EMERGENCY DENTAL SERVICES AND ELDERLY DENTAL CARE SUPPORT

Executive Summary

1. The Government's policy on dental care aims to raise public awareness of oral hygiene and oral health, and encourage proper oral health habits. Under the prevailing policy, the Government mainly undertakes publicity, education and promotion of oral health. Dental care services in Hong Kong are mainly provided by the private sector and non-governmental organisations (NGOs). According to the Government, when considering the strategy for oral health and dental care, and the provision of government-funded oral health measures and curative dental services, the long-term financial sustainability must be taken into account. It is more cost-effective to focus government resources on oral health measures and preventive dental services. At the same time, targeted assistance should be provided to individual under-privileged or disadvantaged groups who had difficulties in obtaining dental services.

2. Emergency dental services are provided for the public by the Department of Health (DH) in designated sessions on designated days in 11 government dental clinics (which are established primarily for fulfilling the obligation for providing dental benefits for civil service eligible persons) (hereinafter referred to as General Public (GP) sessions), and for hospital in-patients and referred patients at the Oral Maxillofacial Surgery and Dental Clinics (OMSDCs) of DH and the Hospital Authority (HA) in seven and six public hospitals respectively (i.e. hospital dental services). Besides, the Government provides dental care support to elderly persons under various initiatives, including the Outreach Dental Care Programme for the Elderly (ODCP) and the Elderly Health Care Voucher Scheme (EHVS) under DH's purview, and the Elderly Dental Assistance Programme (EDAP) administered by the Health Bureau (HHB) and funded under the Community Care Fund (CCF).

3. In December 2022, the Government established the Working Group on Oral Health and Dental Care (the Working Group) to advise the Government on the long-term strategy for oral health and dental care, as well as matters including the enhancement of the scope and mode of services provided or subsidised by the

Government. The Working Group issued an interim report in December 2023 and will issue the final report by late 2024.

4. The Audit Commission (Audit) has recently conducted a review of the work of the Government on the provision of emergency dental services and elderly dental care support.

Emergency dental services

5. Services provided under GP sessions include treatment of acute dental diseases, prescription for pain relief, treatment of oral abscess and teeth extraction, and provision of professional advice based on individual needs of patients. Meanwhile, hospital dental services provided include specialist oral maxillofacial surgery and dental treatment to hospital in-patients, and patients with special oral health care needs and patients with dental emergency needs through referrals (i.e. out-patients) from various sources (e.g. the HA's Specialist Out-patient Clinics, government dental clinics (including GP sessions) and private registered dental or medical practitioners) (paras. 2.2, 2.18, 2.19 and 2.24).

6. ***Need to enhance provision of emergency dental services to the public in need.*** A patient seeking emergency dental services provided at GP session is required to obtain a disc from the respective government dental clinic at the beginning of the session for receiving the services. From 2014-15 to 2018-19, the number of discs for allocation (i.e. disc quota) of the 11 government dental clinics was about 40,000 a year. From 2018-19 to 2022-23, while the disc quotas decreased from 40,322 to 20,337, the disc allocation rate (i.e. the percentage of disc quota allocated) increased from 92.3% to 99.2%. Audit noted that:

(a) according to DH, the disc quotas have been reduced since January 2020 due to the outbreak of coronavirus disease (COVID-19) epidemic and manpower shortage;

(b) according to the Working Group interim report (see para. 3), the Working Group noted the public demand for more disc quotas for GP sessions and recognised the inability to increase disc quotas for GP sessions due to the acute manpower shortage of dental officers in the Government; and

(c) the Government announced in the 2023 Policy Address that it will collaborate with NGOs to increase the emergency dental services targeting at the under-privileged groups with financial difficulties in 2025 through expansion of service capacity, service points and service scope under a new service model.

