worried that it might lead to price war among the EHCPs.

32. In light of the above findings, while further increases in the subsidy level would be much welcomed by both elders and healthcare service providers, caution should be exercised in calibrating the subsidy level through higher annual voucher amount and accumulation limit to bring about the desired healthcare behavioural changes. There could also be considerable implications on the financial sustainability of the Scheme in the long run. Furthermore, more effort is required to remind EHCPs on the importance of keeping their service fees consistent irrespective of whether vouchers are used and price information as transparent as possible to the elders before provision of service so as to avoid unnecessary misunderstanding and disputes.

(f) Impact on health seeking behaviour

(i) Use of vouchers on private primary care services

33. The interim review in 2010 concluded that there was no noticeable change in health seeking behaviour among elders since the launch of the Scheme due to factors such as inertia of elders already seeking care in the public sector and non-participation of healthcare service providers in the Scheme whom the elders usually consulted. The latest review, however, indicated that given sufficient time, the Scheme showed improved acceptance with 94% of the eligible elderly population having used vouchers as at end of 2018, compared with only 42% in 2010 as revealed by eHS(S) data.

34. Indeed, as revealed by the longitudinal survey, the percentage of elders who agreed that the Scheme had encouraged them to seek private primary care services had doubled from 32% in 2010 to 66% when the same group of elders were interviewed again under the 2016 survey. For those who opined that vouchers were not useful in encouraging their use of private healthcare services, the three major reasons quoted were "will use vouchers only if needed", "preferred using public services for treating chronic illness" and "preferred using public services e.g. the Government and HA services". The reason of "too little amount" in 2010 was no longer a major reason in the 2016 survey.

35. Most of the healthcare service providers interviewed in the focus group also agreed that the Scheme could encourage use of private primary care services in the short term, in particular, on curative services.

(ii) Use of vouchers on preventive care services

36. In the 2016 cross-sectional survey, among those who responded that the Scheme had encouraged them to use more private primary care services in 2016, the majority opined that it had encouraged them to attend more acute episodic care services (90%), while 42% claimed that it had encouraged them to seek more preventive care services. In terms of the number of voucher claim transactions, while statistics compiled from eHS(S) data of all transactions from 2009 to 2017 showed an increasing annual proportion of voucher claims made for preventive care over the years, its proportion was still low (13%) in 2017 when compared with that for acute episodic care (54%), as shown in **Table 4**.

Table 4 Percentage of voucher claim transactions by principal reason for visit, 2009 - 2017

Year	Percentage of voucher claim transactions by principal reason for visit			
	Preventive	Management of acute episodic condition	Follow-up/ monitoring of long term condition	Rehabilitation
2009	7%	69%	21%	3%
2010	6%	69%	22%	3%
2011	6%	69%	22%	3%
2012	6%	69%	22%	3%
2013	7%	67%	23%	3%
2014	8%	63%	25%	4%
2015	9%	61%	26%	4%
2016	11%	58%	26%	5%
2017	13%	54%	28%	5%

37. However, the picture became more optimistic if we took the nature of preventive care services and its health seeking pattern into account. Since "preventive care services" (e.g. immunisation, health checks and screening) might not be directly comparable with "management of acute episodic condition" in terms of number of visits made to the EHCPs (as represented by the number of voucher claims), further analysis was made to assess the annual percentage of elders who had made at least one visit for each category of service. With such comparison, a modestly increasing trend was noted for the annual percentage of elders who had visited EHCPs for preventive healthcare services over the years from around 9% in 2010 to around 36% in 2017 (**Table 5**). This was also comparable to the 2016 cross-sectional survey results which found that 30% of elders reported ever using vouchers for preventive care services. For the 70% who had not, around half (54%) indicated that they would consider using vouchers for preventive care services.

Table 5 Percentage of elders who had made at least one visit by principal reason for visit, 2009 - 2017

Year	Percentage of elders by principal reason for visit			
	Preventive	Management of acute episodic condition	Follow-up/ monitoring of long term condition	Rehabilitation
2009	10%	71%	25%	4%
2010	9%	74%	26%	4%
2011	10%	74%	26%	4%
2012	11%	77%	27%	4%
2013	14%	78%	30%	6%
2014	21%	80%	35%	8%
2015	26%	79%	38%	10%
2016	31%	75%	38%	11%
2017	36%	67%	36%	12%

Note: Figures do not add up to 100% as the elders can seek services from more than one category of service in a year.

38. As pointed out in the interim review in 2010, health seeking behaviour of elders may take time to change. The modestly increasing trend observed in the annual percentage of elders having used vouchers on preventive care services between 2010 and 2017 served to illustrate this gradual process. As 69% of elders in the 2016 cross-sectional survey disagreed with setting aside a portion of vouchers for preventive care services, measures to promote use of preventive care services should continue to focus on changing attitudes and shifting culture. It is hoped that with concerted efforts of the Government and healthcare service providers, such trend could be sustained.

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(iii) Use of vouchers on management of chronic disease

39. As revealed by voucher utilisation statistics in eHS(S), around 36% of elders had made voucher claims in 2017 for follow-up/ monitoring of long term condition, a slight increase from 26% in 2010. (**Table 5**)

40. On the other hand, among those who agreed that the Scheme had encouraged their use of private healthcare services, as revealed by the cross-sectional survey in 2016, only 11% said that it had encouraged them to use more services for management of chronic diseases. Less than 10%

of elders in the survey reported having used vouchers for long term conditions. Among those elders who claimed that they had not used vouchers for chronic disease management, only 14% said they would consider doing so. The majority would not consider it because they tended to use public healthcare services. A small number of elders also considered the voucher amount too low. Healthcare service providers in the focus group also opined that the Scheme could not promote the use of vouchers for managing chronic diseases probably due to the inertia of elders already attending the public sector for follow-up on these diseases and the large price difference between the public and private sectors not being conducive for the Scheme to incentivise elders to change their health seeking behaviour.

41. In sum, it was noted that the use of vouchers for management and follow-up of chronic diseases remained relatively low. More educational work in this aspect is worth pursuing.

(iv) Impact on public healthcare services

42. Elderly respondents of the 2016 cross-sectional survey were asked about their usual source of healthcare before and after they started using vouchers. Comparing the situations before and after the use of vouchers it was noted that the percentage of those who "usually attended both public and private services" increased from 49% to 61% after the use of vouchers (i.e. dual utilisation of healthcare services in both sectors). At the same time, the percentage of elders who usually attended public services dropped from 24% to 16%. The dual utilisation of both public and private may be attributed to the Scheme's objective of providing additional choices for elders on top of the existing public primary care services, and the preference of elders to seek services from the public healthcare sector for certain diseases (e.g. chronic diseases). On the other hand, the percentage of those usually attended private services also slightly dropped from 22% to 19%.

