CHAPTER 2

Department of Health
Hospital Authority

Provision of health services for the elderly

Audit Commission
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PROVISION OF HEALTH SERVICES FOR THE ELDERLY

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PROVISION OF HEALTH SERVICES FOR THE ELDERLY

Executive Summary

1. Public health services for the elderly are mainly provided by the Department of Health (DH) and the Hospital Authority (HA). The DH provides the services through its 18 Elderly Health Centres (EHCs), 9 non-governmental organisations (NGOs) under the Elderly Health Assessment Pilot Programme (EHAPP), 18 Visiting Health Teams (VHTs) and the Elderly Health Care Voucher Scheme (EHCVS). The 2014-15 estimated expenditure for the services was $1,034 million. In addition to public hospitals, the HA provides services through its 73 General Out-patient Clinics (GOPCs) and 47 Specialist Out-patient Clinics (SOPCs) in seven clusters. Expenditure for the operation of the HA in 2013-14 was $50 billion. The expenditure spent on elderly patients amounted to around 46% of the HA's total expenditure in 2013-14. The Audit Commission (Audit) has recently conducted a review of the provision of health services for the elderly by the DH and the HA.

Elderly health assessment services of DH

2. The 18 EHCs provide health assessments (first-time and subsequent) in the morning and curative treatments in the afternoon to the elderly (aged 65 or above), who need to apply for enrolment as members of individual EHCs to be eligible for the services (paras. 2.2 and 2.9).

3. ***EHC capacity not timely expanded to cope with the demand for elderly health assessment services.*** In the ten years from 2004 to 2013, the elderly population increased from 831,000 to 1,049,000, but the 18 EHCs provided less than 40,000 health assessments a year to the elderly, without timely expansion. It was only in 2013 that funds for the creation of two additional clinical teams were approved to increase the EHC capacity commencing 2014-15 and 2015-16 (paras. 2.6 and 2.7).

4. ***Significant disparity among the EHCs in allocating manpower resources between first-time and subsequent health assessments.*** In the absence of top-down strategic directions from the DH management, the mix of first-time and subsequent health assessments in 2013 varied significantly among the EHCs. If the mix remained unchanged and assuming zero additional intake and attrition, it would take many years (more than seven years for five EHCs) to clear their backlogs of first-time assessments. First-time assessments are important because 32% of the elderly were found to have medical conditions in their first-time assessments whereas only 7% of them had new medical conditions in their subsequent assessments (paras. 2.5(b) and 2.10).

5. ***Significant disparity in the number of curative treatments conducted by the EHCs.*** Although the manpower of the 18 EHCs was the same (with a clinical team of four staff in each EHC), there was significant disparity in the number of curative treatments conducted by the 18 EHCs whereas each EHC conducted roughly 2,150 health assessments a year. For example, in the period from 2009 to 2013, the Kwai Shing EHC conducted on average 16 curative treatments per day whereas the Shek Wu Hui EHC conducted 33 treatments per day. This suggests that some EHCs might have spare capacity for conducting more health assessments (paras. 2.7, 2.9 and 2.14).

6. ***Implementation of EHAPP.*** The EHAPP is a two-year programme launched in collaboration with nine NGOs in July 2013 to provide subsidised health assessments to 10,000 elderly, who should be recruited by the NGOs through their community networks. Up to mid-July 2014, against the target of 10,000 elderly, only 2,274 had been enrolled. The low enrolment of elderly calls for the DH's attention (paras. 2.28 and 2.29).

Educational and advisory health services provided by VHTs of DH

7. ***Health promotion activities for elderly.*** In 2013, the VHTs conducted 9,176 health promotion activities (HPAs) for the elderly. As no limit is set on the number of HPAs each residential care home for the elderly (RCHE) or non-RCHE (such as District Elderly Community Centre and Neighbourhood Elderly Centre) can receive, 25 RCHEs and 92 non-RCHEs were each provided with a large number of elderly HPAs in the year (ranging from 15 to 38) even when attendances were low.

Furthermore, for some elderly HPAs, carers should accompany the elderly so as to provide them with assistance during the HPAs. Audit noted that in one case, 9 of 10 such HPAs provided to a social centre had no carer attendance (paras. 3.4 to 3.6).

8. ***Comprehensive review of the provision of HPAs.*** The conduct of HPAs accounted for 90% of the VHTs' activities. However, since the establishment of the VHTs in 1998, no review has been conducted to evaluate the effectiveness of the VHTs' provision of the HPAs except for the client satisfaction surveys conducted in 2001 and before to assess the performance of the VHTs (para. 3.10).

Administration of DH's Elderly Health Care Voucher Scheme

9. The EHCVS was first established as a pilot scheme in 2009, and became a recurrent programme in 2014. Elderly aged 70 or above holding a Hong Kong identity card are eligible to join the EHCVS, which aims to subsidise elderly in their use of healthcare services in the private sector. Annual voucher amount was increased from $1,000 for 2013 to $2,000 for 2014. As at 31 March 2014, 556,000 elderly had joined the EHCVS, representing a joining rate of 75%. Estimated expenditure for 2014-15 for settling voucher claims amounted to $846 million (paras. 4.2 and 4.11).

10. ***Participation of private healthcare service providers.*** As at 31 March 2014, of the 29,044 private healthcare service providers, 4,108 had enrolled in the EHCVS. The enrolment rates for Medical Practitioners and Chinese Medicine Practitioners were 34% and 23% respectively. Their services had accounted for 93% of the voucher claims. Audit's analysis of the distribution of the enrolled Medical Practitioners (EMPs)/enrolled Chinese Medicine Practitioners (ECMPs) by districts and the number of eligible elderly residing in each district indicated that the ratios of medical practitioners to eligible elderly in some districts were quite low, even though it is recognised that some elderly residing in one district might receive services in a different district. For example, the ratio in Southern District was one EMP to 770 eligible elderly while that in Yau Tsim Mong District was one EMP to 110 eligible elderly (paras. 4.3 to 4.6).

11. ***Monitoring of voucher claims.*** The DH has adopted a "post-payment approach" in monitoring voucher claims made by enrolled healthcare service providers (EHCPs). It conducts routine checking, which covers all EHCPs by calling from them the elderly's consent forms (for the use of vouchers) relating to a fixed number of claims for a particular month for examination. The standard pattern of routine checking without surprise element should be avoided. Despite that similar errors/omissions were detected in follow-up inspections, the DH had not taken escalated action by issuing advisory letters or warning letters to the EHCPs. Audit examination of consent forms relating to 5,031 claims made by 15 EHCPs revealed that there were errors/omissions in consent forms of 640 (13%) claims, involving a total voucher amount of $171,250. Such errors/omissions included missing/incomplete witness information, missing signature of the elderly, missing date of visiting EHCP or missing personal information of the elderly. Audit also identified a number of unsatisfactory practices. For example, one EMP, instead of requiring the elderly to sign one consent form and specify the total number of vouchers used, required the elderly to sign one consent form for each voucher used, with only one signed form having specified the total number of vouchers used. On the remaining consent forms, the space for filling in the number of vouchers used was left blank. In one case, the elderly signed as many as 59 such "blank forms" for just one consultation. This practice could lead to false claims through using the pre-signed "blank forms" (paras. 4.23, 4.24, 4.27, 4.29 and 4.31 to 4.34).

12. ***Comprehensive review of EHCVS.*** With the increasing financial implications of the EHCVS, it is an opportune time for the Administration to conduct another comprehensive review of the EHCVS. On various occasions, the Food and Health Bureau informed the Legislative Council that a comprehensive review of the EHCVS would be conducted (para. 4.39).

HA's provision of Specialist Out-patient service to elderly patients

13. According to the HA, elderly patients may generally be defined as those aged 65 or above for planning purposes. For its Specialist Out-patient (SOP) service, priority is given according to assessment of individual needs, rather than a person's age. Seven of the eight Specialties provide SOP service to elderly patients. Nonetheless, the elderly have accounted for 34% of the SOP attendances in all Specialties of the HA although they represent only 14% of the population (paras. 5.2, 5.4 and 5.11).

14. ***Elderly patients' waiting time for their first SOPC consultation.*** The GOPCs reserve quotas of consultation for elderly patients. Over 90% of elderly patients can secure an appointment at GOPCs and attend a consultation within two working days. The SOPCs triage patients (including elderly patients) into Priority 1 (urgent), Priority 2 (semi-urgent) and Routine cases based on their individual needs and clinical conditions. In the period from 2009-10 to 2013-14, the HA was able to meet the target median waiting time of Priority 1 and Priority 2 cases. However, the waiting time for first consultation for Routine cases of elderly patients had generally increased. Audit also noted that the elderly patients' waiting time varied significantly among different clusters. Audit found that the disparity was greater among three of the seven Specialties. For these Specialties, the differences between the longest waiting time and the shortest waiting time among the seven clusters were 97, 102 and 104 weeks respectively. With the expected rise in the proportion of elderly population, the demand for SOP service is bound to increase significantly. Management of waiting time at SOPCs will be an escalating challenge for the HA (paras. 5.2 to 5.6, 5.9, 5.10 and 5.12).

15. ***Geriatric SOPCs.*** Geriatrics is a subspecialty under the Medicine Specialty, which has the highest elderly patients' attendance. As at 31 August 2014, the HA had 12 Geriatric SOPCs. Audit visited three of them. The 90th percentile waiting time of Routine cases at the three SOPCs ranged from 78 to 103 weeks. Audit also found that different approaches were used by different SOPCs in scheduling appointments. For example, one SOPC allocated the earliest available appointment slots to Routine cases whereas another scheduled appointment slots to the end of the queue and the third SOPC scheduled appointment slots according to the dates specified by the Medical Officers. Additionally, Audit is concerned that some appointment slots released due to cancellation of appointment might not be put to use in an efficient manner (paras. 5.15, 5.16, 5.18 and 5.19).

16. ***Cross-cluster arrangements.*** To shorten the waiting time for first consultation and reduce the disparity in waiting time among clusters, the HA launched in August 2012 a cross-cluster referral arrangement for SOP service on a pilot basis. Audit noted that currently, the cross-cluster referral arrangement is available for only three of the seven Specialties. Although the HA allows patients to choose an SOPC for first consultation in any cluster according to their preferences, Audit's telephone enquiries to 21 SOPCs in the seven clusters revealed that some clusters did not allow patients from other clusters to attend their SOPCs (paras. 5.30, 5.31, 5.33 and 5.34).

Audit recommendations

17. **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:**

Elderly health assessment services of DH

(a) **critically review the EHC capacity to ascertain if it has been aligned with the growth of the elderly population (para. 2.18(a));**

(b) **set strategic directions, taking on board the audit observations, to assist EHCs to allocate their resources to cope with the growing demand for health assessment services (para. 2.18(c));**

(c) **explore ways to enhance the elderly's enrolment in the EHAPP and fine-tune the programme (para. 2.32(a));**

Educational and advisory health services provided by VHTs of DH

(d) **conduct a comprehensive review of the modus operandi for the provision of HPAs to enhance the service effectiveness, taking on board the audit observations (para. 3.11);**

Administration of DH's Elderly Health Care Voucher Scheme

(e) **continue to encourage more private healthcare service providers to join the EHCVS, especially in districts with a relatively small number of EMPs or ECMPs vis-à-vis a large number of eligible elderly residing in the districts (para. 4.9);**

(f) **review the effectiveness of conducting follow-up inspections to deter errors/omissions and, where warranted, take escalated action by issuing advisory letters or warning letters to the EHCPs (para. 4.37(d)); and**

(g) **plan for the conduct of another comprehensive review of the EHCVS (para. 4.40).**

18. **Audit has also *recommended* that the Chief Executive, HA should:**

HA's provision of Specialist Out-patient service to elderly patients

(a) **shorten the waiting time for Routine cases at the SOPCs as far as possible (para. 5.13(a));**

(b) **conduct a comprehensive review of the appointment scheduling practices of the SOPCs (para. 5.22(a)); and**

(c) **consider extending the cross-cluster referral arrangement to other Specialties and to benefit more elderly patients (para. 5.35(b)).**

Response from the Administration and the Hospital Authority

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

PART 1: INTRODUCTION

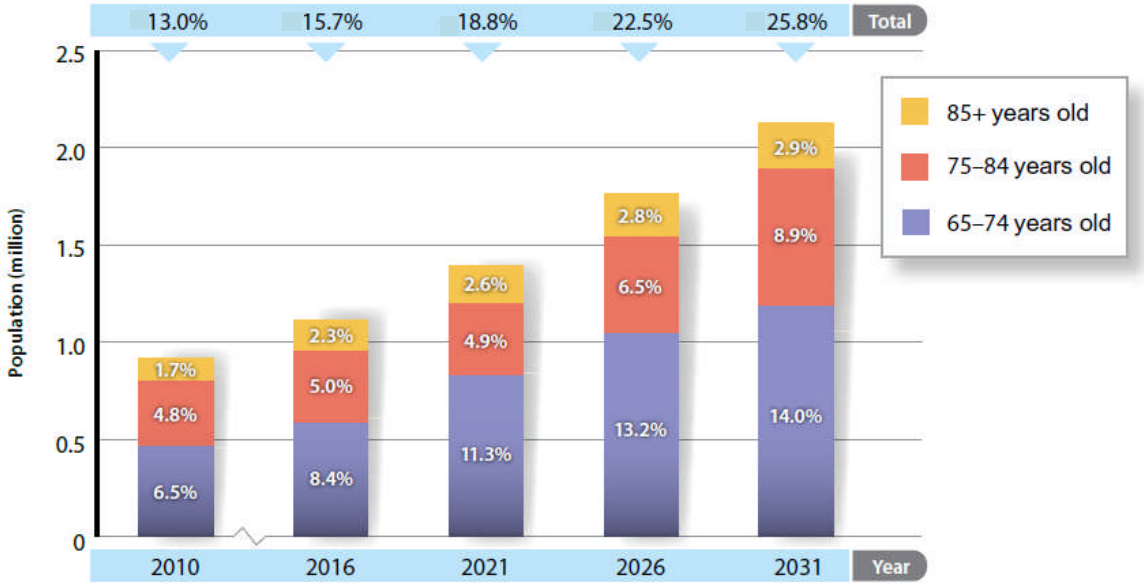
1.1 This PART describes the background to the audit and outlines the audit objective and scope.

Background

1.2 Hong Kong is undergoing a demographic transformation with a significant increase in both the proportion and number of elderly, generally defined as aged 65 or above, in the population (see Figure 1). According to the Census and Statistics Department (C&SD), the number of elderly will increase from one million in 2013 to 1.45 million in 2021 and further to 2.2 million in 2031. This poses challenges to the existing healthcare system as elderly are more prone to health problems than other age groups.

Figure 1

Proportion and number of elderly in Hong Kong (2010 to 2031)



Source: C&SD Population estimates in 2010

Introduction

1.3 Public health services for elderly are mainly provided by the Department of Health (DH) and the Hospital Authority (HA).