In view of the public demand for services provided at GP sessions, Audit considers that DH needs to take measures to enhance provision of emergency dental services to the public in need (i.e. increase the service volume at least to pre-COVID-19 level (i.e. 40,000 service quota for the public a year) in government dental clinics or through a new service model) (paras. 2.3 to 2.7 and 2.14).

7. ***Need to improve the disc distribution arrangement for GP sessions.*** Discs for GP sessions are distributed in the respective clinic on a first-come-first-served basis. DH has taken various measures (e.g. trial use of self-service kiosks) for improving the disc distribution arrangement for GP sessions over the years. Taking into account public views and operational experience, in September 2022, DH implemented the preliminary registration arrangement in 9 of the 11 government dental clinics with GP sessions. Under the arrangement, DH commences registering patients' information at 0:00 a.m. of the day of the GP session and registration will stop when the number of preliminarily registered patients exceeds the number of disc quotas for the respective session. The registered patients can then return to the clinic before the commencement of the GP session for obtaining a disc. According to DH, in 2023-24 (up to October 2023), 98% of the discs were distributed to patients registered through preliminary registration. Audit visited government dental clinics with GP sessions in December 2023 and February 2024 and noted that:

(a) in four clinics, there were a few people queueing at about 5:00 p.m. for discs for the next day GP session with preliminary registration commencing at 0:00 a.m. (i.e. would need to wait for at least 7 hours);

(b) in three clinics, the number of people queueing up at the clinics at 10:00 p.m. accounted for 36% to 57% of the disc quotas, indicating that quite a number of people queued early for a few hours in order to secure a spot for the preliminary registration; and

(c) for one clinic with GP session in the afternoon, registered patients needed to return to the clinic at 11:00 a.m. for obtaining the discs, and return to

the clinic again at 1:30 p.m. when the GP session commences for obtaining the services (paras. 2.8 to 2.12).

8. ***Room for improvement in monitoring the services of DH's OMSDCs.*** Audit noted the following issues:

(a) ***Need to maintain management information on the attendance rates.*** New case appointments at OMSDCs are arranged for patients according to clinical conditions of patients at the time of referral. Follow-up appointments will be arranged as appropriate after the patients attend OMSDCs for the first time. While the attendances of DH's OMSDCs ranged from 54,600 to 67,100 in 2018-19 to 2022-23, DH did not maintain management information on the number of new case and follow-up appointments arranged. As such, the attendance rates of DH's OMSDCs could not be ascertained (para. 2.21); and

(b) ***Need to improve monitoring of achievement of targets on waiting time for new case appointments.*** According to DH's guidelines for its OMSDCs, depending on the clinical conditions of patients, new case appointments shall be arranged according to the targets set for different types of cases (e.g. within 2 weeks for urgent cases). However, information on the achievement of these targets and waiting time for new case appointments for different types of cases was not available (paras. 2.22 and 2.23).

9. ***Room for improvement in monitoring the services of HA's OMSDCs.*** The out-patients' attendance rates of new case appointments ranged from 80% to 88% and those of follow-up appointments ranged from 85% to 89% (para. 2.24). Audit noted the following issues:

(a) ***Need to regularly report achievement of targets on waiting time for new case appointments for urgent and semi-urgent cases.*** According to HA, upon receipt of the patients' referral letters, its OMSDCs will assess the patients' conditions and arrange the first appointments (i.e. new case appointments) according to a triage system. Under the triage system, patients of urgent and semi-urgent cases will be given the first appointments within 2 and 8 weeks from dates of receipt of the referral letters respectively. However, there was no requirement on reporting the achievement of the targets on waiting time for new case appointments at

HA's OMSDCs for these cases nor maintaining the relating supporting documentations (paras. 2.25 and 2.26); and

(b) ***Need to keep under review the waiting time for stable cases.*** According to HA, information on the waiting time for stable cases as well as the number of stable cases waiting for the first appointments were not readily available. Audit examined the appointments arranged by HA for stable cases as at 25 January 2024 at its OMSDCs and noted that the latest appointments arranged were 8 to 63 weeks from that date among the six OMSDCs (para. 2.27).