43. On the other hand, tracking of a cohort of 551 elders aged 70 or above in 2009 through to 2015 on their healthcare services utilisation pattern showed that whilst their overall utilisation of outpatient healthcare services had increased over the years, the increase was more significant for utilisation on private healthcare services (via voucher usage) than for public healthcare services (including services of General Outpatient Clinics (GOPC), Accident and Emergency Departments (AED) and Specialist Outpatient Clinics (SOPC)). In fact, their utilisation of public healthcare services over time seemed to have plateaued after slowly

increasing between 2009 and 2013. 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 healthcare services. How this trend would develop, including whether the Scheme has any long term impact on public healthcare utilisation would require observation over a longer period, as the impact might only be evident after the Scheme had become a recurrent programme in 2014, with the annual voucher amount increased to $2,000. (**Figures 7** and **8**)

Figure 7 The average number of attendance to public services (GOPC, AED and SOPC) and private medical practitioners (using vouchers) per person per year, 2009 – 2015

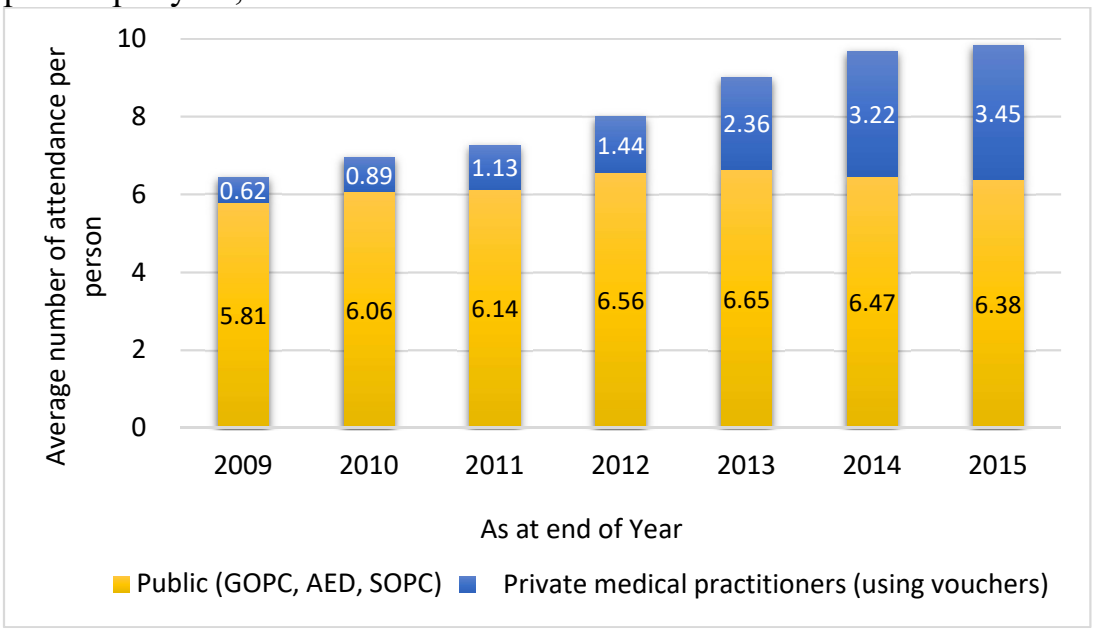
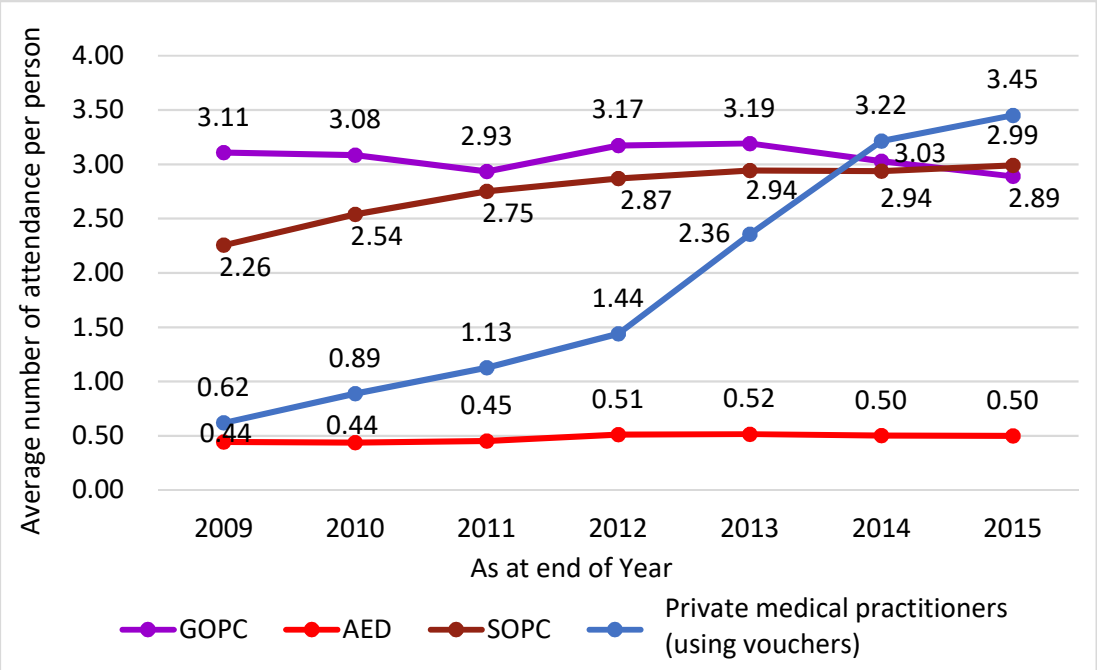


Figure 8 The average number of attendance to GOPC, AED, SOPC and private medical practitioners (using vouchers) per person per year, 2009 - 2015



(v) *Continuity of care*

44. Most healthcare service providers in the focus group opined that the Scheme did not have any impact on building long term doctor-patient relationship. To examine this aspect in greater detail, 10% (19 000) of elders who had made voucher claims in 2009 were randomly selected from the eHS(S) and all their voucher claims made between 2009 and 2017 were analysed. For each year in the first three years (2009-2011) of the Scheme when the annual voucher amount was only $250, over 99% of voucher users who had made two or more visits to medical practitioners in the year visited at most only two different medical practitioners. This percentage dropped gradually to 86% in 2017. The corresponding figures for voucher users seeing one medical practitioner only in 2009 and 2017 were 87% and 52% respectively. (**Table 6**)

