CHAPTER 7

Department of Health
Food and Health Bureau

Provision of dental services

Audit Commission
Hong Kong
3 April 2017

This audit review was carried out under a set of guidelines tabled in the Provisional Legislative Council by the Chairman of the Public Accounts Committee on 11 February 1998. The guidelines were agreed between the Public Accounts Committee and the Director of Audit and accepted by the Government of the Hong Kong Special Administrative Region.

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PROVISION OF DENTAL SERVICES

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PROVISION OF DENTAL SERVICES

Executive Summary

1. In Hong Kong, it is the Government's policy to seek to raise public awareness of oral health and encourage proper oral health habits through promotion and education. School Dental Care Service, comprising basic and preventive dental care, is also provided by the Department of Health (DH) to primary school students. As part of the conditions of service, the Government provides comprehensive dental services to civil service eligible persons (CSEPs) (e.g. civil servants and their family members). While the Government is mindful of the substantial financial resources required if it were to provide comprehensive dental services to all, it recognises the need to provide some essential dental services to the public (e.g. emergency dental services and dental services for the elderly). Government dental services are mainly provided through the DH's 47 dental clinics/units over the territory. In addition, specific dental services subsidised by the Community Care Fund (CCF) and the Food and Health Bureau (FHB) are provided to patients with special needs.

2. In 2015-16, the expenditure on dental services totalled $1,018 million. The total number of attendance for such services (including publicity activities, dental check-ups, dental treatments, etc.) was some 1.5 million. The Audit Commission (Audit) has recently conducted a review of the provision of dental services by the Government.

Provision of promotive and preventive services

3. ***Educational and publicity programmes.*** The DH's Oral Health Education Unit conducted 20 educational and publicity programmes in 2015-16 to help students establish good oral care habits and promote oral health to the public at large. Each programme was free and aimed to serve a specific target group. Audit noted that: (a) over 80% of the participants were kindergarten and nursery students and over 10% were primary school students. For the other target groups, the attendance at programme activities were comparatively low and fluctuated considerably from year to year. For example, secondary school students' attendance at programme activities fluctuated from 210 in 2013-14 to 1,849 in

2015-16. The DH needs to monitor the programme coverage of target groups; (b) for the Brighter Smiles Playland programme, the number of students who did not join the programme had increased from 13,414 in the 2011/12 school year to 16,332 in the 2015/16 school year. There were kindergartens/nurseries which had not enrolled in the programme and therefore their students could not use the programme services; and (c) for the Bright Smiles Mobile Classroom programme, 526 primary schools did not use its services in the 2015/16 school year (paras. 2.2, 2.4 and 2.6 to 2.9).

4. ***School Dental Care Service.*** All primary schools and their students can join the School Dental Care Service on a voluntary basis. Students made about 500,000 dental appointments per year. Audit noted that: (a) many students did not show up to receive dental services as scheduled. The number of unattended appointments increased by 14,260 from 60,703 in the 2011/12 service year to 74,963 in the 2015/16 service year; (b) in the 2015/16 service year, the proportion of Primary 6 students not attending scheduled appointments was the highest at 26%; and (c) appropriate measures could be explored to encourage students' attendance (e.g. reminding students to attend appointments through mobile messaging applications) (paras. 2.13, 2.14, 2.15(a) and 2.18).

Provision of dental services for civil service eligible persons

5. ***Provision of general dental services.*** Comprehensive dental services (comprising general dental services and specialised dental services) were provided to CSEPs as a condition of service. In 2015-16, the total number of attendance was some 720,000. Audit noted that for the provision of general dental services: (a) the DH has set a target that "appointment time for new dental cases within six months" should be met in more than 90% of the cases. For government dental clinics which had a waiting time of more than six months for first-time appointments, the clinics concerned would refer their new cases to other clinics which had shorter waiting time. However, the proportion of CSEPs who declined referrals had increased from 82% as at 1 January 2013 to 90% as at 1 January 2016. The proportion of new cases with waiting time more than six months had increased from 34% as at 1 January 2013 to 46% as at 1 January 2016; (b) in four clinics, as at 1 January 2016, the waiting time for annual check-ups was 13 to 14 months; and (c) there were wide variations in waiting time for dental treatments at different clinics, which ranged from 2 months to 18 months as at 1 January 2016 (paras. 1.4, 1.8, 3.2, 3.4, 3.5 and 3.8).

6. ***Provision of new surgeries at dental clinics.*** To meet service needs, the DH had planned to provide 64 new dental surgeries, which would commence operation in the period 2011-12 to 2015-16. However, there were delays in fitting out some surgeries, and that sufficient Dental Officers could not be recruited to operate the completed surgeries. Of the 64 planned new surgeries, 11 (17%) had not commenced operation as at 30 October 2016. For four surgeries, the delay in operation was over one year (paras. 3.15 and 3.16).

Provision of specific dental services for the public

7. ***Emergency dental services for the public.*** The Government provides emergency dental services (e.g. pain relief and tooth extraction) in General Public Sessions at 11 government dental clinics. Patients seeking emergency dental services are required to obtain a disc from one of these dental clinics. The Sessions had a total quota of about 40,000 discs a year, which are given out on a first-come-first-served basis. Audit noted that the utilisation of General Public Sessions was yet to be maximised. According to a survey conducted by the DH in 2014, some 23% of the respondents seeking emergency dental services had the experience of failing to obtain a disc from a government dental clinic and were turned away. On the other hand, the disc quota was not always fully utilised. For example, in 2015-16, the unutilised disc quota for the year totalled 5,480 discs representing 13.7% of the total disc quota of 40,060 (paras. 1.9 and 4.2 to 4.4).

8. ***Outreach Dental Care Programme for the Elderly.*** The DH has engaged 11 non-governmental organisations (NGOs) to provide outreach dental services to eligible service users at residential care homes and day care centres for the elderly under the Programme. Audit noted that: (a) of the 944 residential care homes/day care centres eligible for services, 182 (19%) homes/centres did not participate in the Programme in the 2015/16 service year; (b) through on-site oral health assessment in the 2015/16 service year, the NGOs found that 32,950 elderly persons at residential care homes/day care centres needed dental treatments. However, 13,324 (40%) of them refused to receive treatment, notwithstanding that they were physically fit for treatments; and (c) to monitor performance, the DH has requested the NGOs to adopt the Dental Clinic Management System (DCMS) to plan and record dental services for individual elderly persons. The DH can view the data input by the participating NGOs and generate service statistics reports through another designated system called DCMS-Outreach Reporting Management Service (DCMS-ORMS). However, it was not the DH's practice to verify NGOs' claims for reimbursement of dental treatments against service statistics reports generated by

the DCMS-ORMS. In 10 of 40 cases examined by Audit, the records in the DCMS had not been accurately and promptly updated for the DH's monitoring purposes (paras. 4.8, 4.9, 4.11(a), 4.13 to 4.15 and 4.18 to 4.21).

9. ***Elderly Dental Assistance Programme.*** In September 2012, the Programme was launched under the CCF. The Programme provides free removable dentures and related dental services to low-income eligible elderly persons. Audit noted that: (a) as at 30 September 2016, of the 134,000 elderly persons eligible for the Programme, only 10,733 (8%) elderly persons had participated in the Programme; (b) through an implementing agent (Organisation A), patients (i.e. elderly persons) were surveyed by telephone to ascertain the dental services they had received. Of the 155 cases surveyed in the period March to September 2016, in 45 cases, potential discrepancies were identified between the services received by patients and the dentists' claims for services provided. In four of the 45 cases, the justifications for not taking further action could be better documented; and (c) as a general rule, the administration cost of a programme of the CCF is capped within 5% of the estimated total disbursement of the programme. However, in the period 2012-13 to 2015-16, the total administration cost spent by Organisation A was equivalent to 18.8% of the Programme's total disbursement of $56.9 million. The FHB needs to work with Organisation A to improve the economy of scale (paras. 4.25, 4.28, 4.32, 4.33 and 4.35 to 4.37).

Attainment of oral health

10. ***Oral health goals of the Government.*** In March 1991, the Dental Sub-Committee of the Medical Development Advisory Committee recommended the setting of a range of oral health goals to be accomplished by 2010 and 2025. Audit noted that: (a) results of the DH's 2011 Oral Health Survey indicated that some oral health goals for 2010 had not been attained (e.g. 49.3% against a goal of 70% of the 5-year-old people surveyed were caries-free); (b) the DH had not published the level of attainment of the oral health goals; and (c) the existing oral health goals, which were set some 26 years ago in 1991, were likely outdated and should be reviewed (paras. 5.2, 5.4, 5.5 and 5.6(a)).

Audit recommendations

11. **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:**

Provision of promotive and preventive services

(a) **consider setting targets for attendance at activities of educational and publicity programmes involving physical participation of the target groups to facilitate measurement of the adequacy of the programmes and identifying room for improvement (para. 2.11(a));**

(b) **explore means to encourage kindergartens/nurseries, which have not enrolled in the Brighter Smiles Playland, to join the Playland so that more students could benefit from Playland activity sessions (para. 2.11(b));**

(c) **further promote the services of the Bright Smiles Mobile Classroom with a view to benefiting more schools (para. 2.11(c))**;

(d) **explore appropriate measures to encourage Primary 6 students' attendance at appointments of the School Dental Care Service (para. 2.23(a));**

(e) **in consultation with the FHB, determine whether the fees for the School Dental Care Service should be revised (para. 2.23(b));**

Provision of dental services for CSEPs

(f) **investigate the reasons for the increasing proportion of CSEPs declining referrals to other clinics with shorter waiting time for new cases, and explore the feasibility of shortening the waiting time for first-time dental appointments (para. 3.13(a));**

(g) **monitor the waiting time for subsequent dental appointments and take further action to shorten the waiting time (para. 3.13(b));**

(h) **closely monitor the progress of the provision of new surgeries, and take prompt remedial action where warranted (para. 3.18(a));**

Provision of specific dental services for the public

(i) **explore ways to maximise the utilisation of General Public Sessions to better meet the public demand with existing resources (para. 4.6);**

(j) **look into the reasons why many residential care homes/day care centres had declined the outreach dental services for the elderly, and take measures to encourage their participation (para. 4.23(a));**

(k) **take measures (e.g. enhancing promotional activities) to encourage elderly persons to receive necessary dental treatments (para. 4.23(d));**

(l) **remind NGOs of the need to accurately and promptly update records of dental services in the DCMS (para. 4.23(f));**

(m) **consider making use of the DCMS-ORMS to substantiate NGOs' claims before making payments to them (para. 4.23(g));**

Attainment of oral health

(n) **conduct a review of the oral health goals (para. 5.7(a)); and**

(o) **after reviewing the oral health goals, consider publishing the level of attainment against the goals (para. 5.7(c)).**

12. **Audit has *recommended* that the Secretary for Food and Health should:**

(a) **take measures to encourage participation of elderly persons in the Elderly Dental Assistance Programme (para. 4.38(a));**

(b) **improve the documentation of the justifications for not taking further action on cases with discrepancies identified in telephone surveys of elderly persons (para. 4.38(b)); and**

(c) **work with Organisation A to further reduce the administration cost with a view to meeting the requirement set by the CCF (para. 4.38(c)).**

Response from the Government

13. The Secretary for Food and Health and the Director of Health agree with the audit recommendations.

PART 1: INTRODUCTION

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

Background

1.2 Oral health is essential to general health and quality of life. According to the World Health Organization, oral health is a state of being free from chronic mouth and facial pain, as well as being free from diseases and disorders such as gum disease, tooth decay and tooth loss.