1.4 The DH provides the following major elderly health services:

(a) Elderly Health Centres (EHCs)	:	• To provide health assessments and curative treatments (if health problems are found in the assessment) for elderly aged 65 or above holding a Hong Kong identity (HKID) card or a Certificate of Exemption (COE — Note 1) who are enrolled as members of the EHCs • First EHC started operation in 1994 • Number of centres: 18 (one in each district) • Estimated expenditure for 2014-15: $123.2 million
(b) Elderly Health Assessment Pilot Programme (EHAPP)	:	• To engage non-governmental organisations (NGOs) to recruit 10,000 elderly who are aged 70 or above holding a HKID card or a COE and are not members of the EHCs, and provide health assessment to them • In operation since July 2013 (two-year programme) • Programme expenditure: $12 million

Note 1: *Under the Registration of Persons Regulations (Cap. 177A), the aged, the blind or the infirm who satisfy a registration officer that their personal attendance for registration of HKID cards will injure their health or the health of others, are not required to register or apply for the issue or renewal of an identity card. They can instead apply for a COE.*

(c) Visiting Health Teams (VHTs)	:	• To carry out health education and promotion activities for elderly and their carers at community and residential care settings • In operation since 1998 • Number of teams: 18 (one in each district) • Estimated expenditure for 2014-15: $53.1 million
(d) Elderly Health Care Voucher Scheme (EHCVS)	:	• To subsidise use of healthcare services in the private sector by elderly aged 70 or above holding a HKID card or a COE • Launched in 2009 as a pilot scheme and became a recurrent programme in 2014 • Estimated expenditure for 2014-15: $846 million

1.5 The HA mainly provides primary care through its 73 General Out-patient Clinics (GOPCs), while secondary care and tertiary care are provided through its 47 Specialist Out-patient Clinics (SOPCs) and hospitals. As elderly people are not a homogenous group and the experience of ageing varies from person to person, curative treatments of the GOPCs and SOPCs are provided according to assessment of individual needs, rather than a person's age. The GOPCs reserve quotas of consultation for elderly patients (aged 65 or above). The SOPCs triage their patients for first consultation, including elderly patients, into three categories, namely Priority 1 (urgent), Priority 2 (semi-urgent) and Routine cases, based on their clinical conditions and no separate quotas are reserved for elderly patients.

1.6 In 2013-14, the GOPCs and SOPCs had 5.81 million and 7.04 million attendances respectively, including 2.22 million (38% of 5.81 million) for GOPC attendances and 2.41 million (34% of 7.04 million) SOPC attendances by elderly patients. Expenditure for the operation of the HA in 2013-14 was $50 billion, of which $2,200 million and $9,900 million were spent for the operation of the GOPCs and SOPCs respectively. The expenditure spent on elderly patients by the HA amounted to around 46% of the HA's total expenditure in 2013-14.

Audit review

1.7 The Audit Commission (Audit) has recently conducted a review of the DH's and HA's provision of health services for the elderly. The audit has focused on the following areas:

(a) elderly health assessment services of DH (PART 2);

(b) educational and advisory health services provided by VHTs of DH (PART 3);

(c) administration of the DH's EHCVS (PART 4); and

(d) HA's provision of Specialist Out-patient (SOP) service to elderly patients (PART 5).

General response from the Administration and the Hospital Authority

1.8 The Secretary for Food and Heath, the Director of Health and the Chief Executive, HA agree with the audit recommendations. The Secretary for Food and Health appreciates the effort of Audit in conducting a thorough review on this subject. He has said that the audit recommendations provide useful reference for the DH and the HA to improve elderly health services.

Acknowledgement

1.9 Audit would like to acknowledge with gratitude the full cooperation of the staff of the DH and the HA during the course of the audit review.

PART 2: ELDERLY HEALTH ASSESSMENT SERVICES OF DH

2.1 This PART examines the elderly health assessment services of the DH. Such services are mainly provided by the 18 EHCs, supplemented since July 2013 by a two-year pilot programme, namely the EHAPP. Focus is placed on the following issues:

(a) EHC capacity not coping with the demand for health assessment services (paras. 2.4 to 2.19);

(b) waiting time and elderly not showing up for allied health counselling services (paras. 2.20 to 2.27); and

(c) implementation of EHAPP (paras. 2.28 to 2.33).

Operation of Elderly Health Centres

2.2 Background information on the operation of EHCs is shown below:

(a)	Establishment	:	• 18 EHCs (one in each district of the territory) • First EHC established in 1994
(b)	Eligibility for services	:	Elderly aged 65 or above holding a HKID card or a COE
(c)	Services provided	:	• ***Health assessment.*** Health assessment aims at identifying health risks and detecting diseases. Usually, two to four weeks after the assessment, a doctor will explain the results of the assessment and a nurse will provide health advice to the elderly.

- ***Curative treatments.*** Curative treatments have been provided since 1998. If health problems are found in the assessment, the elderly will be given curative treatments. The elderly can also approach EHCs for general out-patient service when necessary.

- ***Health counselling.*** Whenever necessary after health assessment, the elderly is given health counselling by the EHCs' nurses and allied health staff comprising clinical psychologists, dietitians, occupational therapists, and physiotherapists.

- ***Health promotion and education.*** To increase the health awareness of elderly and their self-care ability, the nurses and allied health staff provide health talks on common health problems/risk factors and weight control in EHCs.

(d) Way to obtain services : An elderly needs to apply for enrolment as a member at an EHC of his choice. Owing to the great demand for the services, the elderly needs to wait for membership enrolment. A health assessment will be conducted on the day the elderly enrol as a member.

(e) Fees for services : Members are required to pay an annual membership fee of $110. During the membership period, they receive health assessment service. They can also receive curative treatments at a charge of $45 per consultation.

(f)	Major statistics of services	:	• Attendances for health assessment in 2013: 38,737 (4,124 first-time assessments and 34,613 subsequent assessments) • Attendances for curative treatments in 2013: 91,602 • Number of members as at 31 March 2014: 118,000 (12% of the elderly population in Hong Kong)
(g)	Manpower	:	• As at 1 June 2014, the 18 EHCs were headed by a Consultant, who reported to the Deputy Director of Health. The EHCs had an establishment of 164 staff comprising: — 6 Senior Medical and Health Officers; — 18 Medical and Health Officers; — 18 Nursing Officers; — 36 Registered Nurses; — 1 Senior Dispenser; — 4 Dispensers; — 32 allied health staff; and — 49 Clerical and Workman grade staff. • Each EHC is manned by a clinical team comprising a Medical and Health Officer and three nursing staff (a Nursing Officer and two Registered Nurses).
(h)	Estimated expenditure for 2014-15	:	$123.2 million

Importance of DH's health assessment services

2.3 The health assessment services provided by the EHCs to elderly play an important role in the healthcare system, as evidenced by the following:

(a) according to the "Primary Care Development in Hong Kong: Strategy Document" published by the Food and Health Bureau (FHB) in 2010, chronic diseases are taking up more and more of the capacity of Hong Kong's healthcare system. They are also the major causes of death. Hong Kong needs to adopt a more preventive approach to tackle disease burden; and

(b) according to the "Hong Kong Reference Framework for Preventive Care for Older Adults in Primary Care Settings" (the Reference Framework) published in 2012 by the Working Group on Primary Care (Note 2), the significant increase in the number of older people and the associated age-related disabilities and chronic diseases create challenges to the existing healthcare system. It has been shown that targeted, proactive and community-based preventive care is more cost-effective than downstream acute care. Therefore, targeted intervention for various health risks at their early stages is of paramount importance not only to the healthcare system, but also to individual older adult's active ageing.

EHC capacity not coping with the demand for health assessment services

2.4 Table 1 shows the output of the 18 EHCs in 2013.

Note 2: *The Working Group on Primary Care is chaired by the Secretary for Food and Health with members including healthcare professionals. The Reference Framework provides a common reference for all healthcare professionals in Hong Kong on the provision of continuous, comprehensive, and evidence-based care for older adults in the community.*

Table 1

Output of EHCs
(2013)

EHC	Number of health assessments			Number of sessions for explaining assessment results	Number of curative treatments
	First-time	Subsequent	Total		
Kowloon City	98	2,095	2,193	1,838	4,503
Yau Ma Tei	104	1,975	2,079	2,343	4,515
Sai Ying Pun	120	2,000	2,120	2,060	4,453
Aberdeen	163	1,961	2,124	2,101	6,472
Tseung Kwan O	163	1,973	2,136	2,011	5,768
Nam Shan	166	2,027	2,193	2,544	4,890
San Po Kong	175	1,947	2,122	1,968	5,273
Wan Chai	183	1,973	2,156	2,076	4,576
Kwai Shing	184	2,028	2,212	2,201	3,785
Tai Po	192	1,933	2,125	2,069	5,423
Shau Kei Wan	204	1,992	2,196	2,207	4,444
Shek Wu Hui	264	1,855	2,119	2,572	8,370
Lam Tin	268	1,950	2,218	2,010	3,960
Tuen Mun	275	1,834	2,109	2,220	5,310
Yuen Long	332	1,866	2,198	2,083	4,304
Tsuen Wan	386	1,706	2,092	1,773	6,014
Tung Chung	407	1,817	2,224	2,074	3,873
Lek Yuen	440	1,681	2,121	1,499	5,669
Total	4,124	34,613	38,737	37,649	91,602

Source: DH records

2.5 Audit found that:

(a) the capacity of the EHCs had not been timely expanded to cope with the demand for health assessment services by the elderly (see paras. 2.6 and 2.7);

(b) in the absence of top-down strategic directions from the DH management, there was significant disparity among the EHCs in the allocation of their manpower resources between first-time and subsequent health assessments (see paras. 2.8 to 2.13);

(c) there was significant disparity in the number of curative treatments conducted by individual EHCs, suggesting that some EHCs might have spare capacity for conducting more health assessments (see para. 2.14); and

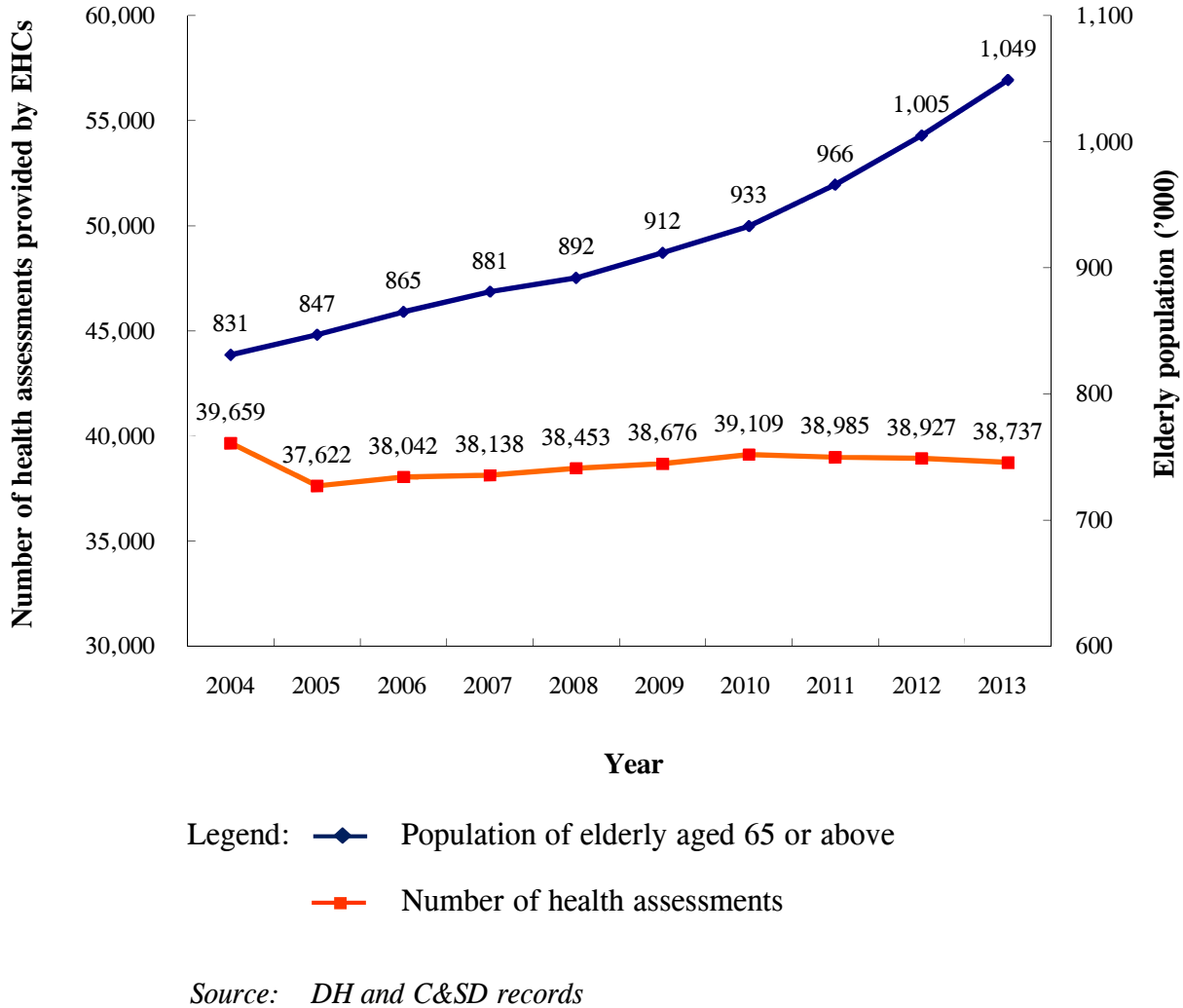
(d) in view of the backlog of first-time health assessments currently accumulated by individual EHCs and the fact that curative treatments are also provided by the HA, there is a need for the DH to critically review its justifications for the EHCs' provision of curative treatments (see paras. 2.15 to 2.17).

EHC capacity not timely expanded to cope with the demand for elderly health assessment services (see para. 2.5(a))

2.6 Table 1 in paragraph 2.4 shows the output of individual EHCs in 2013. It can be seen that individual EHCs had conducted a total of 2,100 to 2,200 health assessments (first-time and subsequent) a year. Figure 2 shows that in the ten years from 2004 to 2013, the elderly population increased from 831,000 in 2004 to 1,049,000 in 2013, but the 18 EHCs provided less than 40,000 health assessments a year to the elderly with limited expansion over the years. This indicates that the EHC capacity has not been timely expanded to align with the growth of the elderly population.

Figure 2

Number of health assessments provided by EHCs vis-à-vis the growth in elderly population (2004 to 2013)



Source: DH and C&SD records

2.7 In the same period, the manpower of the 18 EHCs had remained unchanged. Each EHC continued to maintain a clinical team of four staff, comprising one Medical and Health Officer, one Nursing Officer, and two Registered Nurses. In 2013, the DH's bid for additional manpower for the EHCs

was successful and provisions of $3.3 million and $6.5 million were approved for the creation of one additional clinical team in the Lek Yuen EHC in 2014-15 and another clinical team in the Wan Chai EHC in 2015-16. Audit considers that the DH needs to critically review the EHC capacity to align with the growth of the elderly population.

Significant disparity among the EHCs in allocating manpower resources between first-time and subsequent health assessments (see para. 2.5(b))

2.8 As mentioned in paragraph 2.2(d), an elderly needs to apply for enrolment as a member at an EHC to receive services of the EHC. Owing to great demand, an elderly needs to wait for membership enrolment and a first-time health assessment will be conducted on the day of enrolment. Two types of health assessments are provided to the elderly, namely first-time health assessment and subsequent health assessments. An elderly who has undergone the first-time health assessment can book an appointment for subsequent health assessments 12 months after the previous assessment. The subsequent assessment will be arranged as far as possible within six months from the date of booking. It is the DH's intention to provide health assessment for every member once about every 18 months.

2.9 ***Mix of first-time and subsequent health assessments.*** Every EHC follows largely the same working pattern, as follows:

(a) in the morning (from 8:30 am to 1:00 pm), the 4-staff clinical team conducts health assessments (first-time and subsequent) and explains assessment results; and

(b) in the afternoon (from 2:00 pm to 5:30 pm), the team conducts curative treatments and one to two extra health assessments per day.

The DH plans to conduct 38,600 health assessments (first-time and subsequent) each year, i.e. each EHC is to conduct about 2,150 health assessments a year. Table 1 in paragraph 2.4 shows that in 2013, the EHCs conducted a total of 38,737 health assessments, i.e. an average of 2,150 health assessments for each EHC.