10. ***Way forward.*** Hospital dental services are provided at DH's OMSDCs in seven public hospitals and HA's OMSDCs in six public hospitals (see para. 2). With a view to consolidating public primary healthcare services, the Government is reviewing the roles of key public healthcare service providers (i.e. DH and HA). In this connection, DH would focus on maintaining its public health functions and continue to serve as the Government's public health adviser, whereas HA would focus on its provision of public hospital and related medical treatment and rehabilitation services to the public. According to HHB, it was in the progress of migrating the hospital dental services (i.e. medical treatment) provided by DH to HA (para. 2.30).

Provision of elderly dental care support by the Department of Health

11. ***Need to take further measures to enhance NGOs' performance in reaching their target numbers of service users.*** Under ODCP, DH has engaged NGOs by entering into Funding and Service Agreements (FSAs) for providing free dental care and treatments (e.g. oral examination and fillings) to elderly persons in residential care homes for the elderly (RCHEs) or similar facilities (e.g. nursing homes for the elderly registered under DH) and day care centres for the elderly (DEs) (hereinafter referred to as RCHEs/DEs) through outreach dental teams set up by NGOs. NGOs are required to state in the proposals the number of outreach dental team(s) they would like to operate (each team with a target to provide services to at least 1,000 or 2,000 service users in each service year). RCHEs/DEs and their respective service users may join the programme on a voluntary basis. According to the FSAs of the two FSA periods under examination (i.e. from 1 October 2017 to 31 March 2024), 10 NGOs should operate 23 teams for providing ODCP services to a target of at least 43,000 service users per year. Audit noted that:

(a) the overall target of 43,000 service users had not been met from 2020-21 to 2022-23. According to DH, ODCP services were suspended intermittently due to the outbreak of COVID-19 epidemic in the period from early 2020 to early 2023; and

(b) the number of NGOs that could not achieve their targets ranged from 2 (in 2017-19) to 9 NGOs (in 2020-21). The numbers of service users for two NGOs were less than 50% of the proposed target numbers for three consecutive years (from 2020-21 to 2022-23) (paras. 3.2 to 3.7).

12. ***Need to improve participation rate of RCHEs/DEs.*** Upon award of FSAs, each NGO is assigned a list of RCHEs/DEs. According to FSAs, an NGO is expected to approach and contact all RCHEs/DEs assigned to it for promotion of participation in ODCP in each service year. Audit analysed the participation rates of RCHEs/DEs in ODCP for the period 2017-19 to 2023-24 (up to December 2023) and noted that:

(a) the overall participation rate was 88% in 2017-19 and 68% in 2023-24 (up to December 2023); and

(b) the participation rates of RCHEs/DEs under the purview of three NGOs were lower than 50% persistently (i.e. for three consecutive years or more).

According to DH, there was a number of factors that would affect RCHEs'/DEs' interests in joining ODCP, including but not limited to the premises size and setting, manpower of RCHEs/DEs, as well as individual medical and mental health conditions of the elderly persons. Promotion efforts were made in collaboration with the Social Welfare Department (SWD) from 2014 to 2018 to encourage RCHEs/DEs to participate in ODCP, but was suspended during COVID-19 epidemic. In addition, it was not a standard practice for DH staff to follow up with non-participating RCHEs/DEs. As one of the objectives of ODCP is to provide free dental care to the needy elderly in RCHEs/DEs, who may otherwise be unable to access conventional dental care services, and the participation of RCHEs/DEs in the programme is essential for promoting and improving oral health of the elderly. In Audit's view, DH needs to step up efforts to ascertain the reasons for non-participation in ODCP of RCHEs/DEs (e.g. in collaboration with SWD). DH also needs to strengthen the promotion work in encouraging RCHEs/DEs to join ODCP, including considering collaborating with SWD in related work (paras. 3.5, 3.12, 3.14 and 3.15).