Government policy on dental care

1.3 For dental care, prevention has more long-lasting benefits and is more cost-effective than cure. In Hong Kong, it is the Government's policy to seek to raise public awareness of oral health and encourage proper oral health habits through promotion and education. To this end, the Government provides promotive and preventive services for dental care. Not only can effective prevention improve the overall level of oral health, it can also mitigate the community's financial burden in providing expensive dental treatments.

Introduction

1.4 As part of the conditions of service, the Government provides comprehensive dental services to civil service eligible persons (CSEPs — Note 1).

1.5 The Government is mindful of the substantial financial resources involved in providing comprehensive dental services to the community. Dental services are provided to members of the public mainly by registered dentists working in the private sector and non-governmental organisations (NGOs). Nevertheless, the Government recognises the need to provide some essential dental services to the public, namely, emergency dental services, specialised dental services that are essential for certain people (e.g. oral and maxillofacial surgery), and dental services required by people who may have limited knowledge about oral health or are unable to take care of their teeth properly (i.e. the elderly and people with intellectual disability). Accordingly, in addition to promotion and education, the Government also provides these essential dental services.

Note 1: *CSEPs are:*

(a) monthly paid officers and their family members;

(b) retired Government officers in receipt of a pension and their family members living in Hong Kong;

(c) family members of officers killed on duty and living in Hong Kong;

(d) family members living in Hong Kong and in receipt of a pension under the Widows and Orphans Pension Scheme or Surviving Spouses' and Children's Pensions Scheme following the death of officers while in service or after retirement; and

(e) other persons who are eligible for civil service medical benefits by way of their terms of appointment.

Family members refer to an officer's spouse and children who are unmarried and under the age of 21. For children aged 19 or 20, they must also be in full time education or in full time vocational training, or dependent on the officer as a result of physical or mental infirmity.

1.6 Government dental services are mainly provided through the Department of Health (DH — Note 2) as follows:

(a) promotive and preventive services (see para. 1.7);

(b) dental services for CSEPs (see para. 1.8); and

(c) specific dental services for the public (see paras. 1.9 to 1.11(a)).

In addition, services are also provided by participating NGOs/organisations/private dentists to patients with special needs. These services are subsidised by the Community Care Fund (CCF — Note 3) (see para. 1.11(b)) and the Food and Health Bureau (FHB — see para. 1.11(c)).

Promotive and preventive services

1.7 The DH runs the following programmes to provide promotive and preventive services to different sectors of the community:

Note 2: *The Hospital Authority also provides dental services at selected hospitals. Such services include hospital dental services as well as specialist dental services (mainly specialist oral-maxillofacial surgery) for hospital patients, and patients with special oral health care needs and dental emergency (such as trauma, tumor and cleft deformities) via internal referral. In 2015-16, the Hospital Authority had eight Dental Officers and 14 ancillary dental personnel for its provision of dental services. This audit review does not cover the Hospital Authority's dental services.*

Note 3: *The CCF is a trust fund established in 2011 under the Secretary for Home Affairs Incorporation Ordinance (Cap. 1044) with the Secretary for Home Affairs Incorporated as its trustee. Its objective is to provide assistance to people with financial difficulties, in particular those who fall outside the social safety net or those within the safety net but still have special circumstances that are not covered. In addition, the CCF may consider introducing programmes on a pilot basis to help the Government identify those measures that can be considered for incorporation into its regular assistance and service programmes. The CCF runs a number of assistance programmes, which include dental services for low-income elderly persons.*

(a) ***Educational and publicity programmes.*** Through its Oral Health Education Unit, the DH runs various programmes for students (e.g. arranging interactive activities at DH venues to help pre-primary school students learn good oral care habits) and for the public at large (e.g. launching publicity campaign to promote oral health). All the programmes are free. In the financial year 2015-16, some 1,300 events were held under 20 programmes. Appendix A shows the key programmes run in 2015-16; and

(b) ***School Dental Care Service.*** Through its eight school dental clinics (see Appendix B), the DH has been running the School Dental Care Service for primary school students since 1980. Participating students are scheduled to visit school dental clinics to receive basic and preventive dental care, which are provided by Dental Therapists under the supervision of Dental Officers (see para. 1.14(a) and (c)). For students with permanent resident status, an annual fee of $20 is charged (Note 4). In the 2015/16 service year (Note 5), about 96% of primary school students in Hong Kong participated in the service. Since the 2013/14 service year, the Government has expanded the service to cover students with intellectual disability and/or physical disabilities studying in special schools irrespective of their grades until they reach the age of 18.

Dental services for CSEPs

1.8 As part of civil servants' conditions of service, the Government provides dental services for CSEPs. Services are provided through the DH's 47 clinics/units over the territory, which comprise 38 government dental clinics, 2 orthodontic clinics and 7 Oral Maxillofacial Surgery and Dental Units (OMSDUs):

(a) ***General dental services.*** Dental treatments and annual dental check-ups are provided through government dental clinics (see Photograph 1); and

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Note 4: *For students without permanent resident status, the annual fee is $605.*

Note 5: *A service year for the School Dental Care Service starts in November and ends in October of the ensuing calendar year.*

(b) ***Specialised dental services.*** Specialised services (e.g. oral and maxillofacial surgery, and restorative dental services) are provided through specific government dental clinics, the orthodontic clinics and the OMSDUs (see Photograph 2). To receive the services, CSEPs need to have the referral of government dental clinics.

General dental services are free of charge. For specialised dental services, CSEPs are required to pay fees according to their monthly salaries (see Appendix C). Details of the clinics and OMSDUs are at Appendix D.

Photograph 1

Provision of general dental services at a government dental clinic

Source: DH records

Photograph 2

Provision of specialised dental services at an OMSDU

Source: DH records

Specific dental services for the public

1.9 ***Emergency dental services for the public.*** Since 1947, emergency dental treatments (e.g. pain relief and tooth extraction) have been provided to the public who have acute dental problems. Necessary professional advice is also provided to those receiving the emergency treatments. Emergency dental services (i.e. emergency treatments and the related professional advice) are provided through designated sessions in 11 government dental clinics of the DH (see Appendix D). For eligible people, emergency dental services are free of charge (Note 6).

1.10 ***Specialised dental services for the public.*** The DH's 7 OMSDUs which serve CSEPs (see para. 1.8) also provide specialised dental services for the public (see Appendix D). Members of the public need to have the referral of the Hospital Authority, government dental clinics or private dentists in order to receive

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Note 6: *Eligible people include holders of Hong Kong Identity Card and children who are Hong Kong residents and under 11 years of age. For non-eligible people, the emergency dental services are charged $1,110 per consultation.*

specialised dental services. People are charged a consultation fee (i.e. $100 for the first attendance and $60 for subsequent attendance) and the fees of treatments provided (see Appendix C).

1.11 ***Dental services for people with special needs.*** The Government provides the following specific dental services for people with special needs (i.e. the elderly and people with intellectual disability):

(a) ***DH's Outreach Dental Care Programme for the Elderly.*** This Programme was launched as a regular programme in 2014. Under the Programme, NGOs are engaged to provide on-site primary dental care services (e.g. oral health assessment and care planning) to the eligible elderly residing in residential care homes or using services in day care centres (see Appendix E). For curative treatments which cannot be done on-site, the NGOs will arrange escort service for the elderly to receive treatments at NGO dental clinics. On-site training on oral care is also provided to the elderly, their caregivers and families. For the provision of the Programme, the DH has engaged 11 NGOs under a three-year Funding and Service Agreement, covering the period from October 2014 to September 2017;

(b) ***CCF's Elderly Dental Assistance Programme.*** The Programme, launched in September 2012 under the CCF, provides free removable dentures and other related dental services (including oral examination, scaling and polishing, fillings, tooth extractions and X-ray examination) to low-income eligible elderly persons (see Appendix E). As at 30 September 2016, 415 private dentists and 98 dentists from dental clinics operated by NGOs had participated in the Programme as service providers (i.e. providing dentures and the related dental services). The CCF reimburses the participating dentists and NGOs for the services provided; and

(c) ***FHB's pilot project on dental service for patients with intellectual disability.*** In August 2013, the FHB launched the pilot project which was scheduled to end in August 2017. Under the pilot project, eligible persons aged 18 or above with intellectual disability (see Appendix E) can receive dental check-ups, dental treatments as well as oral health education at dental clinics of participating organisations. The FHB provides subsidy, subject to an established cap of $19,000 for each

eligible patient (see Appendix E), to the participating organisations for the services provided. In March 2017, the participating organisations comprised a private hospital and three organisations. The FHB was working with the participating organisations to evaluate the overall effectiveness of the pilot project, with a view to formulating an appropriate operational model to continue providing dental services to adults with intellectual disability.

A summary of the dental programmes is at Appendix E (Note 7).

Expenditure on dental services and number of attendance

1.12 In 2015-16, the expenditure on dental services totalled $1,018 million (Note 8). The total number of attendance for dental services (including publicity activities, dental check-ups, dental treatments, etc.) was some 1.5 million (see Table 1 for details). Figures 1 and 2 also show the expenditure and the attendance over the past five years from 2011-12 to 2015-16.