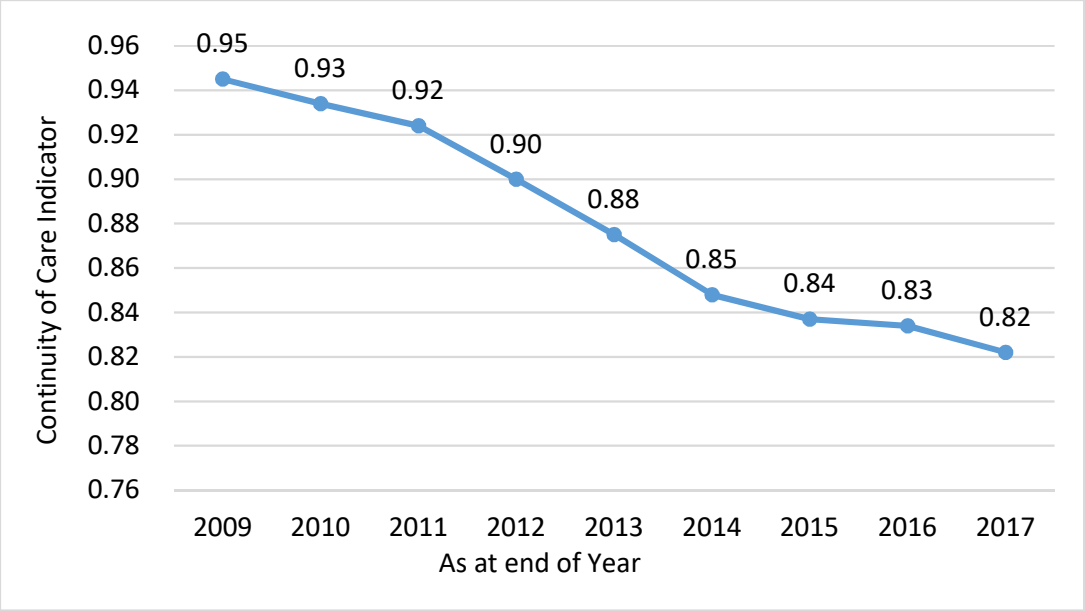
Table 6 Percentage of elders by number of different medical practitioners visited, 2009 - 2017

Year	Among voucher users who had made two or more visits to medical practitioners during each time period, they –				
	visited only one medical practitioner	visited two different medical practitioners	visited three different medical practitioners	visited four different medical practitioners	visited five or more different medical practitioners
2009	87.46%	12.15%	0.39%	0%	0%
2010	84.56%	14.80%	0.64%	0%	0%
2011	82.27%	16.95%	0.76%	0.02%	0%
2012	74.28%	22.64%	2.94%	0.13%	0.01%
2013	65.69%	27.88%	5.70%	0.70%	0.03%
2014	57.72%	31.01%	8.74%	1.95%	0.58%
2015	54.49%	32.36%	10.10%	2.42%	0.63%
2016	53.80%	33.28%	9.88%	2.47%	0.57%
2017	51.59%	34.75%	10.66%	2.42%	0.58%

45. The continuity of care indicator [9], an indicator which measures the extent to which the average elder obtained his/ her care from his/ her most frequently visited medical practitioner as opposed to other medical practitioners that he/ she visited, was calculated. It showed a decreasing trend in continuity of care, with the indicator dropping from 0.95 in 2009 to 0.82 in 2017. The overall indicator for the whole nine-year period was 0.73, which meant that on average, for elders who had two or more visits to medical practitioners using vouchers during those nine years, 73% of visits were made to the same private medical practitioner that they most frequently visited (**Figure 9**).

[9] Frohlich N, Katz A, De Coster C, Dik N, Soodeen R, Watson D, Bogdanovic B. Profiling Primary Care Physician Practice in Manitoba Winnipeg, Manitoba Centre for Health Policy, August 2006. http://mchp-appserv.cpe.umanitoba.ca/reference/primary.profiling.pdf (accessed on 1 March 2019)

Figure 9 Continuity of care indicators, 2009 – 2017



46. The above observations showed that the continuity of care, although on a decreasing trend, was fair. There could be a number of reasons that could explain the drop in the continuity of care indicator over the years. Possible reasons might include the increases in the annual voucher amount which facilitated elders to visit medical practitioners more often [10], and participation of more medical practitioners in the Scheme which provided elders with more choices to meet their different healthcare needs through patronising different medical practitioners. Moreover, the indicator might have underestimated continuity, as continuity provided in a group practice setting could not be captured by our analysis. The possibility of doctor-shopping being induced by increases in the annual voucher amount might also be a factor.

(g) Monitoring

(i) Risk-based post-payment checking

47. According to the voucher claim statistics in 2018, an average of over 14 000 claims were made each day by EHCPs [11]. In order to ensure proper disbursement of public monies in handling reimbursements, DH adopts a post-payment checking system based on a risk-based approach for checking and auditing the validity of voucher claims on a sampling basis.

[10] The average number of visits to medical practitioners per elder per year using vouchers increased from 1.8 in 2009 to 4.4 in 2017.

[11] There is an average of around 7 400, 7 600 and 9 500 claims made by EHCPs each day in 2015, 2016 and 2017 respectively.

48. The monitoring mechanism included –

(a) routine checking of selected claims made by EHCPs;

(b) detection of aberrant patterns of transactions so as to take timely follow-up actions and necessary investigation; and

(c) conducting investigations into complaints/ intelligence received.

49. In the course of checking and investigation, consent forms signed by the elders concerned and relevant information, such as service records kept by EHCPs, would be checked against the data kept in the eHS(S). Elders would also be contacted where necessary to ascertain whether transactions did take place.

50. Since the Scheme was launched in 2009 and up till end-2018, DH had conducted checking of 358 105 claim transactions (representing about 2% of all claim transactions made) according to the above monitoring mechanism. The checking has identified 3 954 anomalous claims, representing around 1% of all claims checked and some $1.96 million in claim amount. When anomalous claims were found, the EHCP would not be reimbursed with the amount. If the EHCP had already been reimbursed, he/ she would be requested to repay the Government the relevant amount.

51. During DH's monitoring and investigation activities, if any fraud or criminal element was suspected, the case would be referred to the Police and DH would provide necessary assistance to the Police's investigations. If the EHCP was suspected of violation of his/ her professional code of practice, he/ she would be referred to the relevant professional regulatory board/ council. EHCPs suspected to have engaged in serious malpractices or misconduct would be disqualified from the Scheme.

