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.