Note 7: *People with special needs may also receive government subsidised dental services under the following two schemes:*

(a) ***Comprehensive Social Security Assistance Scheme.*** *The Scheme, run by the Social Welfare Department, is not a dental programme. However, for recipients of social security assistance aged 60 or above, dental grants may also be provided to those who are disabled or medically certified to be in ill-health. In 2015-16, the number of dental grant cases was 12,466 and the amount of dental grants was about $73 million. This audit review does not cover the Comprehensive Social Security Assistance Scheme which is not a dental programme per se; and*

(b) ***Elderly Health Care Voucher Scheme.*** *The Scheme, run by the DH, provides financial subsidies for elderly persons aged 70 or above to use primary care services in the private sector, including dental services. In 2015-16, about 114,000 claims were made by dentists for services provided under the Scheme, involving about $103 million. An audit review of the Scheme was conducted in 2014, results of which were included in Chapter 2 of the Director of Audit's Report No. 63 of October 2014.*

Note 8: *The amount did not include expenditure on the Hospital Authority's dental services, dental grants under the Comprehensive Social Security Assistance Scheme and claims by dentists under the Elderly Health Care Voucher Scheme.*

Table 1

Expenditure on dental services and number of attendance (2015-16)

Dental service	Provided by	Expenditure ($ million)	Number of attendance
Promotive and preventive services			
Educational and publicity programmes	DH	31	217,422
School Dental Care Service (Note 1)	DH	240	426,826
Sub-total		271	644,248
Dental services for CSEPs			
General dental services	DH	543	648,901
Specialised dental services	DH	55	72,013
Sub-total		598	720,914
Specific dental services for the public			
Emergency dental services (Note 2)	DH	5	39,196
Specialised dental services	DH	53	56,346
Outreach Dental Care Programme for the Elderly	DH	33	48,351
Elderly Dental Assistance Programme (Note 3)	CCF	54	4,959
Pilot project on dental service for patients with intellectual disability (Note 3)	FHB	4	557
Sub-total		149	149,409
Total		**1,018**	**1,514,571**

Source: DH and FHB records

Table 1 (Cont'd)

Note 1: The attendance of School Dental Care Service comprised:

	No.
Primary school students (500,459 less 74,963 — see items (a) & (b) of Table 5 in para. 2.14)	*425,496*
Children (aged under 18) of CSEPs and the Hospital Authority's staff and retirees	*1,330*
	426,826

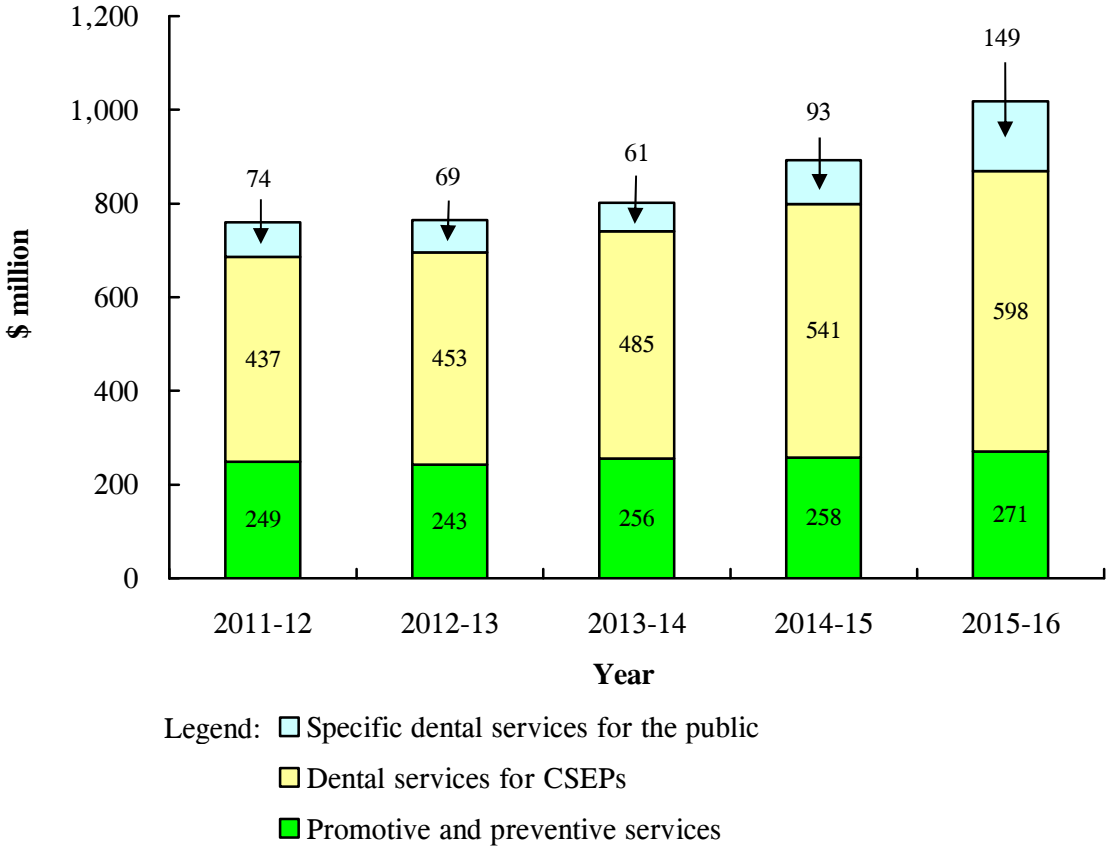
Note 2: The attendance for emergency dental services comprised:

	No.
General Public Session attendance (see Table 10 in para. 4.4)	*34,580*
Attendance for follow-up treatment (e.g. removing stitches)	*1,699*
Inmates' dental attendance	*2,917*
	39,196

Note 3: The programme/project had a higher cost per attendance due to their unique features, i.e. dentures and services were provided by private dentists to elderly persons under the Elderly Dental Assistance Programme, and provision of dental services by a private hospital and three organisations under the pilot project for patients with intellectual disability generally required the use of anesthetics.

Figure 1

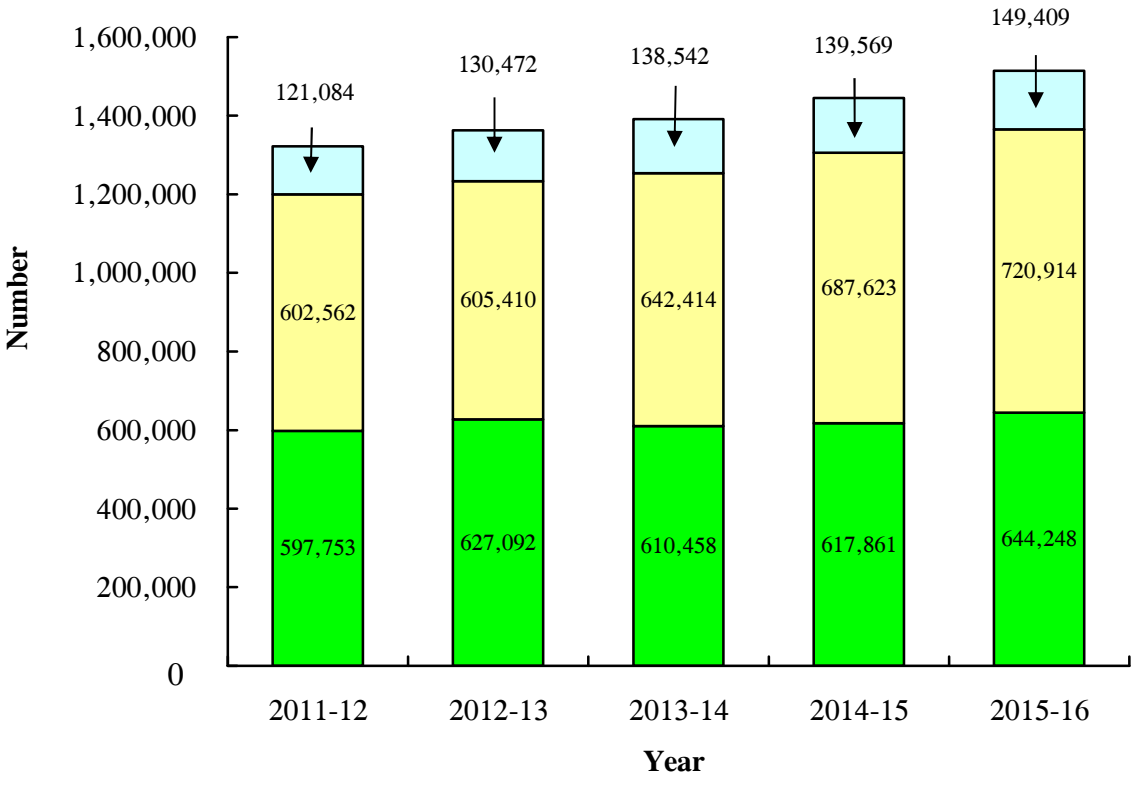
Expenditure on dental services
(2011-12 to 2015-16)



Source: DH and FHB records

Figure 2

Attendance for dental services
(2011-12 to 2015-16)



Source: *DH and FHB records*

Staff for the provision of dental services by the DH

1.13 The clinics and OMSDUs mentioned in paragraph 1.8 belong to the DH's Dental Service. An extract of the DH organisation chart (showing the Service) is at Appendix F. As at 30 September 2016, the Service had 1,319 staff comprising 982 dental personnel and 337 administrative and supporting staff (see Appendix G).

1.14 The 982 dental personnel comprised staff of five different grades:

(a) ***Dental Officer grade (316 staff).*** Dental Officers are dentists who possess a practising certificate issued by the Dental Council of Hong Kong (Note 9). They provide dental treatment to patients and deal with emergency cases;

(b) ***Dental Technician grade (47 staff).*** Dental Technicians work in dental laboratories. They are responsible for the fabrication of dental prostheses;

(c) ***Dental Therapist grade (268 staff).*** Dental Therapists carry out, under the supervision of Dental Officers, simple operative dental work (e.g. simple extraction and preventive measures) on patients below the age of 18. They also provide oral health education;

(d) ***Dental Surgery Assistant grade (338 staff).*** Dental Surgery Assistants assist dentists at the chair side in the treatment and care of patients; and

(e) ***Dental Hygienist grade (13 staff).*** Dental Hygienists undertake, under the supervision of Dental Officers, dental work such as cleaning and polishing of teeth, scaling of teeth, and providing oral health education.

Staff in the Dental Officer grade ((a) above) are dental professional staff. Other staff ((b) to (e) above) are ancillary dental personnel.

Note 9: *The Dental Council of Hong Kong, established under the Dentists Registration Ordinance (Cap. 156), is responsible for the registration of dentists, the conduct of the licensing examination, the maintenance of ethics, professional standards and discipline of the profession. As at February 2017, there were some 2,400 dentists registered under the Council's General Register of Dentists.*

Oral health surveys

1.15 In 2001, the DH conducted a territory-wide oral health survey to collect information in relation to oral health condition of the people in Hong Kong. The survey indicated that the oral health in Hong Kong was found to be in the same ranking as if not better than most developed countries. In 2011, the DH conducted the second oral health survey, which focused on two preventable diseases, namely, tooth decay and gum disease. The 2011 survey showed that the level of oral health in Hong Kong in terms of the degree of tooth loss was among the best compared with many developed countries.

Audit review

1.16 In October 2016, the Audit Commission (Audit) commenced a review to examine the provision of dental services by the Government. The audit has focused on the following areas:

(a) provision of promotive and preventive services (PART 2);

(b) provision of dental services for CSEPs (PART 3);

(c) provision of specific dental services for the public (PART 4); and

(d) attainment of oral health (PART 5).

Audit has found room for improvement in the above areas and has made a number of recommendations to address the issues.

Acknowledgement

1.17 Audit would like to acknowledge with gratitude the full cooperation of the staff of the DH, the FHB and the Home Affairs Bureau during the course of the audit review.