2.10 Audit found that the mix of first-time and subsequent health assessments varied significantly among the EHCs and it would take years for most of the EHCs to clear their first assessments' backlogs (see Table 2).

Table 2

Health assessments conducted by EHCs
(2013)

EHC	Number of assessments			First-time assessments as a percentage of total assessments	Number of elderly on waiting list for first-time assessment as at 31.12.2013	Number of years required to clear the waiting list
	First-time (a)	Subsequent (b)	Total (c) = (a) + (b)	(d) = $\frac{(a)}{(c)} \times 100\%$	(e)	(f) = (e) ÷ (a)
Kowloon City	98	2,095	2,193	4.5%	746	7.6
Yau Ma Tei	104	1,975	2,079	5.0%	997	9.6
Sai Ying Pun	120	2,000	2,120	5.7%	965	8.0
Aberdeen	163	1,961	2,124	7.7%	463	2.8
Tseung Kwan O	163	1,973	2,136	7.6%	1,228	7.5
Nam Shan	166	2,027	2,193	7.6%	880	5.3
San Po Kong	175	1,947	2,122	8.2%	347	2.0
Wan Chai	183	1,973	2,156	8.5%	1,760	9.6
Kwai Shing	184	2,028	2,212	8.3%	465	2.5
Tai Po	192	1,933	2,125	9.0%	713	3.7
Shau Kei Wan	204	1,992	2,196	9.3%	1,196	5.9
Shek Wu Hui	264	1,855	2,119	12.5%	340	1.3
Lam Tin	268	1,950	2,218	12.1%	533	2.0
Tuen Mun	275	1,834	2,109	13.0%	946	3.4
Yuen Long	332	1,866	2,198	15.1%	331	1.0
Tsuen Wan	386	1,706	2,092	18.5%	973	2.5
Tung Chung	407	1,817	2,224	18.3%	832	2.0
Lek Yuen	440	1,681	2,121	20.7%	1,426	3.2
Overall	4,124	34,613	38,737	10.6%	15,141	3.7

Source: Audit analysis of DH records

Take the Kowloon City EHC, Lek Yuen EHC and Yau Ma Tei EHC in Table 2 as illustrations:

(a) the Kowloon City EHC had allocated only 4.5% of its health assessment sessions to first-time assessments whereas the Lek Yuen EHC had allocated 20.7% to first-time assessments. As a result, despite the fact that the Lek Yuen EHC had a waiting list of 1,426 elderly awaiting membership enrolment and first-time assessments, it would take only 3.2 years to clear the waiting list whereas the Kowloon City EHC had a waiting list of 746 and it would take 7.6 years assuming zero additional intake and attrition over the period; and

(b) some EHCs would take a long time to clear their waiting list of elderly awaiting membership enrolment and first-time assessments (see Column (f) in Table 2). For example, in the case of the Yau Ma Tei EHC, if the 2013 assessment mix remained unchanged, it would take some nine years (997 elderly ÷ 104 first-time assessments a year) to clear its waiting list of 997 elderly, assuming zero additional intake and attrition over the period.

First-time assessments are important because an analysis of the 38,927 elderly health assessment cases of 2012 indicated that 32% of the 5,067 elderly were found to have medical conditions in their first-time assessments whereas only 7% of the 33,860 elderly had new medical conditions in their subsequent assessments (see para. 2.13(b)). According to the DH, the EHCs had conducted more subsequent assessments than first-time assessments because it was the DH's intention of allowing all members to receive their subsequent health assessments about once every 18 months (see para. 2.8), with the remaining capacity made available for first-time assessments. Audit considers that the DH needs to explore the feasibility of setting a performance pledge for the waiting time for first-time assessment.

2.11 ***Waiting time for first-time health assessment.*** As at 31 December 2013, 15,141 elderly were waiting for first-time health assessments (see Column (e) in Table 2). In the past few years, both the number of elderly waiting for first-time health assessments and the average median waiting time had been rising (see Table 3).

Table 3

Number of elderly waiting for first-time health assessment and the average median waiting time (2011 to 2014)

Year	Number of elderly waiting for first-time health assessment (as at 31 December)	Average median waiting time (Note) (Month)
2011	10,401	10.4
2012	12,525	12.3
2013	15,141	16.6
2014 (Up to 31 March)	15,702	18.2

Source: *DH records*

Note: *The waiting time refers to the duration between the date when an elderly applies for enrolment at an EHC to the date of enrolment (which is also the date of first-time health assessment).*

Table 4 further shows that in 2013, the median waiting time for first-time health assessments for individual EHCs ranged from 8.7 to 28.6 months, indicating that all the 18 EHCs had a backlog of elderly waiting for membership enrolment and first-time health assessments.

Table 4

Median waiting time for first-time health assessment
(31 December 2013)

EHC	Number of elderly waiting for first-time health assessment	Median waiting time (Month)
Tai Po	713	28.6
Wan Chai	1,760	27.8
Yau Ma Tei	997	25.4
Kowloon City	746	23.4
Lek Yuen	1,426	22.8
Sai Ying Pun	965	22.8
Shau Kei Wan	1,196	21.5
Tseung Kwan O	1,228	20.5
Nam Shan	880	17.3
San Po Kong	347	15.9
Tuen Mun	946	15.0
Tsuen Wan	973	12.7
Aberdeen	463	11.5
Lam Tin	533	11.1
Shek Wu Hui	340	10.8
Kwai Shing	465	10.4
Tung Chung	832	10.4
Yuen Long	331	8.7
Overall	15,141	16.6

Source: DH records

2.12 ***Waiting time for subsequent health assessments.*** The DH has set a target of allowing the elderly to receive their subsequent health assessments once every 18 months. In the period from 2004 to 2013, the average waiting time for subsequent health assessments in different EHCs ranged from 16.3 to 18.8 months. The target of once every 18 months for subsequent health assessment had largely been met.

2.13 ***Need for a critical review of the assessment mix for individual EHCs.*** There was wide disparity among the EHCs in the mix of first-time health assessments and subsequent health assessments, and a long waiting list of elderly awaiting first-time health assessments as reported in Table 2 (see para. 2.10). Audit considers that the DH needs to set top-down strategic directions on how individual EHCs should allocate their health assessment sessions, so that the EHCs can adjust their individual assessment mix taking into account the local elderly needs. In this connection, it should be noted that:

(a) according to the Reference Framework (see para. 2.3(b)), the frequency of health assessment on different groups (such as those with or without risk factors like smoking) of the elderly may vary from once every one to three years;

(b) first-time assessment is important because, as mentioned in paragraph 2.10, an analysis of the health data of all the 38,927 elderly who had undergone health assessments in 2012 indicated that 32% of the 5,067 elderly who had undergone first-time assessments were found to have medical conditions. By comparison, only 7% of the 33,860 elderly who had undergone subsequent assessments were found to have new medical conditions; and

(c) some years ago, the DH reshuffled some of the EHC sessions for subsequent assessments to first-time assessments and successfully reduced the waiting time from 38.3 months in 2007 to 10.4 months in 2011.

Significant disparity in the number of curative treatments conducted by the EHCs (see para. 2.5(c))

2.14 As mentioned in paragraph 2.9(b), the EHCs conducted curative treatments in the afternoons. Audit found that there was significant disparity in the

number of curative treatments conducted by individual EHCs (see Table 5). This suggests that some EHCs might have spare capacity in the afternoon. For example, in the past five years, the Kwai Shing EHC conducted on average 16 curative treatments per day whereas the Shek Wu Hui EHC conducted 33 treatments per day. Given the long waiting list of elderly for first-time assessment, the DH can consider making effective use of the spare capacity for conducting more health assessments.

Table 5

Average number of daily curative treatments of 18 EHCs (2009 to 2013)

EHC	Average number					
	2009	2010	2011	2012	2013	Overall
Shek Wu Hui	31	33	33	33	34	33
Aberdeen	28	27	26	27	26	27
Lek Yuen	28	27	28	25	23	26
Tseung Kwan O	26	25	25	25	24	25
Tsuen Wan	26	26	25	25	25	25
San Po Kong	23	23	23	23	22	23
Tai Po	25	23	23	22	22	23
Tuen Mun	23	22	22	22	22	22
Sai Ying Pun	22	24	21	19	18	21
Kowloon City	20	21	20	19	18	19
Wan Chai	18	19	19	19	19	19
Yau Ma Tei	19	19	18	19	18	19
Shau Kei Wan	16	18	19	18	18	18
Nam Shan	16	16	17	21	20	18
Lam Tin	20	19	18	17	16	18
Tung Chung	15	15	16	17	16	16
Kwai Shing	16	15	16	16	15	16
Yuen Long	16	16	16	17	18	16
Total	388	388	385	384	374	384

Source: *DH records*

Remarks: *The EHCs do not limit the number of curative treatments provided in the afternoons.*

Need for the DH to critically review the justifications for the provision of curative treatments by the EHCs (see para. 2.5(d))

2.15 The EHCs provide curative treatments to members. Likewise, the HA provides such service through its GOPCs. At a meeting of the Legislative Council (LegCo)'s Panel on Health Services held in 1997, the DH indicated that the two systems would run in parallel during the initial operation of the EHCs, and undertook to conduct a review of the operation of both systems at a later stage. Audit, however, noted that no such review has been conducted.

2.16 Audit notes that the DH has adopted a multi-disciplinary approach to provide comprehensive healthcare to elderly using a family medicine perspective (see para. 2.2(c)). However, in view of the importance of the health assessment services and given the long waiting list for health assessment service for each EHC, the DH needs to critically review the justifications for the provision of curative treatments.

2.17 In September 2014, the DH informed Audit that starting from a few years ago, the EHCs had already devoted more emphasis to health assessment as evidenced by the fact that 7 of the 18 EHCs had conducted one to two more health assessments in the afternoon (originally devoted to providing curative treatments) per week. Starting from June 2014, two more EHCs had followed suit.

Audit recommendations

2.18 **Audit has *recommended* that the Director of Health should:**

(a) **critically review the EHC capacity to ascertain if it has been aligned with the growth of the elderly population;**

(b) **explore the feasibility of setting a performance pledge for the waiting time for the elderly who wish to enrol for EHC membership and first-time health assessment;**

(c) **set strategic directions, taking on board the audit observations (see paras. 2.6 to 2.17), to assist the EHCs to allocate their resources to cope with the growing demand for health assessment services; and**

(d) **keep the strategic directions in (c) above under regular review and monitor the waiting list of elderly awaiting membership enrolment and first-time health assessment in each EHC.**

Response from the Administration

2.19 The Director of Health agrees with the audit recommendations. She has said that the DH will review the EHC capacity and strategic directions to cope with the growing demand with a view to reducing the waiting time for those who wish to enrol for membership.

Waiting time and elderly not showing up for allied health counselling services

2.20 Apart from the 4-staff clinical team manning each EHC, four groups of allied health staff, comprising eight staff members in each group, visit the EHCs on a regular basis to provide health counselling services in group sessions, as follows:

(a) ***Clinical Psychologists.*** They assist elderly in practising self-management of health behaviours, sustaining mental wellness, coping with ageing, chronic pain, bereavement and common stresses of late life;

(b) ***Dietitians.*** They conduct nutrition assessment of elderly and provide them with diet counselling on their nutrition-related problems;

(c) ***Occupational Therapists.*** They assist elderly to manage their conditions through proper body mechanics, energy conservation technique, and work simplification skills, and to maximise their independence in activities of daily living; and

(d) ***Physiotherapists.*** They promote wellness, health, physical fitness, and prevention of injury and dysfunction among elderly. They also facilitate elderly in self-management of chronic diseases, pain, and injury prevention.

Waiting time for allied health counselling

2.21 The four groups of allied health staff provide counselling to elderly at the 18 EHCs according to a duty roster. For example, in the Aberdeen EHC, counselling services of Physiotherapist, Dietitian, Occupational Therapist and Clinical Psychologist were provided on Mondays, Wednesdays, Thursdays and Fridays respectively. In 2013, the average median waiting time for counselling for the 18 EHCs was about five weeks.

2.22 Audit noted that there was significant disparity among the EHCs in the waiting time for allied health counselling services, ranging from 1.1 to 11 weeks (see Table 6). The DH needs to ascertain the reasons for the significant disparity and take measures to improve the situation.

Table 6

Waiting time for elderly seeking allied health counselling services
(31 December 2013)

EHC	Waiting time (Week)			
	Clinical Psychologist	Dietitian	Occupational Therapist	Physiotherapist
Sai Ying Pun	5.6	5.0	4.1	3.1
Shau Kei Wan	1.7	5.0	2.2	3.3
Wan Chai	11.0	5.2	5.9	6.5
Aberdeen	6.3	8.2	9.4	8.8
Nam Shan	4.2	4.3	6.3	6.3
Lam Tin	2.9	2.6	4.1	1.6
Yau Ma Tei	5.3	4.3	3.3	6.3
San Po Kong	3.5	7.3	6.3	3.8
Kowloon City	2.0	3.5	4.3	3.4
Lek Yuen	2.5	6.1	10.2	5.7
Shek Wu Hui	6.0	6.4	2.9	5.5
Tseung Kwan O	4.8	2.6	5.8	4.4
Tai Po	2.6	6.7	5.9	5.7
Tung Chung	4.2	4.5	6.3	5.5
Tsuen Wan	1.1	6.0	7.8	5.5
Tuen Mun	8.5	4.0	3.4	3.1
Kwai Shing	1.8	5.5	5.1	3.5
Yuen Long	6.5	7.6	3.7	5.0

Source: DH records

2.23 To improve the situation, Audit considers that the DH needs to review the working arrangements of the allied health staff and adjust their duty rosters so that more frequent visits can be made to those EHCs with long waiting time.

Elderly not showing up for allied health counselling services

2.24 Audit noted that although the EHC staff would remind the elderly (or their carers) to attend the counselling one day before the appointment, not all the elderly attended the counselling as scheduled. In 2013, the overall no-show rate of the 18 EHCs was 14.6% (contrasted sharply with 1.2% for health assessments). For six EHCs, the no-show rates were even over 25%. Examples of the EHCs with high no-show rates are shown in Table 7.

Table 7

Examples of EHCs with high no-show rates of allied health counselling services (2013)

Allied health staff	EHC	Total number of			No-show rate	Average number of no-show elderly per session
		sessions (Note)	elderly counselled	no-show elderly		
		(a)	(b)	(c)	$(d) = \frac{(c)}{(b)+(c)} \times 100\%$	(e) = (c) ÷ (a)
Clinical Psychologist	Aberdeen	78	204	96	32.0%	1.2
	Tuen Mun	38	81	35	30.2%	0.9
	Nam Shan	78	203	78	27.8%	1.0
Dietitian	Yuen Long	60	327	100	23.4%	1.7
	Shek Wu Hui	39	217	54	19.9%	1.4
	Aberdeen	72	388	94	19.5%	1.3
Occupational Therapist	Lek Yuen	103	610	130	17.6%	1.3
	Aberdeen	69	273	81	22.9%	1.2
	Tung Chung	36	151	33	17.9%	0.9
Physiotherapist	Lek Yuen	71	350	55	13.6%	0.8
	Aberdeen	83	347	80	18.7%	1.0
	Tuen Mun	49	262	47	15.2%	1.0

Source: Audit analysis of DH records

Note: Usually a number of elderly were counselled in a session.

2.25 To enhance the efficient use of the counselling resources, the DH needs to take measures to minimise the number of elderly not showing up. In this connection, Audit noted that the SOPCs of the HA had adopted a practice of expanding the clinics' booking capacities, taking into account past no-show rates (i.e. making provision to allow for overbooking of appointments). According to overseas studies, overbooking would address patient no-shows and enable clinics to serve more patients. The studies found that many clinics achieved positive results after allowing overbooking of appointments.