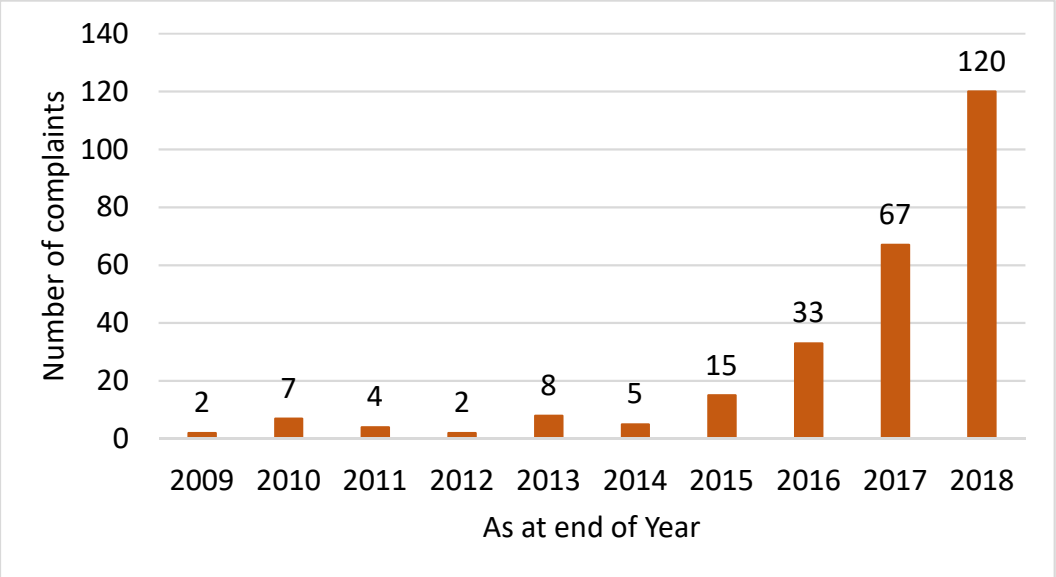
52. Since the launching of the Scheme in 2009 and up till end-2018, DH had disqualified 26 EHCPs from the Scheme (11 medical practitioners, 8 Chinese medicine practitioners, 4 optometrists, 1 dentist, 1 medical laboratory technologist and 1 registered nurse) and had referred 54 and 10 cases to the Police and the relevant professional regulatory boards/ councils respectively.

53. Of the 54 cases referred to the Police, as at end 2018, 1 EHCP was prosecuted and sentenced to imprisonment for making false voucher claims under the Scheme, 1 EHCP was convicted for making fraudulent

claim under the Vaccination Subsidy Scheme and 6 persons, who were relatives of voucher users, were convicted of making false voucher claims under the Scheme. The Police did not launch any prosecution in 32 cases after investigation. The remaining 14 cases were still under the investigation of the Police as at end-2018.

54. In terms of complaints/ media reports/ intelligence received against EHCPs, a notable increase has been observed since 2015 (**Figure 10**). To study the situation further, the complaints between 2014 (since the Scheme was regularised) and 2018 against EHCPs were examined. Among the 240 complaints, most were against medical practitioners and Chinese medicine practitioners, followed by optometrists. A small number was against nurses, medical laboratory technologists, physiotherapists, and occupational therapists (**Table 7**).

Figure 10 Number of complaints* against EHCPs, 2009 - 2018



**Including complaints, media reports and intelligence*

Table 7 Number of complaints* against EHCPs by type of healthcare profession, 2014 - 2018

	Number of complaints* against EHCPs					
	2014	2015	2016	2017	2018	Total
Medical Practitioners	1	11	18	21	33	84
Chinese Medicine Practitioners	3	2	4	16	55	80
Dentists	0	0	5	3	11	19
Occupational Therapists	0	0	0	1	0	1
Physiotherapists	0	0	0	0	2	2
Medical Laboratory Technologists	0	0	0	1	2	3
Radiographers	0	0	0	0	0	0
Nurses	0	0	0	3	1	4
Chiropractors	0	0	0	0	0	0
Optometrists (Part I)	1	2	6	22	16	47
Total	5	15	33	67	120	240

**Including complaints, media reports and intelligence*

55. Most of the complaints against EHCPs are related to improper voucher claims and issues related to service charges. Investigation of these cases are not always easy, as many elders may not want to testify against the EHCP concerned. Moreover, in order to allow greater flexibility for the elders, the Scheme currently does not have any restrictions on the number of claims or amount of claims that can be made by each healthcare profession for each elder.

(ii) Review of the monitoring system

56. In view of the increasing number of complaints and media reports about cases of suspected misuse of vouchers, DH carried out a major review on the monitoring mechanism and its related protocol in 2016, with introduction of further measures to strengthen the monitoring system. For example, DH had introduced graded levels of actions against EHCPs who breached the terms and conditions of the Scheme Agreement in accordance with the gravity of cases including the issuance of advisory and warning letters in addition to the recovery of relevant amounts of voucher payment as appropriate. DH had also enhanced the detection of aberrant claim transactions patterns in eHS(S) since March 2018 to identify cases for targeted inspection visits and introduced a new clause in the Scheme Agreement with effect from October 2018 for temporary suspension of an EHCP's account pending the investigation outcome of suspected non-compliances and irregularities. From time to time, new directives were also issued to the EHCPs to address potential misuse of vouchers.

57. Apart from the above, DH regularly issues to EHCPs a set of Proper Practices to remind them of the requirements of the Scheme when making voucher claims, 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 patients at their request before providing service, and allowing patients to choose from different healthcare treatment/ management options which may have different service charges after considering the explanation provided by the EHCP's healthcare staff.

(iii) Improper voucher use

58. The Scheme implemented the "money follows the patient" concept, enabling elders to choose their own private primary care services in their local communities that suit their health needs most. In order to provide flexibility to elders, there is no limitation on the voucher amount to be used each time or among different healthcare professions as long as there is a positive balance. However, it had appeared from anecdotal reports and complaints received by DH that such flexibility might have been exploited by some EHCPs to maximise profits, through persuasion of elders to use their vouchers on healthcare services or prescription of products that they might not need. Indeed, the number of complaints received by DH against EHCPs had surged since 2015 (15 complaints), reaching a record high of 120 in 2018. While DH will continue to take stringent measures in the monitoring and investigation of improper voucher claims as a downstream measure to deter abuse (such as suspending reimbursements, requesting repayment of reimbursed vouchers from the EHCPs, issuing warning letters, disqualifying them from participating in the Scheme, and referring suspected cases of fraud or professional misconduct to the relevant authorities and professional regulatory boards/ councils respectively), taking an upstream approach to prevent misuse is equally important and may prove more cost-effective in the long run.