PART 2: PROVISION OF PROMOTIVE AND PREVENTIVE SERVICES

2.1 This PART examines the provision of promotive and preventive services for oral health, focusing on the DH's:

(a) educational and publicity programmes (paras. 2.2 to 2.12); and

(b) School Dental Care Service (paras. 2.13 to 2.24).

Educational and publicity programmes

2.2 The DH's Oral Health Education Unit leads and supports oral health education as well as oral health promotion in the territory. The Unit conducted 20 educational and publicity programmes in 2015-16 to help students establish good oral care habits and promote oral health to the public at large. The programmes were free, each of which aimed to serve a specific target group (see Photographs 3 and 4). Appendix A shows the key programmes.

Photographs 3 and 4

Examples of educational and publicity programmes on oral health

Photograph 3

Poster of a programme for the general public

Photograph 4

A programme for kindergarten students

Source: DH records

Need to monitor the coverage of target groups

2.3 The DH adopted target-specific methods to promote oral health awareness and disseminate oral health messages to target groups. For example:

(a) for kindergarten students, face-to-face activities were arranged for free. The activities were welcomed by schools because oral health practice was a part of their curricula;

(b) for the general public, the Love Teeth Campaign aimed to reach them through different channels (TV advertisements, carnivals and other activities). According to the latest telephone evaluation survey conducted in 2016, 83% of the respondents in a representative sample were aware of the DH's promotional materials and for some messages, over 50% of the

respondents could recall the oral health information after one year. The Campaign provided a seeding effect for disseminating the oral health information and heightening public awareness. Events and activities organised under the Campaign were designed to radiate oral health care messages through the participants and the media, so that they could help spread the messages to the community; and

(c) for primary and secondary school students, the DH adopted the "train-the-trainer" approach, i.e. there were programmes which would nurture oral health promoters at school level who would in turn educate their peers. From 2012 to 2016, there were a total of 336 primary schools participating in the programmes (accounting for 50% of the total number of schools).

2.4 Table 2 shows, for each target group, the attendance at activities of educational and publicity programmes in the period 2011-12 to 2015-16.

Table 2

Attendance of educational and publicity programmes
(2011-12 to 2015-16)

Target group	Attendance at programme activities (No. of people)					Range of attendance (No. of people)	
	2011-12	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**From**	**To**
Kindergarten and nursery students	153,217	185,384	172,427	172,532	177,589	153,217	185,384
Special school students	35	361	89	395	4,768	35	4,768
Primary school students	33,245	29,929	23,235	22,285	25,056	22,285	33,245
Secondary school students	414	333	210	255	1,849	210	1,849
General public	421	1,241	524	6,085	8,160	421	8,160
Overall	187,332	217,248	196,485	201,552	217,422	187,332	217,422

Source: Audit analysis of DH records

As shown in Table 2, the attendance at programme activities fluctuated from year to year. Over 80% of the participants were kindergarten and nursery students and over 10% were primary school students. For the other target groups, the number of participants were comparatively low and fluctuation was considerable. For example, secondary school students' attendance at programme activities fluctuated from 210 people in 2013-14 to 1,849 people in 2015-16.

2.5 Upon enquiry, the DH informed Audit in March 2017 that:

(a) attendance should not be the only measurement of the overall effectiveness of educational and publicity programmes. There are other activities which aim to reach out to the target groups through mass media and electronic means; and

(b) not all educational and publicity programmes involve attendance of the target groups.

2.6 Audit considers that there is a need for the DH to monitor the coverage of target groups by the educational and publicity programmes. In particular, the DH needs to consider setting targets for attendance of the programmes involving physical participation of the target groups, to facilitate measurement of the adequacy of the programmes and identifying room for improvement.

Room for encouraging more kindergartens/nurseries to join Brighter Smiles Playland

2.7 The Brighter Smiles Playland (the Playland) programme provides interactive activities (e.g. role-playing as dentists and learning the use of oral health cleaning aids) for kindergarten 2 (K2) students and nursery 3 (N3) students (i.e. children of four years old). More than 2,200 activity sessions are available for booking by schools every year (Note 10). Audit noted that while the utilisation rates of the Playland had increased from 89% to 92% from 2011/12 to 2015/16 school years respectively (Note 11), the number of K2 and N3 students who did not join the programme had increased from 13,414 in 2011/12 to 16,332 in 2015/16 (see Table 3).

Note 10: *Each activity session, facilitated by DH staff, is conducted in an activity room which can accommodate 30 students. The Playland has altogether three activity rooms (sized 330 square metres in total) which are located in a school dental clinic.*

Note 11: *A school year refers to the period from 1 September to 30 June of the ensuing calendar year.*

Table 3

Utilisation of the Playland activity sessions and number of K2 and N3 students (2011/12 to 2015/16 school years)

	2011/12	2012/13	2013/14	2014/15	2015/16
No. of sessions available (a)	2,316	2,253	2,283	2,265	2,292
No. of sessions booked (b)	2,070	2,067	2,055	2,091	2,112
No. of sessions not utilised (c) = (a) – (b)	246	186	228	174	180
Utilisation rate (d) = (b)/(a) ×100%	89%	92%	90%	92%	92%
No. of K2 and N3 students in Hong Kong (e)	53,977	56,483	56,699	58,738	63,315
No. of K2 and N3 students using Playland (f)	40,563	42,734	42,886	44,281	46,983
No. of K2 and N3 students not using Playland (g) = (e) – (f)	13,414	13,749	13,813	14,457	16,332

Source: Audit analysis of DH records

2.8 In February 2017, the DH informed Audit that there were kindergartens/nurseries which had not enrolled in the Playland and therefore their K2/N3 students could not use the Playland services. Audit considers that the DH needs to explore means to encourage those kindergartens/nurseries, which have not enrolled in the Playland, to join the programme so that more students could benefit from Playland activity sessions.

Room for improving utilisation of Bright Smiles Mobile Classroom

2.9 Under the Bright Smiles Mobile Classroom programme, a roving oral health education bus visits different primary schools to enrich the oral health

knowledge of students. Schools can apply for programme services through the Internet. Audit noted that in the 2011/12 to 2015/16 school years, the overall utilisation rate of the programme services was 84%. The number of service days (Note 12) unutilised in the 2011/12 to 2015/16 school years averaged 23 days a year. Nevertheless, 526 primary schools did not use the services in 2015/16 (see Table 4).

Table 4

Utilisation of Bright Smiles Mobile Classroom services and number of primary schools in Hong Kong (2011/12 to 2015/16 school years)

	2011/12	2012/13	2013/14	2014/15	2015/16
No. of service days (a)	161	148	137	117	159
No. of booked days (b)	145	119	118	88	137
No. of service days not utilised (c) = (a) – (b)	16	29	19	29	22
Utilisation rate (d) = (b)/(a) ×100%	90%	80%	86%	75%	86%
No. of primary schools in Hong Kong (Note) (e)	568	569	569	571	572
No. of primary schools using programme services (f)	50	46	38	32	46
No. of primary schools not using programme services (g)= (e) – (f)	518	523	531	539	526

Source: Audit analysis of DH records

Note: The figures refer to the number of primary schools published by the Education Bureau.

Note 12: *Service days exclude non-working days, school holidays and maintenance days of the roving oral health education bus.*

2.10 Audit considers that the DH needs to further promote the services of the Bright Smiles Mobile Classroom, with a view to maximising its utilisation and benefiting more schools.

Audit recommendations

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

(a) **consider setting targets for attendance at activities of educational and publicity programmes involving physical participation of the target groups to facilitate measurement of the adequacy of the programmes and identifying room for improvement;**

(b) **explore means to encourage those kindergartens/nurseries, which have not enrolled in the Playland, to join the Playland so that more students could benefit from Playland activity sessions; and**

(c) **further promote the services of the Bright Smiles Mobile Classroom, with a view to maximising its utilisation and benefiting more schools.**

Response from the Government

2.12 The Director of Health generally agrees with the audit recommendations. She has said that target(s) for attendance can be set for educational and publicity activities involving physical participation of the target groups. Such target(s) will serve as one of the benchmarks for evaluating the effectiveness of activities concerned.

School Dental Care Service

2.13 The School Dental Care Service aims to promote good oral hygiene and prevent common dental diseases. All primary schools (including special schools) and their students can join the Service on a voluntary basis (Note 13). Key services provided include oral health education (see Photograph 5), annual dental check-ups (see Photograph 6), and basic and preventive dental treatments (e.g. scaling and filling). In the 2015/16 service year, 623 schools and some 325,000 students joined the Service.

Photographs 5 and 6

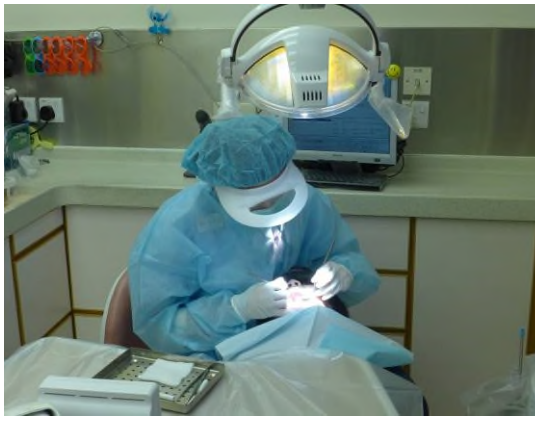
Examples of services provided under the School Dental Care Service

Photograph 5

Oral health education

Photograph 6

A dental check-up



Source: DH records

Note 13: *Primary school students, as well as special school students with intellectual disability and/or physical disabilities under the age of 18 are eligible to join the programme. Students of participating schools can join the programme through their schools. Students of non-participating schools can also join the programme directly with the DH.*

Appointments not attended as scheduled

2.14 Under the School Dental Care Service, students made about 500,000 dental appointments a year. Audit noted that many students did not show up at the appointments to receive the dental services as scheduled. In the 2011/12 to 2015/16 service years, the number of unattended appointments increased by 14,260 from 60,703 in 2011/12 to 74,963 in 2015/16. Moreover, the proportion of appointments which were left unattended had also increased from 12.9% in 2011/12 to 15% in 2015/16 (see Table 5).