Audit recommendations

2.26 **Audit has *recommended* that the Director of Health should:**

(a) **ascertain the reasons for the significant disparity among the EHCs in the waiting time for the elderly who wish to seek allied health counselling services;**

(b) **review the working arrangements of the allied health staff and adjust their duty rosters to allow more frequent visits to those EHCs with long waiting time; and**

(c) **take measures (e.g. allow for overbooking of appointments) to minimise the no-show wastage for allied health counselling services as far as possible.**

Response from the Administration

2.27 The Director of Health agrees with the audit recommendations. She has said that the DH will review the reasons for the disparity in waiting time, the working arrangements of the allied health team, and the reasons for no-shows, with a view to implementing measures to improve the situation.

Implementation of Elderly Health Assessment Pilot Programme

2.28 Background information on the EHAPP is shown below:

(a)	Establishment	:	A two-year programme launched in collaboration with nine NGOs in July 2013
(b)	Eligibility	:	Elderly aged 70 or above holding a HKID card or a COE and not being members of the EHCs
(c)	Objectives	:	To provide voluntary, protocol-based, and subsidised health assessments to 10,000 elderly recruited by the NGOs through their community networks
(d)	Services provided by NGOs	:	• A health assessment for each elderly (Note) • One to two follow-up consultations for discussing findings of the assessment and a tailor-made healthcare plan, and follow-up of the health problems identified • Health promotion sessions
(e)	Phases of implementation	:	• Phase 1: Six-month period from 17 July 2013 to 16 January 2014 for those eligible elderly who meet any of the following conditions: (i) no health assessment received before; (ii) not receiving regular follow-up by healthcare services; or (iii) living alone • Phase 2: 18-month period from 17 January 2014 to 16 July 2015 for all eligible elderly
(f)	Funding	:	• $12 million ($1,200 per elderly × 10,000 elderly) for two years • As at 31 July 2014, $2.28 million paid to the nine NGOs
(g)	Manpower	:	• The DH's Health Care Voucher Unit is responsible for administering the EHAPP (and also the EHCVS — see PART 4).

- As at 1 June 2014, the Unit was headed by an Assistant Director of Health, who reported to the Deputy Director of Health. The Unit had an establishment of 17 staff comprising:

  — 1 Senior Medical and Health Officer, 1 Medical and Health Officer and 1 Nursing Officer;
  — 4 Executive Officer grade staff;
  — 1 Assistant Manager;
  — 6 Administrative Assistants; and
  — 3 Project Assistants.

- For 2013-14, the Unit's expenditure was $9.6 million.

Note: Elderly need to contribute a sum of $100, which can be settled by healthcare vouchers (see PART 4). The sum will be waived and be borne by the Government for elderly receiving the Comprehensive Social Security Assistance and those already under the medical fee waiver mechanism of the medical social services unit of public hospital/clinic, or the Integrated Family Service Centres or Family & Child Protective Services Unit of the Social Welfare Department.

Enrolment of elderly

2.29 The objective of the EHAPP is to provide subsidised health assessment to the elderly. Audit noted that up to mid-July 2014, only 2,274 elderly, against a target of 10,000 elderly, had been enrolled in the pilot programme. One of the nine NGOs which participated in the pilot programme had only enrolled 89 elderly, against its target of 1,000 elderly. The low enrolment of elderly calls for the DH's attention.

2.30 The NGOs informed the DH that according to the information they obtained from the elderly, the reasons for the low enrolment were as follows:

(a) elderly considered themselves in good health;

(b) elderly were afraid that health assessment might reveal health problems for which nothing could be done because of their old age;

(c) elderly were not eligible for joining the pilot programme because they were aged below 70; and

(d) elderly preferred to go to nearby public clinics or hospitals to seek out-patient services when they got sick or needed body check services.

2.31 In April 2014, the DH commissioned a research organisation to evaluate the implementation of the pilot programme. The organisation is required to submit an interim report and a final report by the fourth quarter of 2014 and the end of 2015 respectively. Up to September 2014, the pilot programme had only been implemented for about one year. It would take time to develop.

Audit recommendations

2.32 **Audit has *recommended* that the Director of Health should:**

(a) **explore ways to enhance the elderly's enrolment in the EHAPP and fine-tune the programme in the light of experience, taking into account the feedback from the NGOs (see para. 2.30) and taking on board the recommendations made by the research organisation after its review of the EHAPP (see para. 2.31); and**

(b) **take into account the result of the implementation of the EHAPP in reviewing the EHC capacity to ascertain if it has been aligned with the growth of the elderly population (see para. 2.18(a)).**

Response from the Administration

2.33 The Director of Health agrees with the audit recommendations. She has said that the DH will make reference to:

(a) the review results, as well as the feedback from the elderly and participating NGOs to fine-tune the pilot programme; and

(b) the result of the implementation of the EHAPP when reviewing the capacity of the EHCs.

PART 3: EDUCATIONAL AND ADVISORY HEALTH SERVICES PROVIDED BY VISITING HEALTH TEAMS OF DH

3.1 This PART examines the educational and advisory health services provided by the VHTs of the DH, focusing on the following issues:

(a) health promotion activities (HPAs — paras. 3.3 to 3.12); and

(b) review of health records of residential care homes for the elderly (RCHEs — paras. 3.13 to 3.17).

Background

3.2 Background information on the VHTs is shown below:

(a)	Establishment	:	• 18 VHTs serving the 18 districts in Hong Kong • Started operation in 1998
(b)	Mission	:	To conduct outreach health promotion and education activities to strengthen the healthcare of elderly and to improve their self-care ability and health awareness
(c)	Service recipients	:	The VHTs conducted on-site HPAs mainly for the elderly and carers of the RCHEs and other elderly-related institutions, such as District Elderly Community Centres, Neighbourhood Elderly Centres, Day Care Centres (collectively referred to as "non-RCHEs").

(d) Services provided : All RCHEs must be licensed under the Residential Care Homes (Elderly Persons) Ordinance (Cap. 459). The Social Welfare Department (SWD) is responsible for enforcing the statutory provisions under the Ordinance (a separate audit report on the provision of long-term care services for the elderly is included in Chapter 1 of the Director of Audit's Report No. 63). The services of the VHTs are advisory in nature.

- ***Educational health services.*** The VHTs conduct on-site HPAs in the form of health talks, skill training and support groups. There are 224 topics of HPAs comprising:

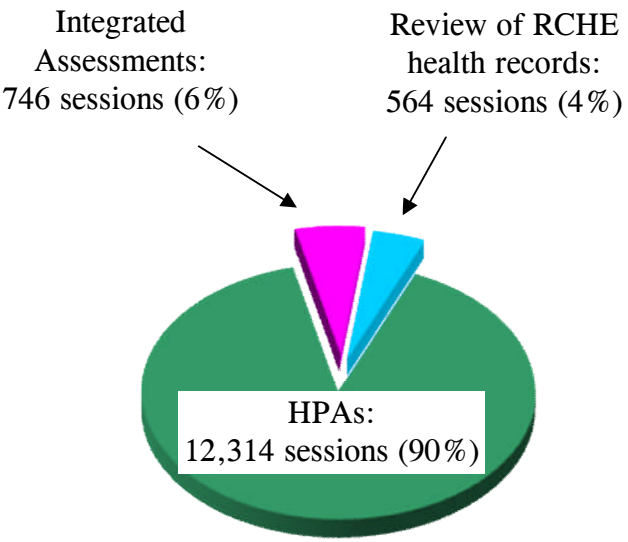
  — ***Elderly HPAs.*** These HPAs are provided on-site to elderly of RCHEs and non-RCHEs. There are 160 topics. Examples of these HPAs include "Influenza", "Hypertension" and "Scabies". Carers of elderly are also welcome to attend the elderly HPAs;

  — ***Carer HPAs.*** These HPAs are provided on-site to carers of RCHEs and non-RCHEs. There are 55 topics including mainly special skills for carers such as "Drug management skills" and "Lifting and transfer"; and

  — ***Elderly-cum-carer HPAs.*** There are 9 topics which could be provided for both elderly and carers. These HPAs include "Social isolation" and "Management of anger".

- ***Advisory services.*** The VHTs conduct reviews of RCHE health records annually to assess RCHEs' standards of keeping elderly health records with a view to identifying areas of improvement. The VHTs also conduct Integrated Assessments annually to ascertain the RCHEs' standards of healthcare measures such as infection control, drug management and fall prevention with a view to identifying areas of improvement.

(e) Services provided in 2013 :



Source: *Audit analysis of DH records*

Remarks: *A session lasts for 45 to 90 minutes.*

(f) Manpower : As at 1 June 2014, the 18 VHTs were headed by an Assistant Director of Health who reported to the Deputy Director of Health. The VHTs had an establishment of 62 staff comprising:

- 1 Senior Medical and Health Officer;
- 5 Medical and Health Officers;
- 17 Nursing Officers;
- 30 Registered Nurses; and
- 9 Motor Drivers (providing transportation for the VHTs and distributing health education and training materials to RCHEs and non-RCHEs).

(g) Estimated expenditure for 2014-15 : $53.1 million

Health promotion activities

3.3 The VHTs conduct on-site HPAs. A list of topics of HPAs is available on the DH's website at http://www.elderly.gov.hk. It is the VHTs' practice to provide HPAs on the request of RCHEs and non-RCHEs as far as possible. No limit is imposed on the number or frequency of HPAs paid to each RCHE or non-RCHE, so long as they made the request. The attendances of HPAs in the years from 2009 to 2013 are shown in Table 8.

Table 8

Attendances of HPAs
(2009 to 2013)

Year	Number of attendees				
	Elderly	Carer	Informal carer (mainly family member)	Others (Note)	Total
2009	199,008	54,250	4,688	415	258,361
2010	222,605	59,383	5,471	547	288,006
2011	233,333	56,509	4,033	284	294,159
2012	233,672	56,971	6,039	619	297,301
2013	233,618	62,229	5,324	566	301,737
Total	1,122,236 (77.9%)	289,342 (20.1%)	25,555 (1.8%)	2,431 (0.2%)	1,439,564 (100%)

Source: DH records

Note: "Others" refers to members of the public, such as volunteers who attended the HPAs conducted by the VHTs.

Health promotion activities for elderly

3.4 ***Elderly HPAs for non-RCHEs.*** The VHTs keep a complete and updated list of RCHEs (748 as at 31 March 2014). To ensure that all RCHEs are provided with health education, the VHTs initiate HPAs for RCHEs which do not make such requests. The VHTs, however, do not maintain a list of non-RCHEs. Audit noted

that lists of several types of non-RCHEs such as District Elderly Community Centres, Neighbourhood Elderly Centres, Social Centres for the Elderly, Enhanced Home and Community Care Services, and Integrated Home Care Services were available on the SWD's website. In Audit's view, the VHTs need to make reference to the SWD's website to maintain an updated list of non-RCHEs so that elderly as well as carers in all non-RCHEs have the opportunities to receive health education.

3.5 ***Some elderly HPAs had low attendance.*** In 2013, the VHTs conducted a total of 9,176 HPAs for the elderly, comprising 3,431 (37%) at RCHEs and 5,745 (63%) at non-RCHEs. As no limit is set on the number of HPAs each RCHE or non-RCHE can receive, Audit noted that some RCHEs and non-RCHEs were provided with a large number of elderly HPAs even when attendances were low. For example, 25 RCHEs were each provided with 15 to 29 elderly HPAs in 2013 (with an average of 18) while 92 non-RCHEs were each provided with 15 to 38 elderly HPAs (with an average of 21), despite that some of the HPAs were poorly attended by the elderly and/or the carers. For example, in the case of one small private RCHE (with only nine elderly residents), 15 HPAs were conducted in 2013, but 1 of the 15 HPAs was attended by only one elderly and each of the remaining 14 HPAs was attended by only two carers (no elderly attended).

3.6 ***Elderly HPAs requiring carer attendances.*** For some elderly HPAs, carers should accompany the elderly in order to provide assistance to them during the HPAs. An example of such HPAs is "Exercise for Frail Elderly". Audit however noted that in the case of one self-financed social centre, ten HPAs of this kind were provided repeatedly to the elderly of the centre but, with the exception of one HPA (which was attended by two carers), the other nine HPAs had no carer attendance.

3.7 ***Contents of HPAs not revised or updated.*** Audit reviewed 160 topics of elderly HPAs and noted that the contents of 70 of them were produced ten years ago. The DH needs to regularly review the contents of the HPAs and update them if necessary.

3.8 ***Attendance by elderly's family members.*** The VHTs encourage the elderly's family members to attend the elderly HPAs. Audit, however, noted that in the five years from 2009 to 2013, the attendance of the elderly's family members was consistently low. The DH needs to explore ways to encourage family members to attend the HPAs. This is particularly useful for those HPAs held at non-RCHEs in order to strengthen the family members' support for the elderly who prefer to age at home. One possible way to facilitate family members' attendance is for the DH to conduct some of the HPAs on Saturdays, Sundays or public holidays as far as practicable.

Health promotion activities for carers

3.9 One main objective of the VHTs is to offer on-site training to carers working in RCHEs so as to enhance their health knowledge and skills in taking care of the elderly. In 2013, the VHTs conducted 1,985 carer HPAs, 93% of which were held at RCHEs. Audit analysis of the carer HPAs revealed that:

(a) although the VHTs had provided carer HPAs to all the RCHEs, not all non-RCHEs had been provided with carer HPAs. Among the 628 non-RCHEs for which the VHTs had provided elderly HPAs, carer HPAs had not been provided to 543 of them;

(b) carer attendance to some of the 1,985 carer HPAs conducted in 2013 was extremely low. For example, 143 (7% of 1,985) carer HPAs were attended by nil to two carers; and

(c) the contents of 25 of the 55 topics on carer HPAs were produced ten years ago.

The DH needs to make reference to the lists of non-RCHEs maintained by the SWD on its website and initiate carer HPAs for them where there are carers in the non-RCHEs. The DH also needs to ascertain the reasons for the low carer attendance for some of the carer HPAs.

Comprehensive review of the provision of HPAs

3.10 The conduct of HPAs accounted for 90% of the VHTs' activities (see para. 3.2(e)). However, since the establishment of the VHTs in 1998, no review has been conducted to evaluate the effectiveness of the VHTs' provision of the HPAs except the conduct of client satisfaction surveys in 2001 and before to assess the performance of the VHTs. To improve the HPAs, the DH needs to conduct a comprehensive review and consider resuming the conduct of client satisfaction survey.

Audit recommendation

3.11 **Audit has *recommended* that the Director of Health should conduct a comprehensive review of the modus operandi for the provision of HPAs to enhance the service effectiveness, taking on board the audit observations (see paras. 3.3 to 3.10).**

Response from the Administration

3.12 The Director of Health agrees with the audit recommendation. She has said that the DH will review the mode of operation of the VHTs in conducting HPAs with a view to introducing service improvements.

Review of health records of RCHEs

3.13 The proper documentation of medical problems, medications and nursing care using an integrated health record is indispensible in improving the standard of care in RCHEs. A proper health record not only facilitates medical decision making but also enhances the communication among the carers. In 1999, the DH found that less than 40% of private RCHEs had individual health record system for their residents. More than 60% of private RCHEs did not have adequate information recorded. The VHTs developed a standard individual health record and introduced it to all private RCHEs in August 1999 with a view to improving and standardising the health record keeping in private RCHEs. Since then, the VHTs have conducted review of health records of the private RCHEs annually to assess their standards of record keeping and to give advice and training to them.