(iv) Over concentration of voucher use

59. The current review also considered the problem of over-concentration of voucher use in individual healthcare service category. Possibly as a result of an increase in the annual voucher amount to $2,000 and accumulation limit to $4,000 since 2014 and as a means to avoid forfeiture of vouchers exceeding the accumulation limit, some elders might use their vouchers on healthcare services or products which they might otherwise not require, such as expensive prescription spectacles. A rapidly growing and disproportionate amount of vouchers spent on optometry services was observed.

60. Between 2015 and 2018, an unusual trend was observed for voucher claims made for optometry services in terms of the following aspects –

- the relative proportion of voucher amount claimed by optometry services under the Scheme had increased from 4% to 27%, whereas the number of optometrists enrolled under the Scheme represented only 5% and 9% of all EHCPs respectively (**Table 8** and **Table 9**

(c) and (f))

- The year-on-year increase in the amount of vouchers claimed by optometry services was disproportionally high compared with the increase in total amount of vouchers claimed by all healthcare services (**Table 9** (a) and (b))

- The median amount of each claim spent on optometry services was the highest among all healthcare services, with a high proportion of claims over $4,000. Among all voucher claims above $4,000, 76% were spent on optometry services, and 38% of the claims above $4,000 spent on optometry services belonged to the highest band, i.e. $4,751 to $5,000 (**Figures 11 to 13**).

Table 8 Number of healthcare professionals enrolled in the Scheme, their voucher amount claimed and number of voucher claim transactions, 2017 - 2018

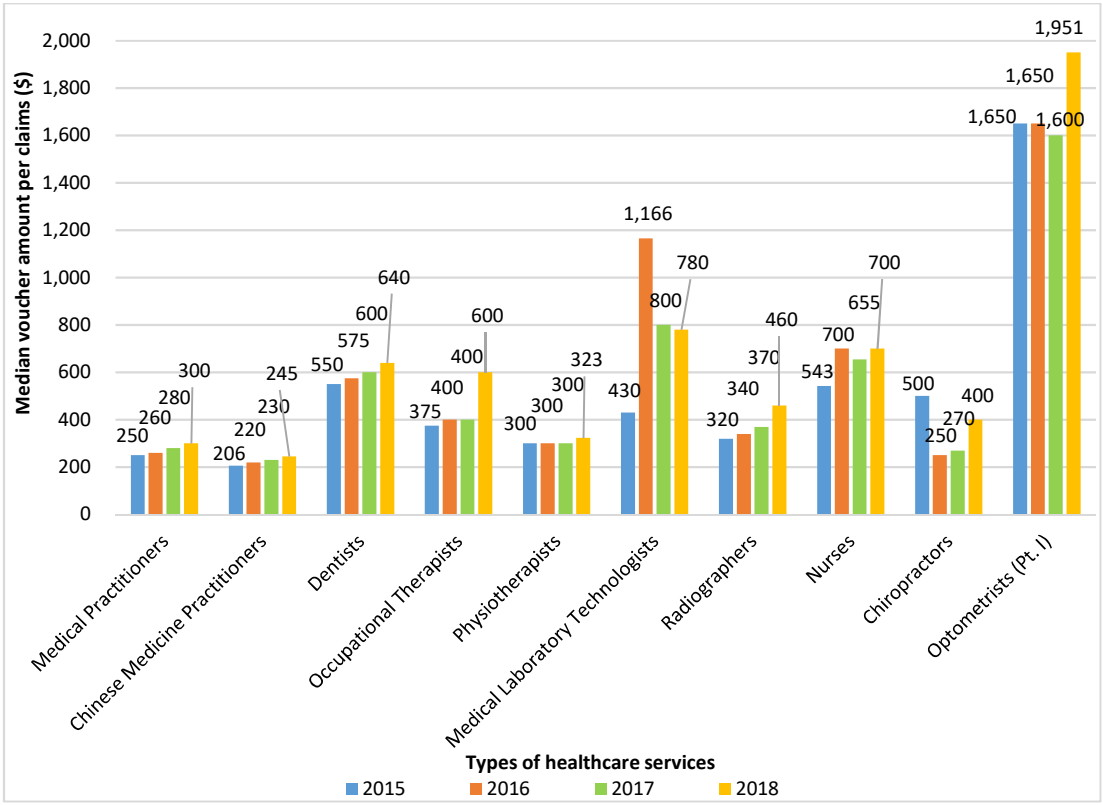
	2017			2018		
	No. of healthcare professionals enrolled at year-end	Voucher amount claimed ($'000)	No. of voucher claim transactions	No. of healthcare professionals enrolled at year-end	Voucher amount claimed ($'000)	No. of voucher claim transactions
Medical Practitioners	2 387 (33%)	774,088 (51.7%)	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

Table 9 Percentage of voucher amount claimed by optometrists (Part I) and number of optometrists (Part I) enrolled under the Scheme, 2015 - 2018

	2015	2016	2017	2018
(a) Amount of vouchers claimed by all types of healthcare professionals in Hong Kong (in $'000)	905,790	1,069,087	1,498,542	2,800,688
Percentage increase per year	-	18%	40%	87%
(b) Amount of vouchers claimed by optometrists (Part I) (in $'000)	37,092	128,399	288,582	759,750
Percentage increase per year	-	246%	125%	163%
(c) Percentage of voucher amount claimed by optometrists (Part I) over those by all types of healthcare professionals in Hong Kong (= (b)÷(a))	4%	12%	19%	27%
(d) Number of all types of healthcare professionals enrolled under the Scheme in Hong Kong	5 259	6 144	7 153	7 941
(e) Number of optometrists (Part I) enrolled under the Scheme	265	533	641	697
(f) Percentage of optometrists (Part I) over all types of healthcare professionals enrolled under the Scheme in Hong Kong (=(e) ÷(d))	5%	9%	9%	9%

Note: 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.