Table 5

Dental appointments of the School Dental Care Service
(2011/12 to 2015/16 service years)

	2011/12	**2012/13**	**2013/14**	**2014/15**	**2015/16**
No. of appointments made (a)	469,591	469,146	474,846	481,671	500,459
No. of appointments unattended (b)	60,703	60,843	62,384	66,679	74,963
Proportion of appointments unattended (c)=(b)/(a)×100%	12.9%	13.0%	13.1%	13.8%	15.0%

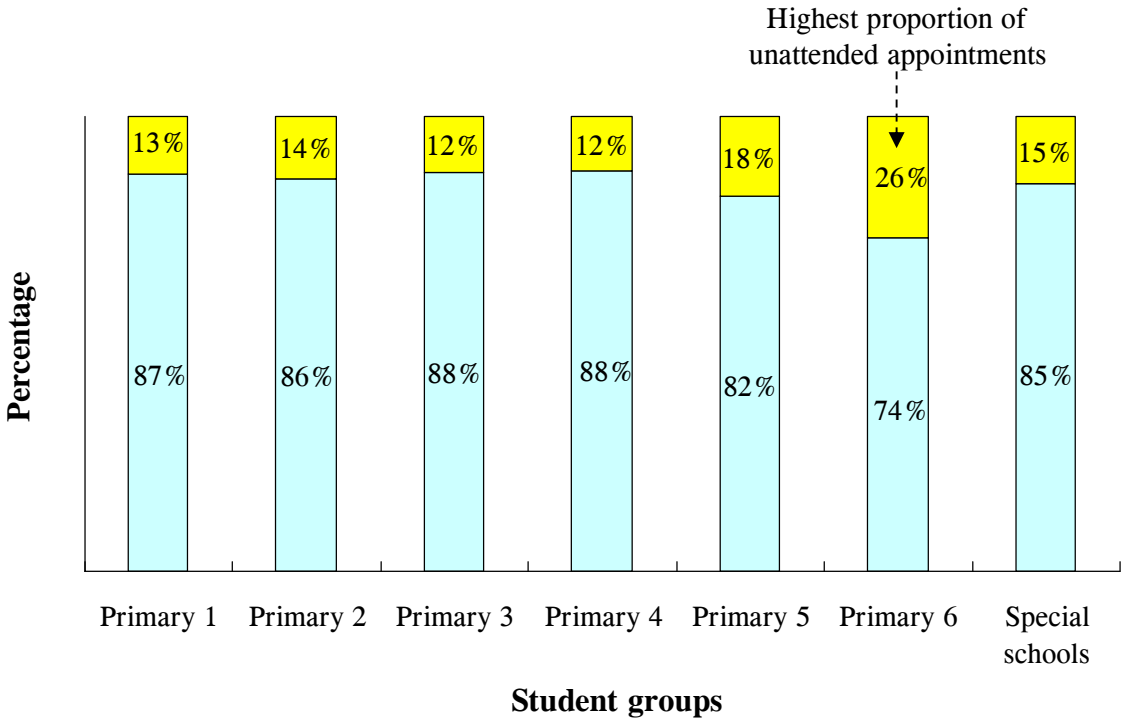
Source: Audit analysis of DH records

2.15 Audit analysed the dental appointments made under the Service in 2015/16 and found that:

(a) the proportion of Primary 6 students not attending scheduled appointments was the highest at 26%. For other students, the proportion ranged from 12% to 18% (see Figure 3); and

Figure 3

Dental appointments of different student groups
(2015/16 service year)

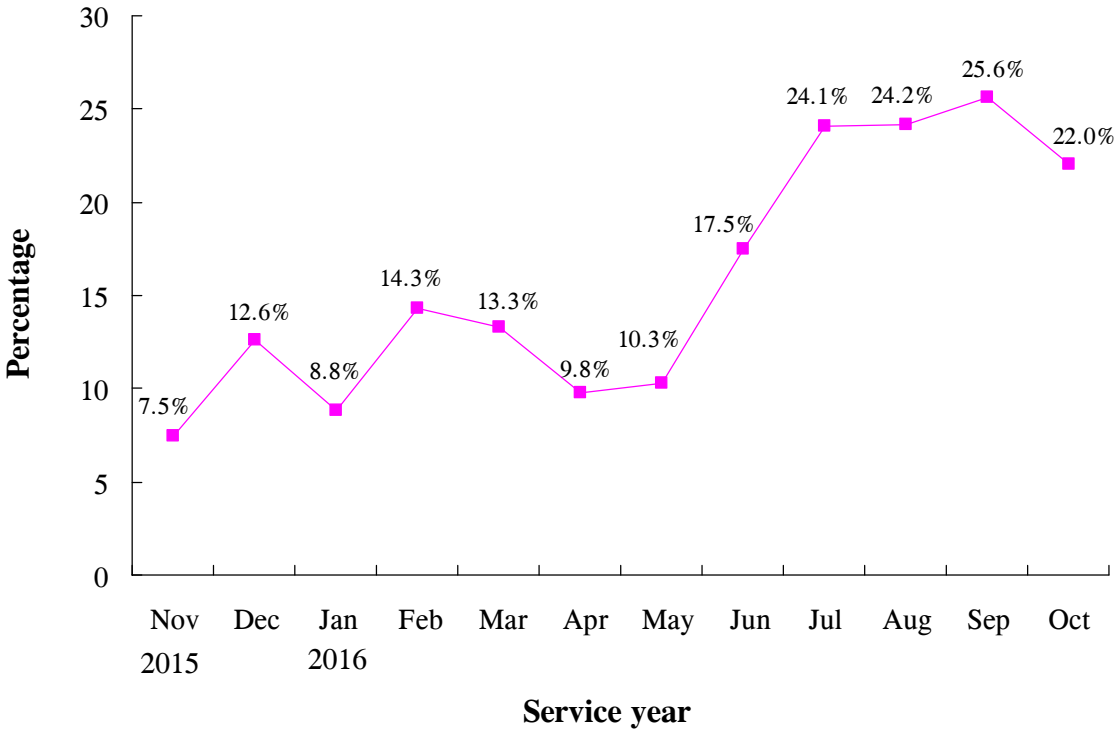


Source: *Audit analysis of DH records*

(b) appointments were more likely to be unattended as the service year went by, with seasonal peaks in months where there were school examinations (e.g. June) and long holidays (e.g. December, February, July and August) (see Figure 4).

Figure 4

Monthly percentage of dental appointments unattended (2015/16 service year)



Source: Audit analysis of DH records

2.16 During the course of audit, the DH informed Audit that the DH was well aware of the proportions of unattended appointments as mentioned in paragraphs 2.14 and 2.15. The situation was actually mitigated to a certain extent by over-booking so that unattended slots would be filled up as far as possible. The unattended slots would also be filled up by unscheduled walk-in appointments.

2.17 Audit also noted that some practices might not have provided students sufficient incentives to not miss their scheduled dental appointments:

(a) the School Dental Care Service provided round-trip transport for Primary 1 to 5 students to attend scheduled appointments for dental check-ups during school hours. According to the DH, school examinations and academic activities might have priority over attending dental consultations for Primary 6 students. Dental appointments were therefore scheduled outside school hours for them. Primary 6 students had to make their own transportation arrangements to attend the appointments (Note 14);

(b) the School Dental Care Service had an appointment reminder service via e-mail, which was available through registration on its website. However, registration for the service was made on a voluntary basis and utilisation of the service was not high. As at 1 February 2017, the number of registered users was only about 16,000 (out of a total of 325,000 eligible students); and

(c) students were charged a low nominal annual fee of $20 for the School Dental Care Service. The fee had not been revised for some time and students were heavily subsidised (see paras. 2.19 to 2.22).

2.18 According to the DH, regular dental check-ups (which were on a voluntary basis) were recommended for maintaining good oral health. In Audit's view, the particularly high proportion of Primary 6 students not attending scheduled appointments for dental check-ups is a cause for concern. The DH needs to explore appropriate measures to encourage students' attendance, such as providing bus services for Primary 6 students, promoting on-line registration for the appointment reminder service, and reminding students to attend appointments through mobile messaging applications.

Note 14: *For special school students, to meet their special needs, transport arrangements were made by the schools concerned.*

Target levels of cost recovery not achieved

2.19 The annual fee for the School Dental Care Service is $20 for eligible students and $605 for non-eligible students (Note 15). These fees were set in 1993 and 2003 respectively. The Service is heavily subsidised by the Government (Note 16). Audit noted that:

(a) while the Service was mainly preventive in nature, it also had a curative element. As agreed between the DH and the Financial Services and the Treasury Bureau (FSTB), 70% of the cost of School Dental Care Service was for preventive treatments whereas the remaining 30% was for curative treatments. For eligible students, preventive treatments were not to be charged, and the target level of cost recovery for curative treatments was 20%. Non-eligible students were to be fully charged for both preventive treatments and curative treatments;

(b) based on the aforesaid principles, the DH prepared a costing statement in April 2014. The statement indicated that the target cost to be recovered from an eligible student was $64 (i.e. full cost of $1,061 × 30% for curative treatments × 20% cost recovery rate), against the existing fee of $20. Moreover, the cost to be recovered from a non-eligible student was $1,061, against the existing fee of $605; and

(c) the fees, however, had not been revised. Accordingly, the target levels of cost recovery had not been achieved. The percentage of target cost recovered was only 31% (i.e. $20 out of $64) for eligible students and 57% (i.e. $605 out of $1,061) for non-eligible students.

Note 15: *Non-eligible students include the following persons:*

(a) students who were born in Hong Kong but their permanent resident status is not established; and

(b) students who were not born in Hong Kong and are holding valid travel documents with a "visitor" or "two-way permit holder" status.

Note 16: *In 2015-16, revenue from annual fees of the programme was about $6.4 million while the total programme expenditure was $240 million.*

2.20 According to Financial Circular No. 6/2016, Directors of Bureaux and Controlling Officers should aim at achieving the agreed targets for cost recovery as early as possible. Moreover, according to the 2013-14 Budget Speech, to prevent cost-recovery items from turning into heavily subsidised items, fees and charges should be reviewed, in particular those that had not been revised for many years and did not directly affect people's livelihood, as well as those that had low cost-recovery rates.

2.21 Upon enquiry, the DH informed Audit in February 2017 that:

(a) the DH had reviewed regularly the annual fee for the School Dental Care Service;

(b) about revising the fees, as stated in the 2013-14 Budget Speech and the 2014-15 Budget Speech, the Government would first deal with fees that did not directly affect people's livelihood. Against this background, it was the DH's understanding that fee reviews of the School Dental Care Service should be completed after the reviews of other non-livelihood items; and

(c) the DH had from time to time consulted with the FHB and the FSTB about fee-related matters. The DH and the FHB planned to further seek the FSTB's clarification on handling reviews of livelihood-related fees based on prudence principle.

In this connection, Audit noted that as mentioned in the 2015-16 Budget Speech, the Government had also started to review livelihood-related fees and charges from 2015-16.

2.22 Audit considers that the DH needs to, in consultation with the FHB, determine whether the fees for the School Dental Care Service should be revised.

Audit recommendations

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

(a) **explore appropriate measures to encourage Primary 6 students' attendance at appointments of the School Dental Care Service; and**

(b) **in consultation with the FHB, determine whether the fees for the School Dental Care Service should be revised.**

Response from the Government

2.24 The Director of Health generally agrees with the audit recommendations.

PART 3: PROVISION OF DENTAL SERVICES FOR CIVIL SERVICE ELIGIBLE PERSONS

3.1 This PART examines the provision of dental services for CSEPs, focusing on:

(a) provision of general dental services (paras. 3.2 to 3.14); and

(b) provision of new surgeries at dental clinics (paras. 3.15 to 3.19).