13. ***Need to step up monitoring of submission of reports by NGOs.*** NGOs are required under FSAs to submit reports, including annual evaluation reports and audited financial reports for ODCP within a specified timeframe after the close of the respective service year. Audit noted non-submission and delays in submission of the reports for the period 2017-19 to 2022-23 by NGOs. In particular, one NGO had not submitted the annual evaluation reports for all the 5 service years despite repeated reminders by DH, and DH withheld payments of the last instalments of the annual grant to the NGO for the relevant service years. However, reminders were not always sent to other NGOs for non-submission/delays in submission of reports, and DH had not issued guidelines on follow-up actions on overdue reports to its staff (paras. 3.24 and 3.25).

14. ***Need to further encourage NGOs to participate in ODCP.*** DH invited NGOs that operate dental services to participate in ODCP via an invitation for proposal exercise for each FSA period. According to DH, it intended to enter into contracts with about 16 to 20 selected NGOs. Since the launch of ODCP in 2014, the number of NGOs submitting proposals ranged from 10 to 11 (paras. 3.27 and 3.28).

15. ***Need to consider service performance of NGOs in assessment.*** Under DH's criteria for assessing suitability of NGOs for providing ODCP services, NGOs must fulfil essential requirements and attain an overall passing score to be considered for participating in ODCP (e.g. on quality of proposal). Past performance of the participating NGOs was not one of the assessment criteria. Given that some NGOs did not achieve the service targets persistently and not submitting reports timely, DH needs to consider including past performance of NGOs as one of the criteria for assessing the suitability of NGOs for provision of services in future invitation for proposal exercises for ODCP as appropriate (paras. 3.29 and 3.30).

16. ***Need to remind dentists to inform DH timely of changes for updating information on EHVS website.*** Elderly persons aged 65 or above can make use of vouchers under EHVS for receiving private primary healthcare services that best suit their health care needs, including dental services. DH publishes the list of dentists enrolled in EHVS on EHVS website. In January 2024, Audit made anonymous enquiries to 20 private dental clinics involving 41 dentists on the EHVS dentist list as at 31 January 2024 and found that 4 (10%) dentists no longer allowed patients to use the vouchers under EHVS and 11 (27%) dentists no longer worked in the clinics (paras. 3.35 and 3.36).

Implementation of the Elderly Dental Assistance Programme

17. ***Need to further encourage eligible elderly persons to participate in EDAP.*** EDAP, funded by CCF (overseen by the Commission on Poverty (CoP)), aims to provide low-income elderly persons with free removable dentures and related dental services (including oral examination, scaling and polishing). HHB, responsible for administering, implementing and monitoring EDAP on behalf of CoP, has entrusted Organisation A as the implementing agent to assist in the implementation of the programme. In 2022-23, the number of applications for EDAP was 29,675 and the expenditure was $292 million. Audit noted that:

(a) while the participation rates of EDAP increased from 10% in 2018-19 to 20% in 2022-23, according to the Interim Report of the Working Group (see para. 3), the number of applicants for EDAP was rather low, indicating that some eligible elderly persons had not benefitted from the programme. According to HHB, the low participation rate was due to reluctance and unwillingness of the eligible elderly persons to accept dental treatments, or some of them had already had their own dentures; and

(b) Organisation A had estimated the numbers of beneficiaries under EDAP and the actual numbers of beneficiaries for the service years 2018/19 to 2022/23 were less than the estimated numbers by 13% to 53%.

Given that the numbers of beneficiaries were less than those estimated by Organisation A in the past few years, HHB needs to, in collaboration with Organisation A, formulate further measures to encourage participation (paras. 4.2 to 4.4, 4.6, 4.7 and 4.9).

18. ***Room for improvement in vetting applicants' eligibility***. According to the eligibility criteria, persons eligible to apply for assistance under EDAP include elderly persons who have not benefitted from ODCP previously. Audit noted that with the imposition of the relevant eligibility criterion in September 2015 and up to December 2023, there was no random checking against DH records on whether the applicant had previously benefitted from ODCP. HHB started to carry out the relevant checks on a sampling basis since January 2024 and some ineligible cases were found (para. 4.11).