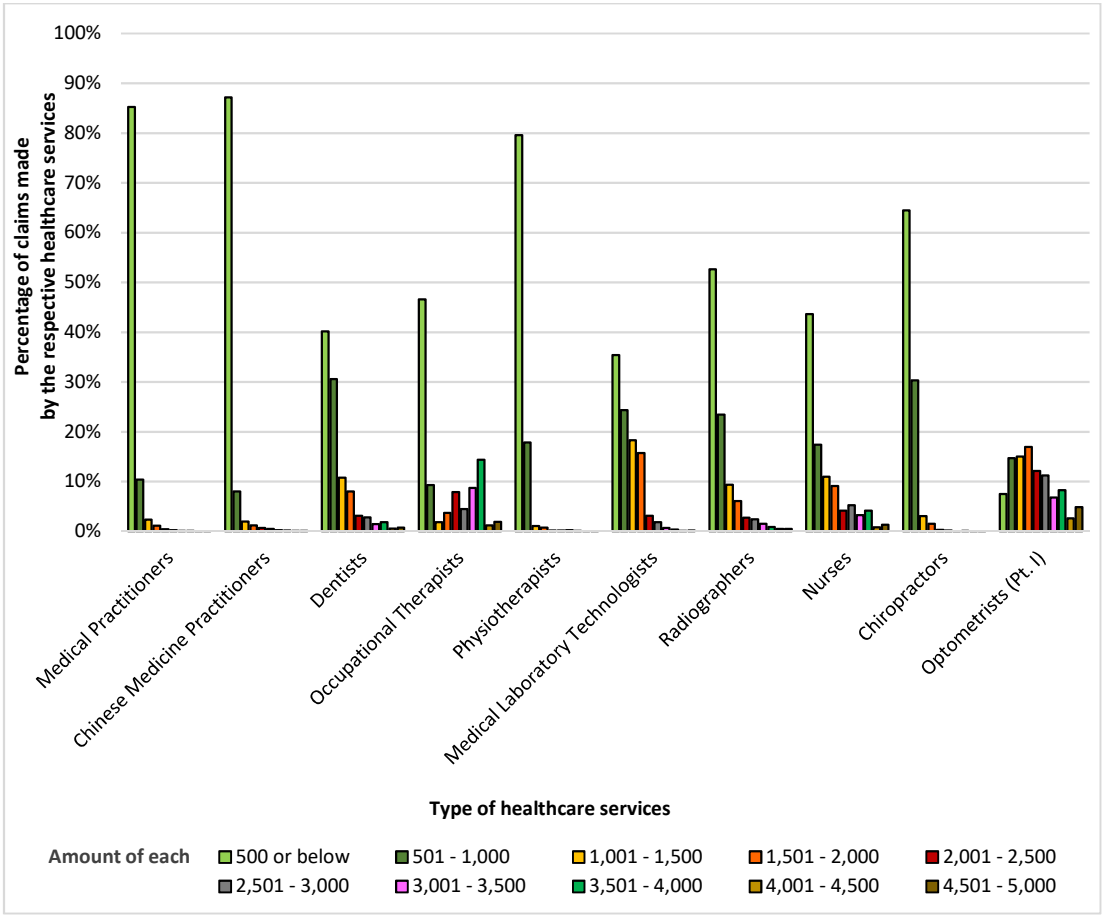
Figure 11 Median voucher amount per claim by types of healthcare services, 2015 - 2018



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 EHCPs 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.*

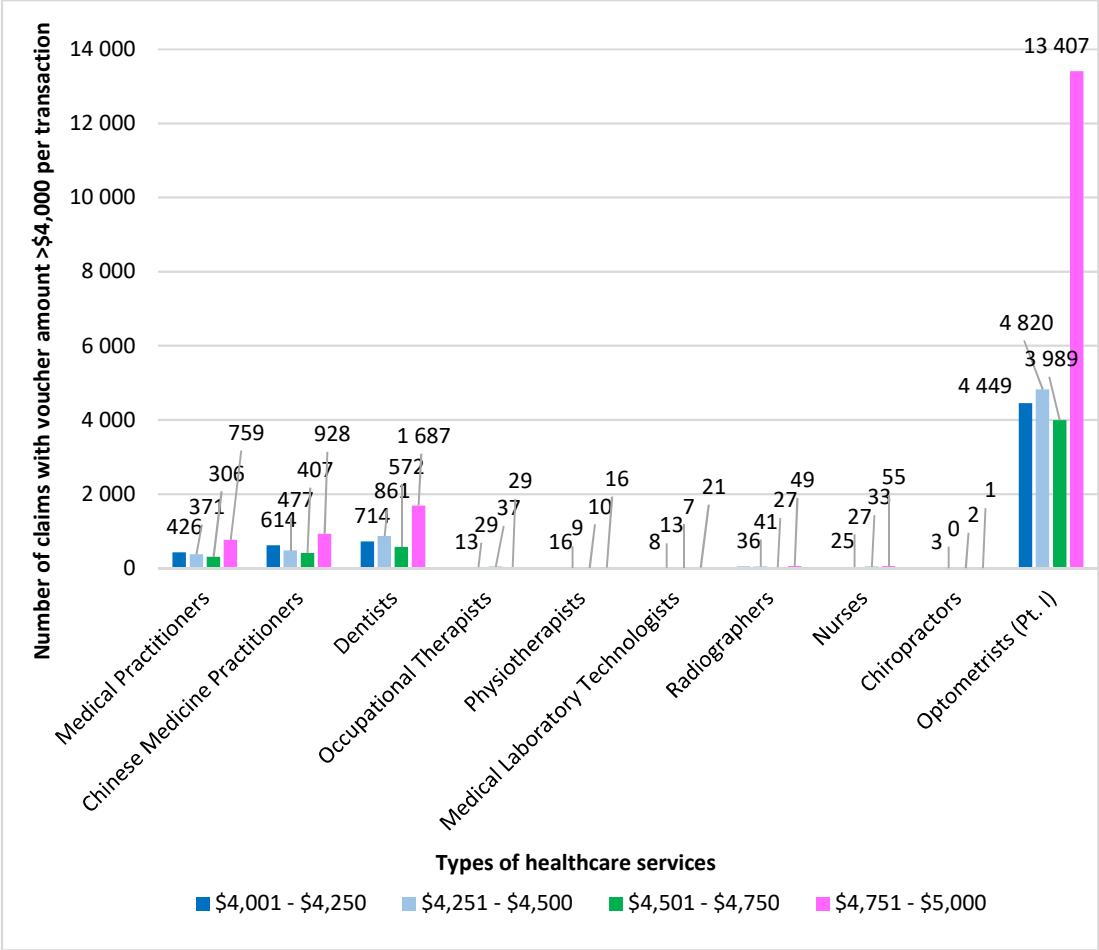
Figure 12 Distribution of amount of vouchers per claim by types of healthcare services, 2018



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 EHCPs 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 13 Number of claims exceeding $4,000 per claim by types of healthcare services, 8 June - 31 December 2018



Note: 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.

61. This over-concentration of use of vouchers on services provided by a particular healthcare profession may not be conducive to the Scheme's aim of encouraging the use of private primary care services as elders might be left with no or insufficient vouchers for other primary care services.