Provision of general dental services

3.2 The Government has been providing dental services for CSEPs as a condition of service since the 1940s. As at 29 February 2016, the total number of CSEPs was 532,163 (Note 17). These persons, if in need of general dental services (e.g. annual check-ups), are required to book an appointment with one of the 38 government dental clinics.

3.3 The DH monitors the waiting time for general dental services provided to CSEPs. For this purpose, waiting time refers to the period of time that a dental appointment has to be booked in advance.

Waiting more than six months for first-time appointments

3.4 In its Controlling Officer's Report, for new cases (i.e. first-time appointment) of general dental services, the DH has set a target that "appointment time for new dental cases within six months" should be met in more than 90% of the cases. Records indicated that, for the years from 2013 to 2016, the DH was

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Note 17: *In the ten-year period from 2007 to 2016, the total number of CSEPs increased by 9% from 489,471 to 532,163. According to a projection submitted by the Civil Service Bureau to the Legislative Council Panel on Public Service in May 2015, some 86,000 civil servants would be retiring in the 15-year period from 2017-18 to 2031-32. The increasing trend in the number of CSEPs will likely continue in the coming years.*

able to meet this performance target. Upon enquiry, the DH informed Audit in February 2017 that:

(a) for more than 90% of new dental cases, the DH was able to offer a first-time appointment to CSEPs at clinics with a waiting time of not longer than six months. For clinics which had a waiting time of more than six months, the clinics concerned would refer their new cases to other clinics which had shorter waiting time; and

(b) some CSEPs, however, might decline to take up the DH's referral offers and opt for appointments at some other dental clinics that they preferred. In determining whether the performance target was met, the DH adopted an approach where patients who declined to take up appointments at dental clinics with a waiting time within six months would be regarded as refusal cases. These cases would not be counted in assessing the DH's performance in meeting the performance target. This approach had been agreed with the Civil Service Bureau.

3.5 To ascertain how long CSEPs had actually waited for their first-time appointments, Audit analysed the new cases which were yet to be served as at 1 January 2013 and 1 January 2016. Table 6 shows that for a large proportion of cases, the waiting time for first-time appointments was more than six months. The number of new cases waiting to be served had increased from 943 as at 1 January 2013 to 1,501 as at 1 January 2016 (a 59% increase), and the proportion of cases with waiting time more than six months had increased from 34% as at 1 January 2013 to 46% as at 1 January 2016. Audit noted that 82% of the CSEPs who were offered a referral to other clinics on 1 January 2013 had declined the referral. For those offered a referral on 1 January 2016, 90% of them had declined the referral.

Table 6

Waiting time for first-time appointments
(1 January 2013 and 1 January 2016)

Waiting time	New cases waiting to be served			
	1 January 2013 (No. of cases)		1 January 2016 (No. of cases)	
≤ 3 months	0	618 (66%)	1	804 (54%)
> 3 months to ≤ 6 months	618		803	
> 6 months to ≤ 9 months	74	325 (34%)	211	697 (46%)
> 9 months to ≤ 12 months	105		76	
> 12 months	146		410	
Total	943	100%	1,501	100%

Source: Audit analysis of DH records

3.6 The DH needs to investigate the reasons for the increasing proportion of CSEPs declining referrals to other clinics with shorter waiting time for new cases (see para. 3.5) and, taking into account the results of the investigation, explore the feasibility of shortening the waiting time for first-time dental appointments.

Scope for shortening the waiting time for subsequent appointments

3.7 Subsequent to first-time appointments, CSEPs may book further appointments for dental services. Such services comprise dental treatments and annual check-ups.

3.8 Audit analysed the waiting time for subsequent dental appointments. The analysis covered individual government dental clinics, namely, the 36 clinics as at 1 January 2013 and the 37 clinics as at 1 January 2016. Audit's analysis indicated that in general there were improvements in waiting time. The average waiting time for dental treatments had decreased from 10.2 months as at 1 January 2013 to 8.5 months as at 1 January 2016, and that for annual check-ups had decreased from 12.7 months as at 1 January 2013 to 11.7 months as at 1 January 2016. Upon enquiry, the DH informed Audit in February 2017 that over the years, the DH had

implemented a number of measures with a view to improving the waiting time. For example, clinics of longer waiting time had been paired up with those of shorter waiting time for transferring CSEPs from the former to the latter. Another example was the issuing of letters to CSEPs inviting them to switch to other clinics with less demand for dental services. Audit, however, noted that:

(a) ***Waiting time for annual check-ups exceeding one year.*** In four clinics, the waiting time for annual check-ups as at 1 January 2016 was still over one year (13 to 14 months — see Table 7); and

Table 7

Waiting time of over one year for annual check-ups at four clinics (As at 1 January 2013 and 1 January 2016)

Clinic	As at 1.1.2013	As at 1.1.2016	Improvement over 1.1.2013
	Waiting time (Note) (No. of months)		
Yan Oi Dental Clinic	15	14	1 (6.7%)
Yuen Long Jockey Club Dental Clinic	13	13	0 (0%)
Fanling Health Centre Dental Clinic	14	13	1 (7.1%)
Tai Po Wong Siu Ching Dental Clinic	14	13	1 (7.1%)

Source: Audit analysis of DH records

Note: According to the DH, an interval of 12 months between dental check-ups is generally satisfactory. However, for those whose oral condition is at risk and for those having special needs, a shorter interval (e.g. 6 months) between dental check-ups may be necessary.

(b) ***Wide variations in waiting time.*** As at 1 January 2016, the waiting time for dental treatments at different clinics ranged from 2 months to 18 months, and that for annual check-ups ranged from 9 months to 14 months. Table 8 shows the waiting time among clinics.

Table 8

Waiting time for dental treatments and annual check-ups
(1 January 2016)

Waiting time (No. of months)	Dental treatment (No. of clinics)	Annual check-up (No. of clinics)
1 to 3	2 (5%) (Note 1)	0 (0%)
4 to 6	10 (27%)	0 (0%)
7 to 9	14 (38%)	1 (3%)
10 to 12	7 (19%)	31 (86%)
13 to 15	1 (3%)	4 (11%) (Note 2)
16 to 18	3 (8%) (Note 3)	0 (0%)
Total	37 (100%)	36 (100%) (Note 4)

Source: Audit analysis of DH records

Note 1: The two clinics were the Western Dental Clinic (2-month waiting time) and the Tai O Dental Clinic (2-month waiting time).

Note 2: The four clinics were the Yan Oi Dental Clinic (14-month waiting time), the Yuen Long Jockey Club Dental Clinic (13-month waiting time), the Fanling Health Centre Dental Clinic (13-month waiting time) and the Tai Po Wong Siu Ching Dental Clinic (13-month waiting time).

Note 3: The three clinics were the Yuen Long Jockey Club Dental Clinic (18-month waiting time), the Yan Oi Dental Clinic (17-month waiting time) and the Fanling Health Centre Dental Clinic (16-month waiting time).

Note 4: Of the 37 clinics, only 36 provided the annual check-up service.

3.9 The long waiting time for subsequent dental appointments at some clinics was less than satisfactory. The DH needs to monitor the waiting time for subsequent dental appointments and take further action to shorten the waiting time as appropriate (e.g. consider relocating services among clinics to improve the service capacity of clinics with high service demand). The DH also needs to explore ways to further encourage CSEPs to switch to dental clinics with less demand for subsequent dental appointments.

Need to consider extending a trial scheme

3.10 Against the wide variations in waiting time among clinics, in May 2016, the DH implemented a trial scheme to cease the intake of new cases by two clinics (i.e. the Tai Po Wong Siu Ching Dental Clinic and the Yan Oi Dental Clinic). CSEPs approaching the two clinics for the first time would be redirected to other clinics which had a shorter waiting time.

3.11 Audit noted that apart from the two clinics included in the trial scheme, there were also other clinics that had long service queues. For example, as at 1 January 2016:

(a) the Yuen Long Jockey Club Dental Clinic had a 13-month waiting time for annual check-ups and an 18-month waiting time for dental treatments; and

(b) the Fanling Health Centre Dental Clinic had a 13-month waiting time for annual check-ups and a 16-month waiting time for dental treatments.

3.12 Upon enquiry, the DH informed Audit in February 2017 that it was the DH's plan to implement the trial scheme for six months from May 2016. As a prudent approach, only two clinics were involved as a start. Based on the initial results, the DH was of the view that the trial scheme should be continued to operate at the two clinics (see para. 3.10), subject to review in another six months' time. The DH also informed Audit that it would consider, in consultation with the Civil Service Bureau, the need to extend the trial scheme to other clinics.

Audit recommendations

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

(a) **investigate the reasons for the increasing proportion of CSEPs declining referrals to other clinics with shorter waiting time for new cases and, taking into account the results of the investigation, explore the feasibility of shortening the waiting time for first-time dental appointments;**

(b) **monitor the waiting time for subsequent dental appointments and take further action to shorten the waiting time as appropriate;**

(c) **explore ways to further encourage CSEPs to switch to dental clinics with less demand for subsequent dental appointments; and**

(d) **keep in view the results of the trial scheme to stop the intake of new cases at selected clinics, with a view to determining in a timely manner whether to extend the trial scheme to other clinics.**

Response from the Government

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

(a) CSEPs have different preferences for attending dental clinics. The DH has used different strategies to address the different demands and waiting time among the dental clinics. The DH will keep monitoring the waiting time for the provision of dental services to CSEPs and continue the efforts to identify suitable locations for the provision of dental services to them, with a view to meeting the high demand for dental services in specific districts; and

(b) the DH attaches great importance to the dental care of CSEPs. The waiting time of scheduled appointments will not adversely affect their need for immediate dental treatments. The DH has accorded priority to providing treatments to CSEPs with urgent conditions. All government

dental clinics will provide emergency dental services to them and they could normally receive treatments within the same sessions of attendance.

Provision of new surgeries at dental clinics

3.15 To meet service needs, the DH has planned to provide additional dental surgeries at 11 government dental clinics. The new surgeries aim to provide general dental services for CSEPs. According to the DH's plan, a total of 64 new surgeries would commence operation in the period 2011-12 to 2015-16 (Note 18).

Surgeries not commencing operation as planned

3.16 Of the 64 planned new surgeries, 11 (17%) had not commenced operation as at 30 October 2016. For four surgeries, the delay in operation was over one year (see Table 9). Upon enquiry, in December 2016 and March 2017, the DH informed Audit that seven of the 11 surgeries did not commence operation as scheduled because the premises were being occupied by other user departments and pending handover to the DH. For the remaining four surgeries, there were unexpected delays in fitting out some surgeries (e.g. due to site constraints and technical problems), and that sufficient Dental Officers could not be recruited to operate the completed surgeries. In this connection, Audit noted that the DH conducted one recruitment exercise in each of the three years between 2014 and 2016, but not all the vacancies of Dental Officers could be filled. The DH also informed Audit in February 2017 that it had strategically redeployed manpower to man the surgeries where service demand was high, and had deferred the opening of certain new surgeries where service demand was low. The DH was also exploring other means to supplement the workforce of Dental Officers (Note 19). According to the DH, it was its plan that the four surgeries would commence operation in March 2017.