19. ***Room for improvement in making dental appointments for applicants without indication of preferred dentists***. When an applicant submits an application at a service unit (e.g. an elderly/community centre), if the applicant does not indicate any preference for dentist/dental clinic, the service unit should make an appointment for the applicant based on the quota availability of the participating dentists and with reference to his/her willingness to accept cross-district appointment or not. However, there are no other guidelines on circumstances in which quotas are available for multiple dentists. Audit analysis revealed that in 2022-23, there was a significant variation in the number of new cases taken up by participating dentists under EDAP, ranging from 0 to 318 (averaging 32 cases). Audit examined the application forms of 60 new cases taken up by the 2 dentists (in 2 different districts) with the largest number of new cases and noted that for 11 (18%) cases, the applicants did not indicate preference for a specific dentist on the forms. The reasons for making appointment with the 2 dentists for the 11 cases were not documented in the application forms (paras. 4.18 and 4.19).

20. ***Need to expedite handling of long outstanding cases.*** Claims for payments of fees are submitted to Organisation A by service providers (e.g. dental fees by dentists/dental clinics). Under normal circumstances, if all information is checked and in order, it will take around 2 to 4 months for release of payment. Audit analysed the outstanding cases of claims for payments as at 31 December 2023 and noted that the time lapse for 1,187 (4%) of the outstanding cases was over 1.6 years from the EDAP application dates of the cases (i.e. long outstanding cases). Audit examination of 200 long outstanding cases revealed room for improvement, including:

(a) of the 100 cases with claim forms received from dentists/dental clinics, 73 (73%) cases had been outstanding for over 4 months (counting from the dates of receipt of claim forms), ranging from 123 to 2,984 days (i.e. about 8.2 years), averaging 771 days (i.e. about 2.1 years). For 48 (66%) of the 73 cases, there was no documentation on the reasons for the long processing time or follow-up actions; and

(b) of the 100 cases with claim forms not yet received from dentists/dental clinics, for 54 (54%) cases, Organisation A had taken follow-up actions. However, the follow-up actions for some cases were only taken an average of about one year after the first consultation sessions. For the remaining 46 (46%) cases, there was no evidence of follow-up actions by Organisation A (paras. 4.27 to 4.29).

21. ***Room for improvement in management of service agreements.*** Since entering into the service agreement with Organisation A in 2012, supplementary agreements/amendment letters had been issued for expanding the scope of the programme, changing the ceiling amounts of subsidy or extending the service period of the programme. Audit examination revealed areas for improvement, including:

(a) ***Need to incorporate clauses on safeguarding national security in service agreement.*** The Law of the People's Republic of China on Safeguarding National Security in the Hong Kong Special Administrative Region stipulates that it is the constitutional duty of the Hong Kong Special Administrative Region to safeguard national security. Audit examined the service agreement and the supplementary agreements/amendment letters and noted that there was no specific clause concerning safeguarding national security; and

(b) ***Need to issue supplementary letters timely.*** From time to time, CoP endorsed changes and enhancements to EDAP upon recommendations by CCF Task Force and the Government shall notify the implementing agent in writing of any such amendments and the consequential changes. Audit noted that the time lapse between the endorsement by CoP for the amendments and the issuance of the supplementary letters by HHB in the period from May 2013 to December 2023 ranged from 8 to 376 days (averaging 122 days) (paras. 4.35 to 4.38).