62. Some healthcare professionals in the focus group had proposed setting a price cap to prevent the elders from being invited to misuse vouchers on expensive but unnecessary medicinal products. However, they also expressed concern over implementation difficulties and indirect induction of price inflation as some EHCPs would charge up to the capped amount. Most of them agreed that patient empowerment on the appropriate use of vouchers was essential. They proposed to equip elders with knowledge in choosing the right services and considered it would be the most effective way to improve medical outcomes and to prevent abuse. We also recognise that setting a monetary cap per visit may not be

meaningful unless there is also a cap on the number of visits over a period of time, which however may be overly restrictive on elders.

63. It is also worth noting that under the 2016 cross-sectional survey, 57% of the elders did not agree that a cap on the voucher amount that could be used for each single consultation should be set. Only 30% agreed while 13% answered "don't know".

(h) The Pilot Scheme at HKU-SZH

64. To provide one more service point for Hong Kong elders to use the vouchers and facilitate those who reside in the Mainland or places near Shenzhen to seek medical treatment in Shenzhen, the Government has launched a Pilot Scheme at HKU-SZH since October 2015. Eligible Hong Kong elders can use the vouchers to pay for the fees of outpatient services provided by designated clinics/ departments of the HKU-SZH [12].

Pilot Scheme utilisation and operation

65. The total number of elders who had ever made voucher claims at HKU-SZH rose from 507 to 3 415 between end 2015 to end 2018, with a total amount of over HK$7.3 million claimed under the Pilot Scheme as at 31 December 2018 (to pay for healthcare service fees of around RMB6.3 million). Fifty-nine percent were residing in the Mainland while the rest were residing in Hong Kong. As at end-2018, the cumulative amount of vouchers used in HKU-SZH's Medicine Clinic (about HK$2.9 million) contributed to some 39% of the total amount claimed by HKU-SZH (over HK$7.3 million), which ranked the highest amount among all eligible departments or clinics. Annual post-payment checking visits had been conducted to HKU-SZH by DH since 2016 and so far no irregularities have been identified.

[12] Vouchers can be used for the outpatient services (including preventive care services as well as curative and rehabilitative services) 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.

66. A report on the use of vouchers by elders at HKU-SZH was released by the Hospital in 2018 [5]. The survey[13] on 384 elders found that the three commonest ways for respondents knowing about the services of HKU-SZH were via the publicity of DH (41%), via word of mouth of relatives and friends (35%), and via the website/ WeChat of HKU-SZH (18%).

67. The three commonest reasons that respondents gave for choosing the HKU-SZH were: (1) it adopted "Hong Kong's management model" (73%), (2) it had good customer service (64%), and (3) it had advanced medical equipment (49%).

68. Over 80% of the respondents indicated that they were satisfied with the flow on booking appointments, registration and payment, triage by nurses, seeing medical practitioners, and collecting medication. Over 70% of the respondents were satisfied with the examination and tests provided as well as the effect on treatment. Sixty-six percent of the respondents were satisfied with the standard fees and charges of the services. Overall, 92% of the respondents were satisfied with the services as a whole, with payment made with the vouchers.

69. According to the report, elders had proposed some improvements to the Pilot Scheme, which included increasing the annual voucher amount for those elders who had joined the Guangdong Scheme of the Social Welfare Department (SWD) in order to cover their medical expenses in Shenzhen and extending the usage of vouchers to cover the fees for in-patient services.

IV. CONCLUSIONS AND RECOMMENDATIONS

70. In overall terms, this review showed that the Scheme had largely achieved its objective of providing elders with additional choices for primary care services in the private sector, as evidenced by a marked increase in the take-up rates by elders since 2010. Despite a gradual increase in the annual percentage of elders who had made use of vouchers for preventive care services, the Scheme has a relatively smaller effect in encouraging use of vouchers for management and follow-up of chronic diseases. Private healthcare services paid for by vouchers supplemented rather than replaced public healthcare services, with an increase in proportion of elders with dual utilisation of healthcare services in both

[13] A client satisfaction survey was conducted between 4 September 2018 and 14 September 2018 by HKU-SZH. Elders were invited to complete a questionnaire via face-to-face interview or through completing an electronic form.

sectors. Although the proportion of elders reporting public healthcare services as their usual source of care had decreased, the impact of vouchers on public healthcare services had not been observed within the first two years since the Scheme became recurrent. Meanwhile, spin-off effects such as over-concentration of voucher usage on possibly expensive healthcare products that may compromise the effectiveness of the Scheme warrant urgent actions.

71. 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 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 EHCPs, 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.

72. Having regard to the key findings, we recommend that the following enhancements and refinements to the Scheme be pursued –

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

73. A recurrent theme that has emerged throughout the review was the inability of the Scheme to incentivise the use of private healthcare services for management of chronic diseases, the main argument being the wide price gap between public and private healthcare services, leading to barrier for elders to shift from public to private healthcare sector. On the other hand, the notion of designating vouchers for specific uses (e.g. on preventive services) was not welcomed by elders while opinions from healthcare service providers were mixed. To encourage better and more systematic use of vouchers for preventive care and chronic disease management, it is proposed that we allow the use of vouchers at all DHCs.

74. The setting up of DHCs, as announced in the Policy Address 2017, is aimed at enhancing primary care through medical-social collaboration. We envisage that the elderly population will benefit from DHC services. 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. 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

75. From the review outcome, the Government should strengthen its efforts in promoting better use of vouchers and empower elders to make informed choices and use vouchers wisely.

76. It was noted from the review that use of television announcements of public interest had been very effective in raising awareness and understanding among elders on the Scheme and its enhancement measures. Yet by nature, such brief messages promulgated via the media, posters, pamphlets and the like could only serve to increase general awareness, with little effect in terms of promulgation of the key concepts of primary care, or the more operational details of the Scheme. As such, we noted that some elders were still unclear about the Scheme's coverage and operation, and would like to have more information on aspects like how to find the right EHCP and how to check voucher balance. Moreover, complaints and reports received by DH also revealed the problems of some elders being persuaded by EHCPs to use their vouchers on unnecessary services and products, which might undermine the Scheme's

effectiveness in addressing the primary care needs of elders.

77. In this regard, we recommend strengthening the efforts in promoting better use of vouchers through proactively reaching out to elders, in addition to the existing publicity efforts. The 18 Visiting Health Teams of DH should be mobilised to conduct health talks on the concept of primary healthcare and teach elders on how to use vouchers wisely and properly to meet their healthcare needs through easy-to-understand illustrations.