Note 18: *As at 31 January 2017, of the 64 planned new surgeries, the estimated project cost (including, for example, expenditure for fitting-out and furniture and equipment) of 43 surgeries totalled $68 million. DH records did not provide the estimated project cost of the remaining 21 surgeries.*

Note 19: *According to the DH, in addition to civil service recruitment, it was exploring other means such as hiring part-time/full time contract Dental Officers.*

Table 9

Delay in operation of surgeries
(30 October 2016)

Year within which operation was planned to commence (Note)	No. of new surgeries		Delay (No. of years)
2012-13	2	4 surgeries with delay over 1 year	3 to 4
2014-15	2		1 to 2
2015-16	7		Less than 1
Total	11		

Source: DH records

Note: The DH's plan (see para. 3.15) stated the year of planned commencement of operation, but did not state the exact date of commencement. For audit analysis, the planned commencement date was taken to be the end of the financial year concerned.

3.17 In view of the long waiting time for dental services (see paras. 3.4 to 3.9), there is a need for new surgeries to commence operation in a timely manner. The DH needs to closely monitor the progress of the provision of the new surgeries, and take prompt remedial action where warranted. The DH also needs to continue to explore effective means to meet the manpower requirements for the new surgeries.

Audit recommendations

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

(a) **closely monitor the progress of the provision of new surgeries, and take prompt remedial action where warranted; and**

(b) **continue to explore effective means to meet the manpower requirements for the new surgeries.**

Response from the Government

3.19 The Director of Health agrees with the audit recommendations.

PART 4: PROVISION OF SPECIFIC DENTAL SERVICES FOR THE PUBLIC

4.1 This PART examines the provision of specific dental services for the public, focusing on:

(a) emergency dental services for the public (paras. 4.2 to 4.7);

(b) Outreach Dental Care Programme for the Elderly (paras. 4.8 to 4.24); and

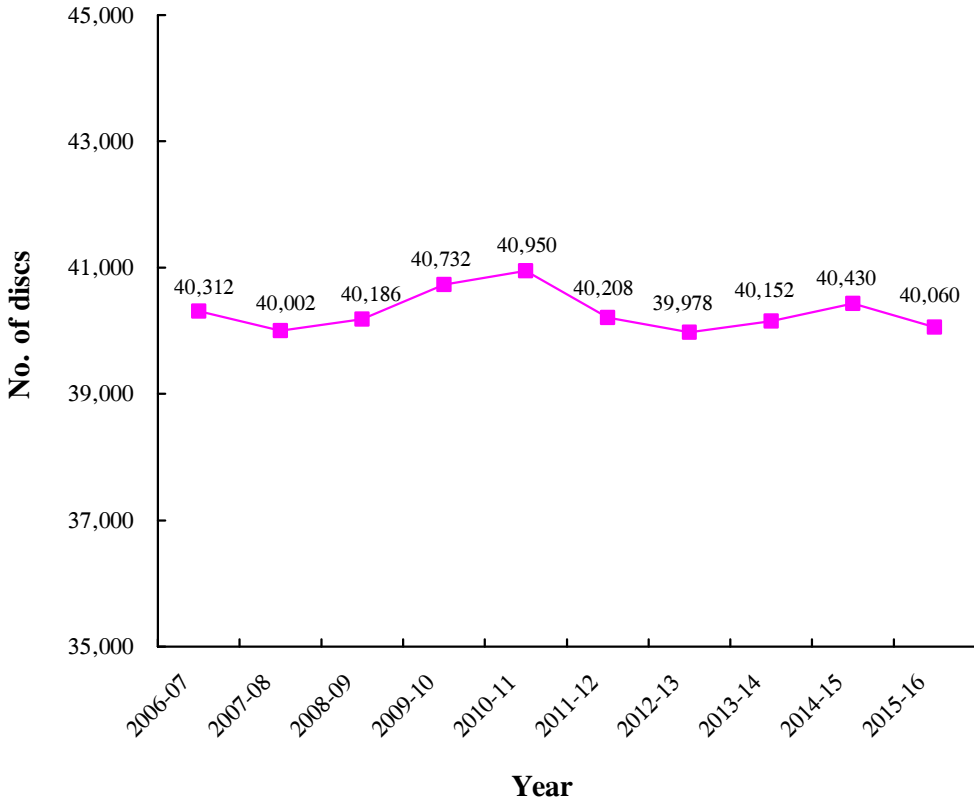
(c) Elderly Dental Assistance Programme (paras. 4.25 to 4.39).

Emergency dental services for the public

4.2 The Government provides emergency dental services in designated sessions on designated days of the week (hereinafter referred to as General Public Sessions) at 11 government dental clinics (see Appendix D). A quota has been set for each General Public Session (see Appendix H). Patients seeking emergency dental services are treated on a first-come-first-served basis. They are required to obtain a disc from one of these government dental clinics. Disc distribution stops when all discs are given out. In the past ten years from 2006-07 to 2015-16, the General Public Sessions of the 11 government dental clinics had a total quota of about 40,000 discs a year (see Figure 5).

Figure 5

DH's disc quota for General Public Sessions (2006-07 to 2015-16)



Source: Audit analysis of DH records

Utilisation of General Public Sessions to be maximised

4.3 According to a survey conducted by the DH in 2014 concerning the General Public Sessions (Note 20), some 23% of the respondents seeking emergency dental services had the experience of failing to obtain a disc from a government dental clinic and were turned away.

Note 20: *The survey, which covered 1,278 respondents, was the latest one conducted by the DH about the utilisation pattern of the General Public Sessions.*

4.4 On the other hand, the disc quota was not always fully utilised. For example, in 2015-16, the General Public Sessions had an overall utilisation rate of 86.3%. The unutilised disc quota for the year totalled 5,480 discs, representing 13.7% of the total disc quota of 40,060. Three of the 11 dental clinics had a high percentage (25.2% to 74.7%) of unutilised disc quota (see Table 10).

Table 10

Utilisation of disc quotas for General Public Sessions (2015-16)

Government dental clinic	Disc quota (No. of discs)				
	Total	Utilised		Unutilised	
Tai O Dental Clinic	384	97	25.3%	287	74.7%
Cheung Chau Dental Clinic	384	192	50.0%	192	50.0%
Kennedy Town Community Complex Dental Clinic	7,896	5,905	74.8%	1,991	25.2%
Kowloon City Dental Clinic	6,090	5,177	85.0%	913	15.0%
Tsuen Wan Government Offices Dental Clinic	8,148	7,193	88.3%	955	11.7%
Fanling Health Centre Dental Clinic	2,500	2,218	88.7%	282	11.3%
Mona Fong Dental Clinic	2,142	1,952	91.1%	190	8.9%
Tai Po Wong Siu Ching Dental Clinic	2,142	1,978	92.3%	164	7.7%
Yuen Long Jockey Club Dental Clinic	4,074	3,769	92.5%	305	7.5%
Kwun Tong Dental Clinic	4,200	4,028	95.9%	172	4.1%
Yan Oi Dental Clinic	2,100	2,071	98.6%	29	1.4%
Overall	40,060	34,580	86.3%	5,480	13.7%

Source: Audit analysis of DH records

4.5 The total unutilised quota of 5,480 discs (see Table 10) was a matter of concern. It was particularly unsatisfactory that the three dental clinics mentioned in paragraph 4.4 accounted for 2,470 (287 + 192 + 1,991) unutilised discs (i.e. 45% of the total 5,480 unutilised quota).

Audit recommendation

4.6 **Audit has *recommended* that the Director of Health should explore ways to maximise the utilisation of General Public Sessions to better meet the public demand with existing resources.**

Response from the Government

4.7 The Director of Health agrees with the audit recommendation.

Outreach Dental Care Programme for the Elderly

4.8 Since April 2011, the Government has promoted the Outreach Dental Care Programme for the Elderly (Note 21). Under the Programme, NGOs are engaged to provide outreach dental services to eligible service users at residential care homes for the elderly and day care centres for the elderly (see Appendix E). The NGOs conduct the Programme through their outreach dental teams, whose team members are NGO staff including dentists. Services of the Programme include on-site oral health assessment (see Photograph 7) and provision of oral care training (e.g. oral health talks) to caregivers (see Photograph 8). For curative treatments that cannot be performed on-site, the NGOs shall arrange escort service for the elderly persons to receive treatments at the NGOs' dental clinics.

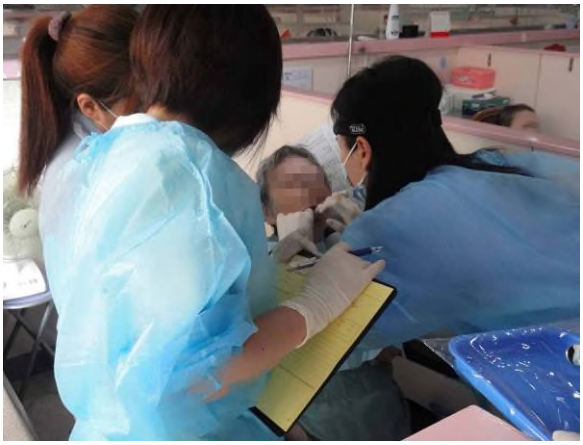
Note 21: *During April 2011 to September 2014, the Government provided outreach dental services to the elderly through the FHB's "Pilot Project on Outreach Primary Dental Care Services for the Elderly in Residential Care Homes and Day Care Centres". In October 2014, the DH's Outreach Dental Care Programme for the Elderly was launched as a regular programme to replace the FHB's pilot project.*

Photographs 7 and 8

Examples of services provided under the Outreach Dental Care Programme for the Elderly

Photograph 7

An on-site oral health assessment



Photograph 8

An oral care training activity

Source: DH records

4.9 For the period October 2014 to September 2017, the DH has engaged 11 NGOs (22 teams in total, each comprising at least a dentist and a dental assistant) each under a three-year Funding and Service Agreement to provide the elderly persons concerned with services covered by the Programme (Note 22). The DH has assigned to each NGO a list of residential care homes/day care centres that the NGO would need to provide outreach dental services during the period. All residential care homes, day care centres and their respective service users may join the Programme on a voluntary basis.

Need to improve service coverage

4.10 A service year for the Outreach Dental Care Programme for the Elderly starts on 1 October and ends on 30 September of the ensuing calendar year. According to the service requirements, for each service year:

Note 22: *The DH conducted an open invitation and received applications from 11 NGOs, all of which were assessed to be suitable for providing the Programme.*

(a) an NGO needs to invite all its responsible residential care homes and day care centres to participate in the Programme; and

(b) each outreach dental team needs to meet the target of providing on-site services to at least 1,000 elderly persons.