Coverage of review of health records

3.14 In 2013, the VHTs visited 564 private RCHEs to review their health records. However, the following types of RCHEs were not reviewed by the VHTs:

(a) 195 non-private RCHEs (such as those subsidised by the Government), despite the fact that some 22,000 elderly resided in these RCHEs. They represented 35% of the elderly residents of all RCHEs in 2013; and

(b) ten private RCHEs which had computerised their health records.

3.15 Upon enquiry, the DH informed Audit in July 2014 that non-private RCHEs were not reviewed because the DH considered that they generally had maintained a higher standard of health record-keeping. It was also the VHTs' practice of not reviewing private RCHEs which had computerised their health records. Audit considers that the DH needs to review whether the existing practice of not reviewing the health records of non-private RCHEs and those private RCHEs which had computerised their health records (see para. 3.14) should be revised. The DH may consider reviewing such RCHEs on, say, a five-year cycle.

Audit recommendation

3.16 **Audit has *recommended* that the Director of Health should review and revise the existing practice of not reviewing the health records of non-private RCHEs and those private RCHEs which had computerised their health records.**

Response from the Administration

3.17 The Director of Health agrees with the audit recommendation. She has said that the DH will conduct an overall review.

PART 4: ADMINISTRATION OF DH'S ELDERLY HEALTH CARE VOUCHER SCHEME

4.1 This PART examines the administration of the DH's EHCVS, focusing on the following issues:

(a) participation of private healthcare service providers (paras. 4.3 to 4.10);

(b) participation of elderly in the EHCVS (paras. 4.11 to 4.22);

(c) monitoring of voucher claims (paras. 4.23 to 4.38); and

(d) comprehensive review of the EHCVS (paras. 4.39 to 4.41).

Background of EHCVS

4.2 Background information on the EHCVS is shown below:

(a)	Establishment	:	• Established on 1 January 2009 as a pilot scheme • Became a recurrent programme on 1 January 2014
(b)	Eligibility	:	Elderly aged 70 or above holding a HKID card or a COE
(c)	Objectives	:	To subsidise elderly in their use of healthcare services in the private sector with emphases on: • providing additional choices for elderly on top of the existing public primary healthcare services with a view to enhancing the primary healthcare services for elderly • implementing the "money-follow-patient" concept to enable elderly to choose within their local communities the private primary healthcare services that best suit their needs

- through providing partial subsidy, helping promote the concept of sharing the costs of healthcare with patients, thus ensuring appropriate use of the primary healthcare services

- with better access and a continuum of care from chosen providers, enhancing the primary healthcare services provided for elderly

(d) Coverage :

- Eligible elderly can use the healthcare vouchers for services provided by private healthcare service providers enrolled in the EHCVS (i.e. enrolled healthcare service providers (EHCPs)).

- Ten categories of private healthcare service providers registered in Hong Kong can apply for enrolment: Medical Practitioners, Chinese Medicine Practitioners, Dentists, Chiropractors, Medical Laboratory Technologists, Occupational Therapists, Optometrists with Part I registration (added to EHCVS in 2012), Physiotherapists, Radiographers, and Registered Nurses and Enrolled Nurses.

- EHCPs are issued a logo (see below) for displaying outside their places of practice. A list of EHCPs is available on the EHCVS's website.

(e)	Face value of voucher	:	$1 per voucher effective July 2014 (previously $50 per voucher)
(f)	Annual voucher amount	:	$2,000 for 2014 (previously $250 for 2009, 2010 and 2011, $500 for 2012, and $1,000 for 2013)
(g)	Accumulation limit of vouchers	:	Unused vouchers can be accumulated up to the accumulation limit of $4,000 (effective June 2014, previously $3,000 effective January 2014).
(h)	How to use the vouchers	:	An elderly needs to open a voucher account at an EHCP's place of practice by presenting his HKID card or COE. Once opened, vouchers (in electronic form) are issued and can be used at any EHCP's place of practice through the DH's web-based eHealth System. The EHCP will then make voucher claims from the DH.
(i)	Number of EHCPs as at 31 March 2014	:	4,108 involving 5,731 places of practice (some EHCPs had more than one place of practice)
(j)	Number of elderly joined EHCVS as at 31 March 2014	:	556,000
(k)	Voucher claims paid during the period from 1 January 2009 to 31 March 2014	:	$770 million

(l)	Estimated expenditure for 2014-15 (for settling voucher claims)	:	$846 million
(m)	Manpower	:	The DH's Health Care Voucher Unit, with an establishment of 17 staff, is responsible for administering the EHCVS (and also the EHAPP — see para. 2.28(g)).

Participation of private healthcare service providers

Enrolment of private healthcare service providers

4.3 ***Overall enrolment.*** The DH estimated that as at 31 March 2014, there were 29,044 private healthcare service providers available in the private practice (Note 3). Of these service providers, 4,108 had enrolled in the EHCVS. The enrolment rates ranged from 1% to 34% for different categories of service providers (see Table 9).

Note 3: *In its estimation, the DH had excluded: (a) those practising overseas or not practising in the profession for reasons such as retired or working in other professions; (b) academics; and (c) those working in the DH or the HA. Nonetheless, the DH did not expect all the 29,044 private healthcare service providers to enrol in the EHCVS. For instance, nurses working in private hospitals are unlikely to enrol.*

Table 9

Enrolment rates of private healthcare service providers (31 March 2014)

Healthcare service provider	Estimated number of service providers in private practice (a)	Number of EHCPs (b)	Enrolment rate (Note) (c) = (b) ÷ (a) × 100%
Medical Practitioner	4,815	1,655	34%
Chiropractor	152	46	30%
Dentist	1,670	447	27%
Optometrist	699	170	24%
Chinese Medicine Practitioner	5,820	1,342	23%
Physiotherapist	1,273	280	22%
Occupational Therapist	653	40	6%
Medical Laboratory Technologist	992	24	2%
Radiographer	787	19	2%
Registered Nurse and Enrolled Nurse	12,183	85	1%

Source: *DH records*

Note: *Based on the estimated number of service providers in private practice, the DH compiles the enrolment rates regularly for monitoring purposes.*

4.4 The services of enrolled Medical Practitioners (EMPs) and enrolled Chinese Medicine Practitioners (ECMPs) are most in demand by the elderly. Their services had accounted for 93% of the voucher claims made by EHCPs.

4.5 ***Distribution of EMPs/ECMPs' places of practice by districts.*** One objective of the EHCVS is to enable the elderly to choose the private primary healthcare services within their local communities. As the services of EMPs and ECMPs were most in demand by the elderly, Audit analysed the distribution of the EMPs/ECMPs by districts and the number of eligible elderly residing in each district. The result is shown in Table 10. There are limitations in the analysis, as the DH has no readily available information on the number of eligible elderly who had joined the EHCVS in different districts. Besides, the elderly may choose to visit the EMPs/ECMPs with places of practice not in their districts. Therefore, Table 10 only shows an indication of the distribution by districts of the EMPs/ECMPs participating in the EHCVS vis-à-vis the number of eligible elderly residing in the districts.

Table 10

Number of eligible elderly, EMPs and ECMPs in 18 districts
(August 2014)

District	Number of eligible elderly (Note 1) (a)	Number of places of practice (Note 2)		Ratio of EMPs to eligible elderly (Note 2) (d) = 1:(a) ÷ (b)	Ratio of ECMPs to eligible elderly (Note 2) (e) = 1:(a) ÷ (c)
		EMPs (b)	ECMPs (c)		
Southern	30,800	40	48	1:770	1:642
Wong Tai Sin	57,600	77	104	1:748	1:554
Sham Shui Po	51,300	92	128	1:558	1:401
Kwai Tsing	55,900	102	75	1:548	1:745
North	25,900	52	80	1:498	1:324
Sha Tin	54,600	117	117	1:467	1:467
Eastern	72,300	155	140	1:466	1:516
Kowloon City	50,200	129	93	1:389	1:540
Kwun Tong	77,900	210	191	1:371	1:408
Islands	11,300	32	24	1:353	1:471
Tai Po	25,000	81	105	1:309	1:238
Yuen Long	42,700	138	70	1:309	1:610
Tuen Mun	35,300	116	135	1:304	1:261
Sai Kung	30,400	115	72	1:264	1:422
Tsuen Wan	31,300	132	137	1:237	1:228
Central and Western	28,900	167	112	1:173	1:258
Wan Chai	19,700	136	171	1:145	1:115
Yau Tsim Mong	35,900	325	329	1:110	1:109
Overall	737,000	2,216	2,131	1:333	1:346

Source: Audit analysis of DH and Planning Department records

Note 1: No statistics were available for the number of elderly in each district who had joined the EHCVS.

Note 2: Some EMPs/ECMPs had more than one place of practice.

4.6 Table 10 shows that the ratios of medical practitioners to eligible elderly in some districts were quite low, even though it is recognised that some elderly residing in one district might receive services in a different district. For example, the ratio in Southern District was one EMP to 770 eligible elderly and that in Kwai Tsing District was one ECMP to 745 eligible elderly, as compared to one EMP to 110 eligible elderly in Yau Tsim Mong District and one ECMP to 115 eligible elderly in Wan Chai District. The distribution of the EMPs and the ECMPs by districts vis-à-vis the number of elderly residing in the districts calls for the DH's ongoing monitoring.

4.7 According to an interim review of the EHCVS completed in February 2011 by the FHB and the DH (the 2011 interim review), the non-enrolment of private healthcare service providers whom the elderly usually visited was the major reason for the elderly not using the vouchers. Given the growing ageing population, Audit considers that the DH needs to take measures to continue encouraging more private healthcare service providers to join the EHCVS. This may help enhance the popularity of the EHCVS.

4.8 In the period from November 2011 to May 2012, the DH launched a six-month publicity programme to encourage private healthcare service providers to enrol in the EHCVS. As a result of the publicity programme, coupled with other enhancements to the EHCVS (Note 4), the enrolment grew by 18% in 2012. With the annual voucher amount increased to $2,000 for 2014 (see para. 4.2(f)), the DH needs to continue its promotion efforts.

Audit recommendation

4.9 **Audit has *recommended* that the Director of Health should continue to encourage more private healthcare service providers to join the EHCVS, especially in districts with a relatively small number of EMPs or ECMPs vis-à-vis a large number of eligible elderly residing in the districts.**

Note 4: *For example, the gradual increase in the annual voucher amount and the inclusion of Optometrists in the EHCVS since 2012 were factors which had, among others, contributed to the increase in enrolment in 2012.*

Response from the Administration

4.10 The Director of Health agrees with the audit recommendation. She has said that the DH will take additional measures and step up publicity further to encourage the participation of private healthcare service providers in the EHCVS.

Participation of elderly in EHCVS

Elderly joining EHCVS

4.11 As at 31 March 2014, 556,000 elderly had joined the EHCVS, net of 100,000 elderly who had already passed away. This represented a joining rate of 75%. Given that not every eligible elderly will join the EHCVS, the DH needs to ascertain whether the 75% joining rate is approaching its optimum level. Audit further noted that the joining rate for elderly in the age group of "70 to below 75" was comparatively lower than that of other age groups (see Table 11). This calls for the DH's attention.

Table 11

Elderly joined the EHCVS
(31 March 2014)

	Aged 70 to below 75	**Aged 75 to below 80**	**Aged 80 to below 85**	**Aged 85 and above**	**Overall**
	('000)	**('000)**	**('000)**	**('000)**	**('000)**
Number of eligible elderly (a)	212	210	164	151	737
Number of elderly joined EHCVS (b)	133	164	136	123	556
Joining rate (c) = (b) ÷ (a) × 100%	63%	78%	83%	81%	75%

Source: DH and C&SD records

Elderly's use of vouchers

4.12 ***Unused vouchers.*** Audit examination revealed that as at 31 December 2013:

(a) 415,000 elderly had vouchers which remained unused. The value of these unused vouchers amounted to $491 million (see Table 12); and

(b) 41,844 (10%) of the 415,000 elderly had never used any of the vouchers issued to them. The value of such unused vouchers amounted to $83 million.

Table 12

Elderly with unused vouchers
(2009 to 2013)

As at	Number of elderly joined EHCVS (a) ('000)	Number of elderly with unused vouchers (b) ('000)	Percentage of elderly with unused vouchers (c) = (b) ÷ (a) × 100% (%)	Cumulative number of unused vouchers (d) ('000)	Cumulative amount of unused vouchers (e) = (d) × $50 ($ million)
31.12.2009	271	150	55%	569	28
31.12.2010	362	233	64%	1,487	74
31.12.2011	423	275	65%	2,358	118
31.12.2012	477	337	71%	4,534	227
31.12.2013	530	415	78%	9,825	491

Source: *Audit analysis of DH records*

Remarks: *Deceased elderly were excluded from Audit's analysis.*

4.13 ***Forfeited vouchers.*** As at 1 January 2014, 53,000 elderly (excluding deceased elderly) had their vouchers forfeited because the value of their unused vouchers had exceeded the accumulation limit (see para. 4.2(g)). These elderly represented 10% of elderly who had joined the EHCVS. The value of vouchers forfeited amounted to $9.6 million.

4.14 ***Promoting the use of vouchers.*** The DH needs to do more to promote the use of the vouchers. In this connection, Audit noted that the DH publicises the EHCVS through the EHCVS's website, TV, radio, as well as broadcasting TV advertisements on buses and Mass Transit Railway trackside/concourse. Promotion materials (including leaflets, posters and DVDs) are also disseminated through channels such as District Elderly Community Centres, Neighbourhood Elderly Centres, EHCs, places of practice of EHCPs, the HA's GOPCs, and the SWD's Senior Citizen Card Office.

4.15 In promoting the use of vouchers, Audit, however, noted that there were incidents when information disseminated was not always up-to-date or there were omissions, as follows:

(a) in early September 2014, Audit visited six EHCs and found that one EHC did not display any promotion materials of the EHCVS;

(b) Audit noted in late August 2014 that an EHCVS poster displayed on a Health Care Voucher Unit notice board located one floor below the Unit publicised outdated EHCVS information. In early June 2014, the DH announced the revision of the annual voucher amount to $2,000. However, the poster showed the old annual voucher amount of $1,000; and

(c) in early September 2014, the name of one ECMP who had passed away in early 2014 was still included in the list of EHCPs on the EHCVS's website.

Audit considers that the DH needs to continue stepping up the promotion of use of vouchers through, for example, other popular media (such as free newspapers) and take steps to ensure that information disseminated is always up-to-date and correct.

4.16 ***Use of vouchers for preventive care.*** Audit noted that in the five years from 2009 to 2013, vouchers were mainly used by elderly for settling medical fees for treating acute episodic conditions. Only a small percentage (less than 9%) of vouchers was used for preventive care purpose such as health assessment (see Table 13).

Table 13

Purposes of vouchers used
(2009 to 2013)

Year	Preventive care (Note 1)	Treating acute episodic conditions (Note 2)	Monitoring of long-term conditions/ rehabilitative care (Note 3)
2009	7.9%	66.8%	25.3%
2010	7.1%	67.5%	25.4%
2011	7.8%	66.8%	25.4%
2012	7.7%	67.6%	24.7%
2013	8.8%	63.7%	27.5%

Source: DH records

Note 1: Preventive care included giving health advice, health assessment and immunisation.

Note 2: Treating acute episodic conditions included treating acute infections, pain and trauma.

Note 3: Monitoring of long-term conditions included management of chronic medical conditions (such as diabetes and hypertension) and physiotherapy for functional restoration. Rehabilitative care included post-operative care, and rehabilitation for trauma and mental health problems.