78. It is envisaged that through empowering elders and imparting to them the knowledge and skills on how to choose the right primary care services, voucher usage can be channelled towards healthcare services that best suit their health needs.

79. 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. Besides, we see the need to develop a more convenient channel for elders to check their voucher balance and transaction history. It is therefore recommended to enhance the current voucher balance enquiry function to allow elders to know the amount of vouchers which will be forfeited on 1 January of the following year (if any) based on the voucher balance as at the day of checking, and check the voucher transaction records in their voucher accounts as well. The Government plans to pursue the latter through the Patient Portal of the Electronic Health Record Sharing System, which is being developed. We expect the above two enhanced functions can be made available in around mid-2019 and the second half of 2020 respectively.

(c) Stepping up monitoring efforts

80. 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 EHCPs. A risk-based approach is adopted to target investigations at EHCPs displaying aberrant patterns of voucher claim transactions and those who had history of non-compliance with Scheme rules. With an increasing number of complaints and media reports about cases of suspected misuse of vouchers, DH seek to enhance the hotline for receiving and handling complaints and enquiries from the public to provide more timely response and support to elders and EHCPs.

(d) Tackling over-concentration of voucher use

81. Given the rapid and disproportionate increase in the amount of vouchers spent on optometry services in the recent few years, we recommend that the voucher amount that can be spent on optometry services during a specified period of time by each elder be capped at a specified level. This is to address the concern 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 healthcare service may render the elders not having vouchers for other types of healthcare services that they may need.

82. The capping proposal would ensure that elders can still use vouchers for optometry services while keeping a decent balance for other uses when needed. To implement this measure, the eHS(S) would be upgraded such that any further claims made by optometrists for any elder above the specified threshold within the specified period would automatically be rejected by the System. The voucher balance checking website and hotline would also advise the amount of vouchers that could be used for optometry services by the elder concerned.

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

83. Our review of the Pilot Scheme found the general sentiment from patients to be very positive – 92% of the interviewees were satisfied with the outpatient service received at HKU-SZH that were paid for by the vouchers and the overall operation of the Scheme was smooth. We also have not identified irregularities in the operation of the Pilot Scheme. In this regard, we propose to regularise the Pilot Scheme at HKU-SZH.

(f) Streamlining enrolment procedures for healthcare service providers

84. With a view to facilitating participation of healthcare service providers in the Scheme, it is recommended to explore the possibility of streamlining the existing enrolment procedures. As a first step, DH has set up a portal page on the website of the Centre for Health Protection that lists all Public-Private Partnership (PPP) programmes (including the Scheme) administered by DH with links to background information, enrolment procedures, etc., of each PPP programme. 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 for the Scheme would also be explored.

(END)

Appendix

Summary of Methodology for the Studies

1. A repeated cross-sectional survey in 2016

A cross-sectional survey was conducted by the JCSPHPC, CUHK in collaboration with DH in 2010 (the 2010 cross-sectional survey) on 1 026 elders aged 70 or above to collect their opinions towards the pilot stage of the Scheme including their healthcare services utilisation pattern, awareness and understanding of the Scheme, attitudes towards voucher use, and voucher use pattern. Results of that survey formed part of DH's interim review of the pilot stage. To conduct the current review, the survey was repeated between June 2016 and January 2017 on another sample of community dwelling elders aged 70 or above by using structured questionnaires and face-to-face interviews. The convenience sampling method was used and elders were recruited from (i) outpatient clinics in both public and private sector for medical practitioner consultation, (ii) neighbourhood elderly centres under the SWD, and (iii) elderly health centres under the DH. A total of 974 elders were successfully interviewed (the response rate was 79%).

2. Longitudinal follow-up survey in 2016

To follow up on the subjects of the 2010 cross-sectional study and assess their changes in awareness, knowledge, attitudes and usage experience of the Scheme over time, a subsequent longitudinal follow-up survey was conducted in 2016 by JCSPHPC, CUHK in collaboration with DH. Among the 1 026 community dwelling elders aged 70 years or above who participated in the cross-sectional survey in 2010, 586 elders gave consent for telephone follow-up interviews and 326 of these elders were later followed up again in August and September 2016 (the response rate was 56%).

3. Focus group study in 2016

A focus group study was conducted by the JCSPHPC, CUHK in collaboration with DH between June 2016 and February 2017. A total of 33 participants were recruited. Among them, 22 (67%) were EHCPs who were recruited through random invitations sent to the list of EHCPs published on DH's website. Nine non-EHCPs were recruited through the networks of CUHK's investigators and through sending invitations to healthcare service providers on the lists maintained by the respective professional regulatory boards/ councils. Two administrators of medical groups also joined. As for the methods, five focus group interviews were

organised to collect opinions on the Scheme from different types of healthcare providers, including: 5 Chinese medicine practitioners (group 1), 4 dentists (group 2), 4 nurses (group 3), 5 chiropractors (group 4), and 8 allied health professionals, i.e. 2 occupational therapists, 2 medical laboratory technologists, and 4 optometrists (Part I) who were regulated by the Supplementary Medical Professions Council in Hong Kong (group 5). Individual telephone interviews were conducted for another 5 medical practitioners who did not have time to attend the focus group. The two administrators of medical groups were also interviewed by telephone.

The focus group interviews were conducted by a moderator and supported by an observer, both from JCSPHPC, CUHK. A discussion guide was used to facilitate the interviewing process. It included four main themes to explore participants' opinions on or experiences in: (i) changes of the Scheme, (ii) impact of the Scheme on voucher users and healthcare service providers, (iii) perceived barriers to participation of healthcare service providers, and (iv) measures for potential Scheme enhancement. Each session of focus group or telephone interview lasted for 90 to 120 minutes.

4. Analysis of linked administrative data from eHS(S) and HA on a selected group of elders

To study the impact of the Scheme on elders' choice between public and private healthcare sectors, data from consenting respondents in the 2016 cross-sectional survey (please see above for details of the survey methodology) were matched with the administrative data of HA and eHS(S) of DH between 2009 and 2015 for assessing the utilisation of public and private services over those years. As not all elders recruited in the 2016 cross-sectional survey had attained the eligible age for using vouchers between 2009 and 2015, only the 551 elders who were born on or before 1939 (i.e. aged 70 or above in 2009) were included in the analysis.

5. Analysis of the voucher utilisation pattern of 19 000 elders who had used vouchers in 2009 from the eHS(S)

To study the continuity of care among elders using vouchers for seeing private medical practitioners, a random sample of 10% (19 000) of elders who had used vouchers in 2009 was selected from the eHS(S). Their utilisation pattern in terms of the number of different private medical practitioners seen was tracked and analysed from 2009 to 2017.