Audit recommendations

22. **Audit recommendations are made in the respective sections of this Audit Report. Only the key ones are highlighted in this Executive Summary. Audit has *recommended* that the Director of Health should:**

Emergency dental services

(a) **keep under review the number of discs for allocation, the utilisation of discs for GP sessions and the measures to address the dentist shortage issue, and take measures to enhance provision of emergency dental services to the public in need (i.e. increase the service volume at least to pre-COVID-19 level (i.e. 40,000 service quota for the public a year) in government dental clinics or through a new service model) (para. 2.16(a));**

(b) **review the disc distribution arrangement for GP sessions with a view to facilitating the public in need in obtaining discs (para. 2.16(b));**

(c) **maintain management information on the attendance rates of DH's OMSDCs (para. 2.31(b));**

(d) **maintain information on the achievement of the targets for arranging new case appointments stipulated in DH's guidelines and the waiting time for different types of new case appointments at DH's OMSDCs (para. 2.31(c));**

Provision of elderly dental care support by DH

(e) **take further measures to enhance NGOs' performance in reaching their target numbers of service users under ODCP, in particular, providing assistance to those with difficulties in achieving the targets as needed (para. 3.32(a));**

(f) **step up efforts to ascertain the reasons for non-participation in ODCP of RCHEs/DEs (e.g. in collaboration with SWD), in particular individual NGOs having RCHEs/DEs with persistent low participation rates under their purview, and take measures to address the issue (para. 3.32(b));**

(g) **strengthen the promotion work in encouraging RCHEs/DEs to join ODCP, including considering collaborating with SWD in related work (para. 3.32(c));**

(h) **take further measures to ensure the timely submission of reports by NGOs and compliance with FSA requirements and keep proper documentation on follow-up actions with NGOs (para. 3.32(g));**

(i) **provide guidelines for staff on the follow-up actions on overdue reports (para. 3.32(h));**

(j) **ascertain the reasons for non-participation in ODCP of NGOs and take measures to encourage more NGOs to submit proposals for participating in ODCP (para. 3.32(i)(i));**

(k) **consider including past performance of NGOs as one of the criteria for assessing the suitability of NGOs for provision of services in future invitation for proposal exercises for ODCP as appropriate (para. 3.32(i)(ii)); and**

(l) **take measures to remind the dentists enrolled in EHVS to inform DH of the changes in their enrolment information in a timely manner for updating the information on EHVS website (para. 3.38(b)).**

23. **Audit has *recommended* that the Chief Executive, HA should, regarding OMSDCs:**

(a) **require HA's staff to report the achievement of targets on the waiting time for new case appointments regularly and maintain the relating supporting documentations for verification (para. 2.32(a)); and**

(b) **maintain management information on the waiting time for stable cases and take measures to shorten the waiting time as appropriate (para. 2.32(b)).**

24. **Audit has *recommended* that the Secretary for Health should:**

Emergency dental services

(a) **take into account the audit observations and recommendations in this Audit Report in merging DH's and HA's hospital dental services (para. 2.33);**

Implementation of EDAP

(b) **in collaboration with Organisation A, formulate further measures to encourage participation (e.g. step up promotion efforts on the benefits of EDAP to the elderly persons and address their concerns about joining the programme) (para. 4.21(a));**

(c) **ensure that the eligibility checking mechanism on EDAP applicants covers all eligibility criteria (e.g. with expansion of eligibility criteria in the future) (para. 4.21(b));**

(d) **require Organisation A to provide guidelines to service units on making appointments with dentists for applicants without indication of preferred dentists/dental clinics, and keep proper documentation on the considerations in making such appointments (para. 4.21(d));**

(e) **require Organisation A to strengthen its efforts in monitoring long outstanding cases, including formulating guidelines on the follow-up actions and the relevant timeframes, and keeping track of the treatment status of long outstanding cases (para. 4.41(b)); and**

(f) **enhance the management of service agreements with the implementing agent, including incorporating specific clauses concerning safeguarding national security, and expediting actions in issuing supplementary letters upon endorsement of amendments to EDAP by CoP (para. 4.41(d)).**

Response from the Government and the Hospital Authority

25. The Secretary for Health, the Director of Health and the Chief Executive, HA agree with the audit recommendations.