4.17 The Government has always emphasised the importance of preventive care in the context of the EHCVS. For example:

(a) at a meeting of the LegCo's Panel on Health Services held in 2007, the FHB emphasised that the EHCVS aims to encourage elderly, among other things, to attach more importance to disease prevention through health checks;

(b) at another meeting of the Panel held in 2011, the FHB emphasised that the EHCVS aims to encourage elderly to seek private healthcare services, in particular preventive care, with a view to improving the health of elderly population; and

(c) as stated in the 2011 interim review (see para. 4.7), "*the elderly are less willing to pay for preventive care than episodic care. This is a conception that has taken root among the elderly, and takes time and the concerted efforts of all — Government, healthcare service providers, the media, etc — to gradually induce a cultural change that puts more value and emphasis on preventive care.*"

4.18 The elderly could have used some of their vouchers which would otherwise be forfeited for preventive care. The DH needs to enhance the promotion of the use of vouchers by elderly to this effect.

Deceased elderly

4.19 The DH conducts monthly record matching with the Immigration Department to identify elderly who have been deceased. For deceased elderly, the DH will insert a remark in the eHealth System and EHCPs will not be able to make any voucher claims from the account of the deceased elderly.

4.20 Audit, however, noted that the eHealth System will not close the deceased elderly's voucher accounts, but will continue issuing vouchers to the deceased elderly. As a result, as at 31 March 2014, the 100,000 deceased elderly (see para. 4.11) had accumulated unused vouchers amounting to $262 million. Besides, in making provision for the EHCVS in the 2014-15 Estimates, the DH had inadvertently included the number of vouchers held by deceased elderly. Audit reckons that the 2014-15 provision had been inflated by some $92 million (Note 5).

Note 5: *The calculation is as follows:*
Elderly who had made use of vouchers (a basis used by the DH for preparing the estimated expenditure for the EHCVS for 2014-15) and were deceased as at 31 December 2013 × annual voucher amount for 2014-15 × voucher utilisation rate (estimated by the DH based on historical data) = 68,000 deceased elderly × $2,000 × 67.5% = $92 million

Audit recommendations

4.21 **Audit has *recommended* that the Director of Health should:**

(a) **continue stepping up the promotion of the EHCVS, particularly among the elderly aged 70 to below 75, and encouraging the elderly to make more use of vouchers for preventive care;**

(b) **in promoting the use of vouchers, ensure that the information is always correct and up-to-date, and reaches as many elderly as possible;**

(c) **enhance the eHealth System so that the deceased elderly's voucher accounts will be closed; and**

(d) **adjust the amount to take into account the deceased elderly, when making provision for the EHCVS in the Estimates.**

Response from the Administration

4.22 The Director of Health agrees with the audit recommendations. She has said that:

(a) the DH will continue stepping up the promotion of the EHCVS and ensure that the promotion information is correct by distributing up-to-date publicity materials and reminding stakeholders to use only the new materials when promoting the EHCVS to the elderly; and

(b) since August 2014, the DH has started working on implementing changes to the eHealth System to manage the voucher accounts of deceased elderly such that they will be excluded when preparing the Estimates for the EHCVS.

Monitoring of voucher claims

4.23 The DH has adopted a "post-payment approach" in monitoring voucher claims made by EHCPs. EHCPs are required to submit claims on-line through the eHealth System. After receiving the claims, the DH will make payments to EHCPs in about one month. It will later on conduct inspections to verify the validity of the claims.

4.24 The DH's inspections mainly include the following:

(a) routine checking covering all EHCPs. In the checking, the DH examines the propriety of the consent forms signed by elderly to confirm the value of vouchers used for the healthcare service, which should match the amount of claims submitted by the EHCPs; and

(b) targeted investigation with focus on the EHCPs with abnormal pattern of voucher claims, such as those with unusually large number of daily claims (as alerted by the eHealth System) and those subject to complaints.

Inspections are conducted by an inspection team headed by an Assistant Manager, supported by six Administrative Assistants.

4.25 For anomalous claims identified in inspections, the DH may seek repayments from the EHCPs, delist them from the EHCVS, and refer their cases to the police (if false claims are suspected) and the relevant professional organisations (for disciplinary investigation).

4.26 In the period from 1 January 2009 to 31 March 2014, the DH had conducted some 7,700 inspections, involving a total of 141,000 claims made by some 3,440 EHCPs (see Table 14).

Table 14

Inspections conducted by DH
(1 January 2009 to 31 March 2014)

Inspection	Number of inspections	Number of claims involved	Number of EHCPs involved
Routine checking	7,200	122,000	3,180
Targeted investigation	500	19,000	260
Total	7,700	141,000	3,440

Source: DH records

According to the inspection results, 1,950 claims related to 99 EHCPs, with claim values ranging from $50 to $255,750 per EHCP, were considered anomalous. In the period from 1 January 2009 to 31 March 2014, the DH had reported six cases to the police for investigation of suspected false claims under the EHCVS and had delisted six EHCPs (three EMPs and three ECMPs). Discounting one case which was still under investigation, the five EHCPs made a total of 1,045 anomalous claims, involving $313,400, which had involved non-compliance with the EHCVS requirements. In September 2014, one ECMP was sentenced to eight months in prison because of making false claims involving some 60 vouchers.

Routine checking

4.27 During the routine checking (see para. 4.24(a)), the DH examines the propriety of consent forms. Under the EHCVS, each time after receiving the service of an EHCP, an elderly is required to complete a standard consent form of the EHCVS at the EHCP's place of practice. The form records the following:

(a) information on the healthcare service provided, such as date of visit, the EHCP's name, value of vouchers used, and co-payment made by the elderly (i.e. amount paid to top up the value of vouchers for the healthcare service bill);

(b) a statement that the elderly consents to the value of vouchers used for the healthcare service provided;

(c) personal information of the elderly (i.e. name, HKID card number and telephone number); and

(d) the signature of the elderly or, if the elderly is illiterate, the signature and personal particulars of the witness (i.e. name and HKID card number) or, if the elderly is mentally incapacitated, the signature and personal particulars of the guardian (i.e. name and HKID card number).

The EHCPs are required to keep these consent forms for a period of seven years. The DH has regarded the examination of these consent forms an important control to deter improper voucher claims.

4.28 The DH has set a target of examining the selected claims of all EHCPs in its routine checking over a defined period of 15 months. The first 15-month period was from May 2011 to July 2012. Audit however noted that the DH's routine checking had always fallen short of the target (see Table 15).

Table 15

Coverage of routine checking conducted by DH
(May 2011 to October 2013)

15-month period	Number of		Coverage	Target achieved
	EHCPs with claims submitted (a)	EHCPs covered by routine checking (b)	(c) = (b) ÷ (a) × 100%	
May 2011 to July 2012	2,290	2,109	92.1%	No
August 2012 to October 2013	2,787	2,191	78.6%	No

Source: *Audit analysis of DH records*

Remarks: *As at time of audit in September 2014, the DH was conducting routine checking for the 15-month period from November 2013 to January 2015.*

The DH needs to expedite its routine checking and cover the examination of selected claims of all EHCPs over a 15-month cycle as far as possible.

Examination of consent forms by DH

4.29 In conducting routine checking, to reduce inconvenience to the EHCPs, the DH telephones the EHCPs in advance and goes to their places of practice to bring the elderly's consent forms back to the DH office for examination. The DH calls for the consent forms relating to a fixed number of claims for a particular month for examination. Audit considers that the DH should avoid adopting a standard pattern of routine checking. For example, it may consider occasionally conducting surprise checking, and selecting claims for different months.

Follow-up inspections

4.30 In addition to routine checking and targeted investigations, the DH conducts follow-up inspections from time to time, e.g. when errors/omissions are detected in the consent forms examined in routine checking. In the period from 1 January 2009 to 31 March 2014, the DH conducted 221 follow-up inspections arising from routine checking, involving 200 EHCPs (Note 6).

4.31 Audit examined the eight follow-up inspections conducted from January to March 2014, and noted that in four of the eight inspections, errors/omissions were still detected. In two of the four inspections, similar errors/omissions (Note 7) as identified in routine checking were still detected in the follow-up inspections (see Table 16). The DH needs to take escalated action by issuing advisory letters or warning letters to the EHCPs. Moreover, the DH needs to enhance the education to be provided to the EHCPs as well as provide more guidelines to help them complete the consent forms and submit the claims properly.

Note 6: *For some EHCPs, the DH conducted more than one follow-up inspection.*

Note 7: *The DH classifies errors/omissions into major and minor errors/omissions. Major errors/omissions include witness information and elderly's signature missing. Minor errors/omissions include date of visiting the EHCP and name of the EHCP missing. For major errors/omissions detected in routine checking, the DH would take actions such as making telephone calls to the elderly to ascertain whether the healthcare services have actually been provided and reminding the EHCPs to avoid errors/omissions in future. For minor errors/omissions, the DH would ask the EHCPs to provide correct information for the claims.*

Table 16

Follow-up inspections with repeated errors/omissions

EHCP	Date of visit	Percentage of consent forms examined	
		With errors/omissions found	With similar major errors/omissions found
Physiotherapist	10.5.2013 (routine checking)	70%	60% (Witness information missing)
	25.2.2014 (follow-up inspection)	45%	10% (Witness information missing)
Chinese Medicine Practitioner	12.3.2013 (routine checking)	45%	35% (Elderly's signature missing)
	20.2.2014 (follow-up inspection)	18%	15% (Elderly's signature missing)

Source: Audit analysis of DH records

Audit examination of consent forms

4.32 ***Errors/omissions in consent forms.*** In early August 2014, Audit examined the consent forms for the three months from April to June 2014 kept by 15 EHCPs. These EHCPs comprised five EMPs, five ECMPs (denoted as EMP 1 to 5 and ECMP 1 to 5 hereinafter), four enrolled Dentists, and one enrolled Optometrist. Audit examined consent forms of 5,031 claims involving a total voucher amount of $1.65 million. The results are as follows:

(a) major errors/omissions were found in consent forms of 303 (6%) claims, involving a total voucher amount of $69,950; and

(b) minor errors/omissions were found in consent forms of 337 (7%) claims, involving a total voucher amount of $101,300.

4.33 Table 17 shows the errors/omissions identified by Audit.

Table 17

Errors/omissions identified in consent forms of 5,031 claims examined by Audit (1 April to 30 June 2014)

Error/omission identified in consent forms	Number of errors/omissions identified
Major error/omission	
Witness information missing/incomplete	268 (38%)
Consent form missing	8 (1%)
Number of vouchers recorded in consent form inconsistent with that in eHealth System	11 (2%)
Elderly's signature missing	17 (2%)
Sub-total	304 (43%)
Minor error/omission	
Date of visiting EHCP missing/inconsistent with that in eHealth System	284 (40%)
Elderly's personal information (e.g. name or HKID card number) missing/inconsistent with that in eHealth System	38 (6%)
Transaction number (Note) missing/inconsistent with that in eHealth System	77 (11%)
EHCP's name missing	1 (0%)
Sub-total	400 (57%)
Total	704 (100%)

Source: *Audit examination of consent forms*

Note: *The eHealth System generates a transaction number for each claim.*

Remarks: *Consent forms of 640 (13%) of 5,031 claims were found to have errors/omissions. Consent forms of some claims were found to have more than one error/omission. Therefore, the number of errors/omissions was greater than the number of claims with errors/omissions.*

The DH needs to keep statistics for the number and percentage of the major and minor errors/omissions to help it identify patterns of deficiencies and devise reminders/guidelines to help the EHCPs reduce errors/omissions.

4.34 ***Unsatisfactory practices adopted by some EHCPs.*** In examining the consent forms, Audit identified a number of unsatisfactory practices which had not been classified as errors/omissions by the DH. Examples are shown below:

(a) ***Signing excessive consent forms.*** Before July 2014, each time an elderly received service from an EHCP, the elderly was required to sign one consent form and specify the total number of vouchers used. EMP 4, however, required the elderly to sign one consent form for each voucher used (each voucher represented a value of $50). Furthermore, although the elderly had signed many consent forms, EMP 4 specified the total number of vouchers used in one form only. On the remaining consent forms, the space for filling in the number of vouchers used was left blank. For example, an elderly had signed four consent forms for four vouchers used, and one of the four consent forms specified that he had used four vouchers, while the other three consent forms had a blank space for the number of vouchers used. In the period from 1 April to 30 June 2014, the elderly who visited EMP 4 had signed over 2,000 consent forms for 586 medical consultations (involving a total voucher amount of $110,150). In one case, the elderly signed as many as 59 such "blank forms" for just one consultation. Audit considers this practice unacceptable because the potential risk of abuse is high as an unscrupulous EHCP can make false claims through using the pre-signed "blank forms";

(b) ***Telephone numbers of elderly missing.*** Elderly are required to state their telephone numbers on the consent forms (see para. 4.27(c)). According to the DH, if major errors/omissions are detected in routine checking, it would contact the elderly to ascertain whether they have actually received services from the EHCPs and used the value of vouchers specified in the consent forms. The DH may also select some elderly during routine checking (even when there are no errors/omissions detected) and contact them to ascertain the genuineness of voucher claims. Audit, however, noted that the telephone numbers of the elderly were missing on 133 consent forms (98% of forms examined by Audit) of ECMP 3, involving a total voucher amount of $25,700, and 89 consent forms (97% of forms examined by Audit) of ECMP 4, involving a total voucher amount of $24,250; and

(c) ***Modification of standard consent forms by EHCP.*** EMP 5 sometimes modified the standard consent form. Such modified consent forms did not include the statement that the elderly consented to the number of vouchers used for the healthcare service provided. The modified consent forms had been used for 118 claims involving a total voucher amount of $30,900.

The identification of various errors/omissions by Audit calls for the DH's attention and follow-up.

Utilisation of identity card readers

4.35 When an elderly visits an EHCP, the EHCP needs to either input the particulars of the elderly on his HKID card into the eHealth System manually or capture the particulars by means of an identity card reader. Since August 2010, the DH has distributed identity card readers to all EHCPs. By using card readers, it can ensure that the personal particulars of the elderly are accurately input into the eHealth System and can help prevent EHCPs from making incorrect claims.

4.36 Audit, however, noted that in the period from 1 January 2011 to 31 March 2014, a substantial number of claims were prepared using manual input of the elderly's personal particulars (see Table 18).

Table 18

Claims which used manual input of elderly's personal particulars (2011 to 2014)

Year	Manual claims	
	Number	As a percentage of total number of claims in the year
2011	450,440	73%
2012	713,106	76%
2013	1,173,031	80%
2014 (up to March)	500,397	83%

Source: Audit analysis of DH records

Audit considers that the DH needs to promote the use of the identity card readers.

Audit recommendations

4.37 **Audit has *recommended* that the Director of Health should**:

(a) **expedite the DH's routine checking to cover the examination of selected claims of all EHCPs over a 15-month cycle as far as possible;**

(b) **avoid adopting a standard pattern of routine checking;**

(c) **keep statistics for the number and percentage of the major and minor errors/omissions to help it identify patterns of deficiencies and devise reminders/guidelines to help the EHCPs reduce errors/omissions;**

(d) **review the effectiveness of conducting follow-up inspections to deter errors/omissions and, where warranted, take escalated action by issuing advisory letters or warning letters to the EHCPs;**

(e) **follow up Audit's findings on consent forms (see paras. 4.32 to 4.34); and**

(f) **encourage the EHCPs to use identity card readers as far as possible and provide assistance to the EHCPs who have difficulties in using the readers.**

Response from the Administration

4.38 The Director of Health agrees with the audit recommendations. She has said that the DH will:

(a) review the inspection protocol, taking into consideration the audit recommendations;

(b) consider taking measures to enhance the EHCPs' compliance with the requirements, including issuing guidelines for them on the proper completion of consent forms, and issuing advisory letters or warning letters where warranted;

(c) follow up Audit's findings on consent forms; and

(d) continue encouraging the EHCPs to use identity card readers when making claims.

Comprehensive review of EHCVS

4.39 In February 2011, the FHB and the DH had completed an interim review of the EHCVS, with recommendations suitably incorporated into the design of the EHCVS as it developed with time. With the increasing financial implications of the EHCVS (amounting to $846 million in 2014-15), it is an opportune time for the Administration to conduct another comprehensive review of the EHCVS. In fact, on various occasions, as shown below, the FHB informed LegCo that a comprehensive review of the EHCVS would be conducted.

(a)	November 2012	:	The FHB informed the Panel on Health Services that a further review of the EHCVS would be initiated after experience was accumulated on its operation.
(b)	December 2012	:	The FHB informed the Finance Committee that the EHCVS would be reviewed after its conversion into a recurrent programme.
(c)	February and December 2013	:	The FHB reiterated to LegCo Members that a review would be conducted to assess the effectiveness of the EHCVS after it had been regularised for a period of time.

Audit recommendation

4.40 **Audit has *recommended* that the Director of Health should plan for the conduct of another comprehensive review of the EHCVS.**

Response from the Administration

4.41 The Director of Health agrees with the audit recommendation. She has said that the Administration already has plans to conduct an evaluation of the EHCVS in mid-2015 after the enhancements of the EHCVS in 2014 have been launched for some time.

PART 5: HA'S PROVISION OF SPECIALIST OUT-PATIENT SERVICE TO ELDERLY PATIENTS

5.1 This PART examines the SOP service (Note 8) provided by the HA, focusing on the following issues:

(a) elderly patients' waiting time for first SOPC consultation (paras. 5.5 to 5.14);

(b) Geriatric SOPCs (paras. 5.15 to 5.23);

(c) Community Geriatric Assessment Teams (paras. 5.24 to 5.28);

(d) cross-cluster arrangements (paras. 5.29 to 5.36); and

(e) waiting time information (paras. 5.37 to 5.42).

Background

5.2 According to the HA, elderly patients may generally be defined as those aged 65 or above for planning purposes. Moreover, the HA considers that defining their need by reference to age is not always an effective strategic response as the experience of ageing varies from person to person. Therefore, the SOP service is provided according to assessment of individual needs, rather than a person's age.

5.3 Background information on the HA's SOPCs is shown below:

Note 8: *A major concern of elderly patients is how fast they can obtain an appointment for medical consultation. As GOPCs reserve quotas of consultation for elderly patients (see para. 5.5), this audit review focuses on the work of the SOPCs.*

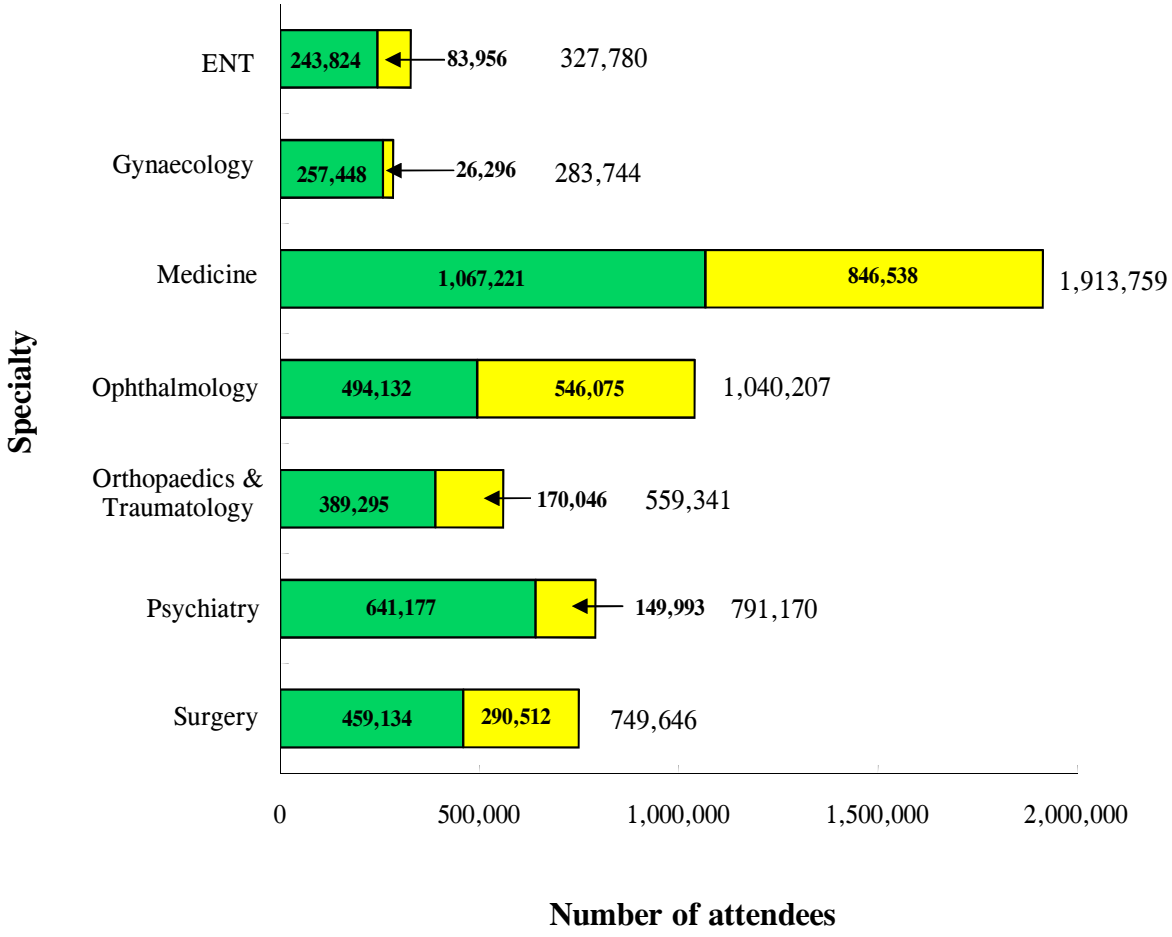
(a)	Establishment	:	• 47 SOPCs provide specialist consultations for patients referred by general practitioners. The following eight Specialties accounted for the great majority of consultations at the SOPCs: — Ear, Nose & Throat (ENT); — Gynaecology; — Medicine; — Ophthalmology; — Orthopaedics & Traumatology; — Psychiatry; — Surgery; and — Paediatrics. • The 47 SOPCs are organised into seven clusters, namely: — Hong Kong East and West; — Kowloon Central, East and West; and — New Territories East and West.
(b)	Attendances	:	In 2013-14, there were 5.91 million attendances (by elderly and non-elderly patients) at the eight Specialties.
(c)	SOP service costs for all Specialties in 2013-14	:	$9,900 million.

Elderly patients' attendance at SOPCs

5.4 In the period from 2009-10 to 2013-14, the attendance of elderly patients (i.e. patients aged 65 or above) at the SOPCs of the seven major Specialties (excluding Paediatrics as the patients were children) increased by 12% from 1.88 million to 2.11 million. In 2013-14, the 2.11 million attendance represented 37% of all attendances (at the seven Specialties) of 5.67 million. Among the seven major Specialties, the Medicine Specialty had the highest elderly patients' attendance of 846,538 (see Figure 3).

Figure 3

Elderly patients' attendance at SOPCs (2013-14)



Source: HA records

Elderly patients' waiting time for first SOPC consultation

Triage system of SOPCs

5.5 Elderly patients can obtain out-patient service at the GOPCs and SOPCs of the HA. The GOPCs are primarily targeted at serving the elderly, people of low-income, and those who are chronically ill. The GOPCs reserve quotas of consultation for elderly patients. The number of quotas reserved at the GOPCs is adjusted from time to time based on factors such as service demand from elderly patients. According to the HA, over 90% of elderly patients are able to secure an appointment at the GOPCs and attend a consultation within two working days.

5.6 Unlike the GOPCs, the SOPCs do not reserve quotas specifically for elderly patients. The SOP service is provided to patients (including elderly patients) according to the assessment of individual needs and clinical conditions, rather than solely their age. Patients referred to SOPCs for first consultation are triaged into one of the three categories of Priority 1 (urgent), Priority 2 (semi-urgent) or Routine based on their clinical conditions. To ensure that urgent cases will not be overlooked, referrals classified as Routine cases are reviewed by a Senior Medical Officer within seven working days. If patients' conditions become acute, they should seek immediate treatment at the Accident and Emergency Departments of hospitals.

Increase in waiting time for first SOPC consultation

5.7 ***Target waiting time.*** Waiting time for medical consultation is always a concern of patients. For follow-up SOPC consultations, the waiting time varies according to the clinical needs of the patients. For first SOPC consultations, the HA sets target median waiting time of 2 and 8 weeks for Priority 1 and Priority 2 cases respectively. No target waiting time is set for Routine cases.

5.8 ***Measures taken to shorten the waiting time.*** Over the years, the HA has implemented a number of improvement measures to shorten the waiting time for first SOPC consultations, including:

(a) ***Retention of medical staff.*** The HA introduced initiatives such as improving working conditions and strengthening the supporting workforce (e.g. phlebotomists) to alleviate the workload of medical staff;

(b) ***Temporary measures.*** In 2013-14, the HA engaged some 300 part-time doctors and "limited registration" doctors to improve the manpower strength. The HA also paid around $70 million as special honorarium to increase the service capacity, including that of the SOPCs, within the HA;

(c) ***Cross-cluster referrals.*** The HA provides options for patients to be channelled to clusters with shorter waiting times;

(d) ***Enhancing transparency.*** The HA recognises the importance to enhance transparency in waiting time performance and has posted waiting time information of SOPCs on its website;

(e) ***Collaboration with Family Medicine.*** The HA has used Family Medicine to help attend newly referred patients who suffered from problems (such as low back pain) that can be dealt with at primary care levels; and

(f) ***Improvement of management tool.*** In the first quarter of 2014, the HA launched an electronic referral system to facilitate clinicians in making referrals to SOPCs.

5.9 In the five years from 2009-10 to 2013-14, the HA was able to meet the target median waiting time of Priority 1 and Priority 2 cases. In respect of Routine cases of elderly patients, the waiting time for first consultation had generally increased (see Table 19). Audit noted that:

(a) the 90th percentile (Note 9) waiting time of the ENT, Ophthalmology and Surgery Specialties had been shortened. However, for the other four Specialties namely, Gynaecology, Medicine, Orthopaedics &

Note 9: *The 90th percentile waiting time is an index adopted internationally to denote the longest waiting time of patients for consultations. The HA monitors waiting time by regularly compiling the waiting times in median (50th percentile) and the 90th percentile waiting time. Nevertheless, from time to time, the HA provides the Legislative Council with information on the lower quartile (25th percentile), median (50th percentile), upper quartile (75th percentile) and the longest (90th percentile) waiting time.*

Traumatology and Psychiatry, the 90th percentile waiting time had increased. The increase was particularly significant in the Orthopaedics & Traumatology and Psychiatry Specialties — 48 and 21 weeks respectively; and

(b) the 25th percentile waiting time of five major Specialties namely ENT, Gynaecology, Medicine, Orthopaedics & Traumatology and Psychiatry, had increased by 1 week to 12 weeks.

Table 19

Waiting time of elderly patients categorised as Routine cases (2009-10 and 2013-14)

Specialty	25th percentile waiting time (Week)			90th percentile waiting time (Week)		
	2009-10	2013-14	Increase/ (Decrease)	2009-10	2013-14	Increase/ (Decrease)
1. ENT	2	14	12	72	61	(11)
2. Gynaecology	10	11	1	47	61	14
3. Medicine	9	14	5	60	75	15
4. Ophthalmology	16	15	(1)	114	69	(45)
5. Orthopaedics & Traumatology	20	25	5	78	126	48
6. Psychiatry	1	6	5	45	66	21
7. Surgery	13	13	0	122	111	(11)

Source: HA records

Disparity in waiting time among clusters

5.10 Audit analysis of the 90th percentile waiting time for Routine cases of the seven Specialties revealed that the elderly patients' waiting time varied significantly among different clusters. For the three Specialties namely, Orthopaedics & Traumatology, Psychiatry, and Surgery, elderly patients of the Kowloon East Cluster had to wait about 100 weeks longer than those of the Hong Kong East Cluster (see Table 20).

Table 20

Disparity in elderly patients' waiting time for Routine cases at SOPCs of different clusters (2013-14)

Specialty	Shortest 90th percentile waiting time		Longest 90th percentile waiting time		Disparity (c) = (b) − (a) (Week)
	Cluster	Number of weeks (a)	Cluster	Number of weeks (b)	
1. ENT	Kowloon Central	27	HK West	95	68
2. Gynaecology	HK West	19	Kowloon East	94	75
3. Medicine	HK East	46	NT East	85	39
4. Ophthalmology	HK West	21	NT East	99	78
5. Orthopaedics & Traumatology	HK East	52	Kowloon East	149	97
6. Psychiatry	HK East	30	Kowloon East	132	102
7. Surgery	HK East	47	Kowloon East	151	104

Source: *HA records*

Remarks: *HK denotes Hong Kong and NT denotes New Territories.*

Further efforts to meet demand for SOP service

5.11 Elderly's attendance at SOPCs is generally higher than that of the non-elderly. According to the HA, while only 14% of the population belongs to the elderly group, they account for 34% of the SOP attendances in all Specialties. The elderly group has an SOP attendance rate three times of that of the non-elderly group.

5.12 The ability of the HA to manage the waiting time for SOP service hinges on manpower and service capacity. With the expected rise in the proportion of elderly population from 14% in 2013 to 19% in 2021 and further to 26% in 2031, the demand for SOP service is bound to increase significantly. Management of waiting time at SOPCs will undoubtedly be an escalating challenge for the HA. The HA needs to take further action to meet the demand for SOP service by elderly patients.

Audit recommendations

5.13 **Audit has *recommended* that the Chief Executive, HA should formulate an action plan and step up efforts to:**

(a) **shorten the waiting time for Routine cases at the SOPCs as far as possible; and**

(b) **reduce the disparity in the waiting time for first consultation at SOPCs of different clusters (for example by extending the scope of cross-cluster referral arrangement — see para. 5.29).**

Response from the Hospital Authority

5.14 The Chief Executive, HA has said that the HA agrees in principle with the audit recommendations. He has also said that the HA:

(a) has been striving to shorten the waiting time for Routine cases subject to manpower availability, and will continue to monitor the overall waiting time; and

(b) will review the disparity of waiting time in different clusters, and will extend the cross-cluster referral arrangement in appropriate clinical context.

Geriatric SOPCs

Audit's visits to Geriatric SOPCs

5.15 Geriatrics is a subspecialty under the Medicine Specialty, which has the highest elderly patients' attendance (see para. 5.4). Geriatric SOPCs provide specialist consultation service exclusively to elderly patients with specific medical problems such as incontinence and memory loss. As at 31 August 2014, there were 12 Geriatric SOPCs in the 7 clusters of the HA. In August 2014, Audit visited three Geriatric SOPCs located at the Caritas Medical Centre (CMC), the Princess Margaret Hospital (PMH) and the Queen Mary Hospital (QMH) to examine their waiting time and appointment booking procedures.

Waiting time of Geriatric SOPCs visited by Audit

5.16 In 2013-14, the longest (i.e. 90th percentile) waiting time of Routine cases at the three Geriatric SOPCs visited by Audit ranged from 78 weeks to 103 weeks (see Table 21).

Table 21

Waiting time (90th percentile) of Routine cases at three Geriatric SOPCs visited by Audit (2013-14)

Geriatric SOPC	Waiting time (Week)
CMC	85
PMH	78
QMH	103

Source: HA records

Appointment scheduling for first and follow-up consultations

5.17 The number of appointment slots available for booking at an SOPC is decided by the cluster management and the doctors and nurses in charge of the SOPC. Factors taken into account in determining the number of available appointment slots include past utilisation statistics, seasonal factors (such as winter surge), and manpower factors (such as maternity leave of staff). The number of appointment slots available for booking are preset in the Out-patient Appointment System (OPAS), which is a system designed to assist the daily booking operation. The booking clerks of the SOPCs are responsible for scheduling appointment slots in the OPAS.

5.18 Audit conducted an analysis of the appointment scheduling practices of the three Geriatric SOPCs in 2013-14 (see Table 22).

Table 22

Scheduling of appointment slots in OPAS in three Geriatric SOPCs visited by Audit (2013-14)

Geriatric SOPC	First consultation		Follow-up consultation	
	Total number of slots	Number of slots unscheduled	Total number of slots	Number of slots unscheduled
CMC	1,851	538 (29%)	28,777	0 (0%)
PMH	731	222 (30%)	14,378	676 (5%)
QMH	312	66 (21%)	1,692	0 (0%)

Source: Audit analysis of HA records

Upon enquiry, the HA informed Audit in September 2014 that to cater for unexpected fluctuation in service demand particularly from patients with urgent and serious conditions (i.e. those categorised as Priority 1 and Priority 2 patients) and the uncertainties, the SOPCs had factored in certain reserves in their bookings and a certain level of unscheduled appointment slots in the OPAS was unavoidable. According to the HA, there was no capacity wastage in SOPCs in general because some of the unscheduled appointment slots were subsequently used for attending to

urgent and serious cases and other unforeseeable cases. However, Audit noted that as shown in Table 22, the number of unscheduled appointment slots for the three Geriatric SOPCs varied. This indicated that the scheduling practices among the three clinics could have contributed to the less than optimal utilisation of appointment slots in the OPAS. There is room for improvement in the monitoring and booking of appointment slots in the SOPCs.

5.19 ***Appointment slots available due to cancellation of appointments.*** Audit observed the booking processes of the three Geriatric SOPCs and found that different booking practices were adopted by them. The booking clerk of the Geriatric SOPC at the QMH allocated the earliest available appointment slots to Routine cases. However, the booking practice of the SOPCs at the PMH and that at the CMC were different:

(a) the booking clerk of the Geriatric SOPC at the PMH scheduled the appointment slots of Routine cases to the end of the queue; and

(b) the booking clerk of the Geriatric SOPC at the CMC scheduled appointment slots of Routine cases according to the dates specified by the Medical Officers. However, the Medical Officers kept manual booking records and therefore did not have the up-to-date information on appointment slots released due to cancelled appointments.

Under the practices of the SOPCs at the PMH and the CMC, some appointment slots released due to cancellation of appointment might not be put to use in an efficient manner.

5.20 To ensure that appointment slots for bookings are optimally utilised, the booking of appointment slots through the OPAS requires close monitoring. The HA needs to review the appointment booking procedures of the Geriatric SOPCs and implement measures to improve the appointment scheduling as far as possible, with reference to the practice of Geriatric SOPC of the QMH.

Practices adopted to clear backlog of Routine cases

5.21 Audit further noted that the Geriatric SOPC of the PMH has adopted the following practices to clear the backlog of Routine cases:

(a) ***Family Medicine Specialists attend Routine cases.*** Since October 2013, the PMH's Family Medicine Specialists have helped attend Routine cases involving patients who suffered from problems that can be dealt with at primary care levels (such as low back pain). Up to June 2014, 820 Routine cases had been transferred to the Family Medicine Specialists. The 90th percentile waiting time of these patients was shortened from 78 weeks to 17 weeks; and

(b) ***Transfer Routine RCHEs' cases to the Community Geriatric Assessment Teams (CGATs).*** Since December 2011, all Routine cases involving elderly residing in the RCHEs have been transferred to the CGATs (see para. 5.24). The Visiting Medical Officers of the CGATs provide medical consultation service to elderly residing in the RCHEs twice a week.

In view of the good practices of the Geriatric SOPCs at the PMH in clearing the backlog of Routine cases, the HA needs to consider encouraging other SOPCs to adopt similar practices.

Audit recommendations

5.22 **Audit has *recommended* that the Chief Executive, HA should:**

(a) **conduct a comprehensive review of the appointment scheduling practices of the SOPCs;**

(b) **in the light of the results of the review, implement measures to optimise the use of the earliest available appointment slots in scheduling appointments for patients;**

(c) **take action to ensure that the appointment slots from cancelled appointments are timely released and are put to effective use as far as possible; and**

(d) **disseminate the good practices for clearing backlog of Routine cases, and encourage SOPCs to adopt such good practices.**

Response from the Hospital Authority

5.23 The Chief Executive, HA has said that the HA agrees with the audit recommendations. He has also said that the HA will consider measures to optimise the scheduling arrangements for SOPCs.

Community Geriatric Assessment Teams

5.24 The CGATs were set up under the Department of Medicine in 1994 to provide outreach medical consultation service to elderly residing in the RCHEs. Each CGAT consists of a team of medical, nursing, physiotherapy, occupational therapy, and social work professionals. In 2006 and 2010, the HA evaluated the CGATs' service and concluded that the service was effective in reducing Accident and Emergency attendances, and hospital admissions of elderly residents of the RCHEs. The service costs of the CGATs for 2013-14 were $314 million.

5.25 As at 31 March 2014, there were 13 CGATs. They provided service to 638 (89%) of the 715 licensed RCHEs in Hong Kong (Note 10). There were some 4,500 elderly residing in the remaining 77 RCHEs (715 minus 638) who did not receive CGATs' service. According to the HA, in the past few years, the service coverage of the CGATs had not been changed.

5.26 According to the HA, a Working Group set up under the Geriatrics Subcommittee (Note 11) conducts on-going review to address service and operational issues and proposes clinical service programs to enhance the quality of healthcare of residents in RCHEs. In 2012, the Working Group completed a review of the service of the CGATs. The review focused on the objectives, service scope, target groups, mechanism for prioritisation of new RCHEs to be covered, as well as exploring alternative service models to support the care of RCHE residents.

Note 10: *Twenty-one RCHEs, which had their own medical practitioners to provide medical consultation for their elderly residents, were excluded.*

Note 11: *The Geriatrics Subcommittee comprises doctors from the Department of Medicine and Geriatrics of various HA clusters/hospitals. The Subcommittee meets quarterly to discuss professional matters related to geriatric services, including service development, quality assurance, workforce and training.*

The Working Group concluded that when resources were available through the HA's annual planning mechanism, the CGATs would adopt a set of criteria for prioritising new RCHEs to be covered.

Audit recommendations

5.27 **Audit has *recommended* that the Chief Executive, HA should:**

(a) **formulate a long-term plan for delivering the service of the CGATs; and**

(b) **in formulating the long-term plan, consider extending the service coverage of the CGATs with a view to enhancing the quality of healthcare of elderly residing in RCHEs.**

Response from the Hospital Authority

5.28 The Chief Executive, HA has said that the HA agrees with the audit recommendations. He has also said that:

(a) the HA has in recent years extended its service coverage of the CGATs to RCHE residents; and

(b) the HA will continue to review its service model and provision as appropriate with a view to enhancing the quality of healthcare of elderly residing in RCHEs.

Cross-cluster arrangements

5.29 Under the HA's cross-cluster arrangements, a patient may attend an SOPC with shorter waiting time at another cluster. There are two kinds of cross-cluster arrangements. One is the cross-cluster referral arrangement and the other is the patient-initiated cross-cluster appointment booking.

Cross-cluster referral arrangement

5.30 In August 2012, the HA launched the cross-cluster referral arrangement for SOP service on a pilot basis to shorten the waiting time for first consultation and reduce the disparity in waiting time among clusters. Under the arrangement, patients of Routine cases may be offered an appointment at an SOPC in a cluster with shorter waiting time.

5.31 The cross-cluster referral arrangement is currently only available for three Specialties namely, ENT, Gynaecology and Ophthalmology. Up to 31 May 2014, the arrangement had benefited 3,438 patients (see Table 23).

Table 23

Patients benefited from cross-cluster referral arrangement (31 May 2014)

Specialty	Cross-cluster		90th percentile waiting time for Routine cases		Waiting time shortened	Average number of patients benefited per month (Note)	Total number of patients benefited	Number of elderly patients benefited
	From	To	Before referral (a) (Week)	After referral (b) (Week)	(c) = (a) − (b) (Week)			
1. ENT	Kowloon East	Kowloon Central	79	25	54	136	3,002	642
2. Gynaecology	NT East	HK East	127	22	105	11	151	1
3. Ophthalmology	NT East	HK West	69	22	47	36	285	94
						Overall	3,438	737

Source: *HA records*

Note: *Up to 31 May 2014, the cross-cluster referral arrangement for the Specialties of ENT, Gynaecology and Ophthalmology had been implemented for 22, 14 and 8 months respectively. The average number of patients benefited for each of the three Specialties is calculated by dividing the corresponding total number of patients benefited by 22, 14 and 8 months.*

Remarks: *HK denotes Hong Kong and NT denotes New Territories.*

Audit noted that the average number of patients of the two Specialties (Gynaecology and Ophthalmology) benefited from the cross-cluster referral arrangement was significantly less than that of the ENT Specialty.

5.32 To enable more patients (including elderly patients) to benefit from the cross-cluster referral arrangement and in view of the significant disparity in the elderly patients' waiting time among clusters for Specialties (see para. 5.10), Audit considers that the HA needs to encourage the clusters of the three Specialties to initiate more referrals where the patient cases are found suitable and to consider extending the arrangement to other Specialties.

Patient-initiated cross-cluster appointment booking

5.33 In general, the HA allows patients to select an SOPC for first consultation in any cluster according to their preferences. In August 2014, Audit made telephone enquiries to 21 SOPCs (one SOPC for each of the three Specialties of Medicine, Ophthalmology and Surgery in each of the seven clusters). Audit noted that of the 21 SOPCs:

(a) one SOPC in each of the Hong Kong East Cluster, the Kowloon Central Cluster, the New Territories East Cluster, and the New Territories West Cluster refused patients residing in other clusters to attend their SOPCs; and

(b) one SOPC in each of the Hong Kong West Cluster, and the Kowloon Central Cluster replied that the Medical Officer would decide whether the patients are allowed to receive consultations at the SOPC after screening the patients' referral letters (see Table 24).

Table 24

Results of Audit's telephone enquiries for cross-cluster appointment booking (August 2014)

Specialty	Cross-cluster appointment booking			
	Accepted	Rejected	To be decided by Medical Officer	Total
Medicine	5	0	2	7
Ophthalmology	3	4	0	7
Surgery	7	0	0	7
Total	15	4	2	21

Source: Audit's telephone enquiries in August 2014

5.34 The results of Audit's telephone enquiries revealed that some clusters did not allow patients from other clusters to book appointments in their SOPCs. The HA needs to take measures to remind clusters to allow patients to attend SOPCs of their choices whenever clinical condition and capacity afford.

Audit recommendations

5.35 **Audit has *recommended* that the Chief Executive, HA should:**

(a) **initiate more cross-cluster referrals where the patient cases are found suitable;**

(b) **consider extending the cross-cluster referral arrangement to more Specialties and to benefit more elderly patients; and**

(c) **take measures to remind staff of SOPCs in all clusters to allow patients to attend SOPCs of their choices whenever clinical condition and capacity afford.**

Response from the Hospital Authority

5.36 The Chief Executive, HA has said that the HA agrees with the audit recommendations. He has also said that the HA will review the disparity of waiting time in different clusters, and will extend the cross-cluster referral arrangement in appropriate clinical context.

Waiting time information

5.37 The disclosure of waiting time information facilitates patients to make informed decisions in treatment choices and plans (including initiating cross-cluster arrangements). At the meeting of the LegCo's Panel on Health Services held in January 2013, the HA committed to report the waiting time information of the SOP service in the public domain by phases.

Waiting time information displayed at SOPCs

5.38 In June 2014, Audit visited seven SOPCs of the ENT Specialty and found that the ways the SOPCs displayed waiting time information were very different (see Table 25). For example, SOPC 1 displayed the waiting time information of all other clusters' SOPCs while SOPC 7 only displayed its own waiting time information. Displaying waiting time information of the SOPCs in all clusters would help patients (including elderly patients and their family members or carers) make informed decisions in treatment choices and plans. Audit considers that the HA needs to take measures to ensure that waiting time information displayed at SOPCs is comprehensive, consistent and is updated regularly.

Table 25

Waiting time information displayed by seven SOPCs of the ENT Specialty (June 2014)

SOPC	Cluster	Display of waiting time			Location of display	Waiting time position last updated
		Own SOPC	Other SOPCs in same cluster	Other SOPCs in all clusters		
1	HK East	Yes	Yes	Yes	Registration counter	April 2014
2	NT East	Yes	Yes	No	Registration counter	Not shown
3	Kowloon East	Yes	Not applicable (Note)	No	Registration counter	Not shown
4	HK West	Yes	No	No	SOPC entrance	April 2014
5	Kowloon Central	Yes	No	No	Registration counter	Not shown
6	Kowloon West	Yes	No	No	Registration counter	May 2014
7	NT West	Yes	No	No	Registration counter	Not shown

Source: Audit visits to the SOPCs in June 2014

Note: There was only one SOPC of the ENT Specialty in the Kowloon East Cluster.

Waiting time information posted on HA's website

5.39 In August 2014, Audit also reviewed the waiting time information posted on HA's website. Audit found that only the waiting time information of five Specialties, namely ENT, Gynaecology, Ophthalmology, Orthopaedics and Traumatology, and Paediatrics for the period from July 2013 to June 2014 was posted on the website.

5.40 To facilitate patients to make informed treatment choices and better planning, Audit considers that the HA needs to expedite action to disclose the waiting time information of all the Specialties on its website.

Audit recommendations

5.41 **Audit has *recommended* that the Chief Executive, HA should:**

(a) **implement measures to ensure that comprehensive and updated waiting time information is displayed at all SOPCs; and**

(b) **expedite action to disclose the waiting time information of all the Specialties on the HA's website to facilitate patients to make informed treatment choices and better planning.**

Response from the Hospital Authority

5.42 The Chief Executive, HA has said that the HA agrees with the audit recommendations. He has also said that the HA will take measures to display comprehensive and updated waiting time information as appropriate in a timely manner.

Acronyms and abbreviations

Audit	Audit Commission
CGAT	Community Geriatric Assessment Team
CMC	Caritas Medical Centre
COE	Certificate of Exemption
C&SD	Census and Statistics Department
DH	Department of Health
ECMP	Enrolled Chinese Medicine Practitioner
EHAPP	Elderly Health Assessment Pilot Programme
EHC	Elderly Health Centre
EHCP	Enrolled healthcare service provider
EHCVS	Elderly Health Care Voucher Scheme
EMP	Enrolled Medical Practitioner
ENT	Ear, Nose & Throat
FHB	Food and Health Bureau
GOPC	General Out-patient Clinic
HA	Hospital Authority
HKID card	Hong Kong identity card
HPAs	Health promotion activities
LegCo	Legislative Council
NGO	Non-governmental organisation

OPAS	Out-patient Appointment System
PMH	Princess Margaret Hospital
QMH	Queen Mary Hospital
RCHE	Residential care home for the elderly
SOP	Specialist Out-patient
SOPC	Specialist Out-patient Clinic
SWD	Social Welfare Department
VHT	Visiting Health Team