4.11 Audit examined the provision of services by the NGOs in the 2015/16 service year and noted that:

(a) ***Some residential care homes/day care centres did not participate in the Programme.*** Of the 944 residential care homes/day care centres that had been assigned to the 11 NGOs, 182 (19%) homes/centres did not participate in the Programme in the 2015/16 service year. For three NGOs (NGOs A, B and C), more than 30% of the homes/centres which had been assigned to them did not participate in the Programme in the service year (see Table 11). According to the DH, these residential care homes/day care centres declined to participate in the Programme notwithstanding that the NGOs had introduced the Programme to them;

Table 11

Residential care homes/day care centres not participating in the Outreach Dental Care Programme for the Elderly (2015/16 service year)

NGO	No. of homes/centres		
	Assigned to the NGO	Participated in the Programme	Not participated in the Programme
A	45	20 (44%)	25 (56%)
B	40	21 (53%)	19 (47%)
C	99	67 (68%)	32 (32%)
D	61	47 (77%)	14 (23%)
E	64	52 (81%)	12 (19%)
F	104	87 (84%)	17 (16%)
G	56	47 (84%)	9 (16%)
H	354	308 (87%)	46 (13%)
I	25	22 (88%)	3 (12%)
J	75	71 (95%)	4 (5%)
K	21	20 (95%)	1 (5%)
Overall	944	762 (81%)	182 (19%) (Note)

Source: Audit analysis of DH records

Note: Of the 182 homes/centres, 127 (70%) also did not participate in the Programme in the 2014/15 service year.

(b) ***Oral care training not provided.*** The outreach dental teams visited the 762 residential care homes/day care centres which participated in the Programme in the 2015/16 service year. Returns of the NGOs submitted to the DH indicated that, during the visits to 76 (10%) homes/centres, no oral care training was provided. This was mainly because, according to the DH, many homes/centres declined the offer to receive training; and

(c) ***Target number of elderly persons not served.*** The 22 outreach dental teams served (i.e. providing on-site services — see para. 4.10(b)) a total of 46,337 elderly persons, averaging 2,106 per team, in the 2015/16 service year. For one team, only 868 elderly persons were served, falling short of the required number of 1,000 persons by 132 (13.2%) (Note 23).

4.12 Participation in the Programme is on a voluntary basis (see para. 4.9). Audit considers that the DH needs to look into the reasons why many residential care homes/day care centres declined to receive outreach dental services, and take measures to encourage their participation in the Programme. The DH also needs to ensure that each outreach dental team serves not less than 1,000 elderly persons as required for the effective use of resources.

Many elderly persons did not receive the required treatments

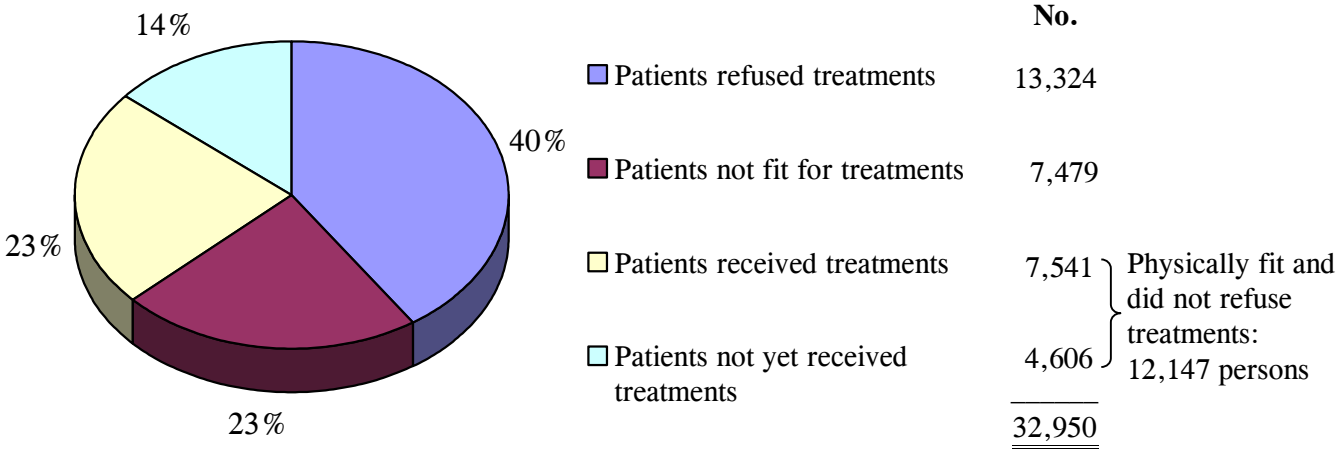
4.13 In the 2015/16 service year, the outreach dental teams served 46,337 elderly persons, and provided on-site oral health assessment to them.

4.14 Through the oral health assessment, the outreach dental teams found that 32,950 elderly persons needed dental treatments. However, many of them refused to receive treatments (13,324 persons) or were not physically fit for treatments (7,479 persons), leaving 12,147 (37%) of the elderly persons who could be provided with dental treatments. As at 31 December 2016, only 7,541 (62%) of the 12,147 elderly persons had received treatments. The remaining 4,606 of the 12,147 elderly persons had not yet received treatments (see Figure 6).

Note 23: *For outreach dental teams of other NGOs, the number of elderly persons served by each team ranged from 1,397 to 2,751.*

Figure 6

Provision of dental treatments to 32,950 elderly persons who needed dental treatments (31 December 2016)



Source: Audit analysis of DH records

4.15 The large number of elderly persons (40%) who refused to accept treatments, notwithstanding that they were physically fit, warrants additional enquiry. Audit also noted that, for the 4,606 patients who were yet to receive treatments, the reasons for not yet providing them with the treatments had not been documented.

4.16 Upon enquiry, the DH informed Audit in February 2017 that:

(a) of the 4,606 patients mentioned in paragraph 4.15 who had not yet received treatments, treatments had been planned for in 4,372 cases. These cases were at different stages of being followed up such as awaiting patients' consent or patients hospitalised. Real-time updating and documentation for these cases was not feasible. For the remaining 234 cases, records showed that treatments were not planned due to other reasons. The exact reasons for these 234 cases, however, had not been documented; and

(b) as already stated in the Oral Health Surveys conducted by the DH in both 2001 and 2011, consideration of dental treatments for frail older people should be balanced between potential harm and benefits. It was an international professional consensus that for treating frail elderly persons, the focus should be on maintaining comfort and functions rather than treating all oral problems.

4.17 Audit considers that there is a need for the DH to ascertain the underlying reasons why many elderly persons who were physically fit had refused to accept treatments under the Programme, and to enhance promotional activities to encourage elderly persons to receive the necessary dental treatments. The DH also needs to closely monitor those cases for which treatments were yet to be provided under the Programme (4,372 cases for the 2015/16 service year — see para. 4.16(a)), so as to ensure that necessary treatments are provided in a timely manner.

Records of dental services not accurately and promptly updated

4.18 For monitoring purposes, the DH has requested the NGOs to adopt the Dental Clinic Management System (DCMS). The DCMS serves as a platform for NGO dentists to plan and record dental services for individual elderly persons (e.g. for recording the results of oral health assessment conducted, dental treatments planned, and dental treatments actually provided). The DH can view the data input by the participating NGOs and generate service statistics reports through another designated system called DCMS-Outreach Reporting Management Service (DCMS-ORMS).

4.19 From time to time, NGOs submitted claims to the DH for reimbursement of dental treatments. Audit selected 40 claims totalling $367,690 submitted in the 2014/15 and 2015/16 service years, and checked against the service statistics reports generated by the DCMS-ORMS. Audit found discrepancies in 10 (25%) cases involving claims of $89,680. Details are as follows:

(a) in 9 cases, the dates of treatment recorded in the DCMS did not match with the information in the claim forms; and

(b) in 1 case, the DCMS indicated that the treatment had been "planned" only, but it did not indicate that the treatment had been performed.

4.20 Upon enquiry, the DH informed Audit in February 2017 that it had verified with the NGOs concerned. The discrepancies in the 10 cases were mainly due to input errors committed by NGO staff (Note 24). Audit considers that records in the DCMS are prime records of dental services rendered by the NGOs. It is important that the records are accurately and promptly updated by the NGOs for the DH's monitoring purposes.

4.21 As at the time of audit in November 2016, Audit also noted that it was not the DH's practice to verify NGOs' claims for payments against records in the DCMS-ORMS. The DH paid NGOs according to their claims and verified their claims later on a sample basis through on-site examinations (see para. 4.22).

Follow-up actions on on-site examinations took considerable time

4.22 After making payments to NGOs, the DH conducts on-site oral examinations of elderly persons to verify NGOs' claims for payments. The examinations are conducted on a sample basis. Audit noted that, for one NGO, follow-up actions on on-site examinations were still in progress after considerable time had elapsed (see Case 1).

Note 24: *According to the DH, for each of the nine cases mentioned in paragraph 4.19(a), the date of entering data into the DCMS had been wrongly recorded as "date of treatment" by NGO staff, which therefore did not match the treatment date in the claim forms. For the case mentioned in paragraph 4.19(b), the NGO did not update the DCMS to indicate that the treatment had been subsequently performed.*

Case 1

Follow-up actions on on-site examinations

1. In the 2014/15 and 2015/16 service years, an NGO provided dental treatments (e.g. fillings for teeth) to elderly persons under the Outreach Dental Care Programme for the Elderly. The DH made payments (averaging $2,507 per case) to the NGO basing on its claims for payments.

2. In November 2015, the DH selected eight claims from the NGO for verification. The DH conducted on-site oral examinations of the elderly persons concerned, and found that the services claimed to have been provided to two elderly persons could not be verified:

Elderly person	Service claimed	Amount claimed ($)	The DH's finding	Response of the NGO
1	Filling for 1 tooth	350	No filling was found in the tooth concerned	The NGO explained that the services had been planned (and hence payment claimed) but subsequently other treatments were provided instead as the oral health condition of the elderly persons had changed.
2	Fillings for 6 teeth	2,100	All the teeth concerned were missing	

3. The NGO acknowledged that its staff had made a mistake in submitting claims for the originally prescribed treatments, without realising that the treatments actually provided was different due to changes of oral condition of the elderly persons concerned. The DH accepted that changes of oral condition among frail older people were common, and that the discrepancies were caused by manual errors without any fraudulent intentions.

4. In December 2015, as a follow-up action to ascertain whether there were other cases of similar errors, the DH requested the NGO to review all its claims and report the review results by January 2016. In March 2016, upon the DH's request, the NGO met with the DH to follow up the matters. In June 2016, the NGO informed the DH that an independent auditor had been engaged to review the claims.

5. In January 2017, the DH received the review results from the NGO. In February 2017, the DH was verifying the results.

Case 1 (Cont'd)

Audit comments

6. While the DH was verifying the review results from the NGO, it was not entirely satisfactory that follow-up actions were not completed over one year after the claims were selected for verification in November 2015. The DH needs to take prompt action to recover any payments for services that have not been provided (e.g. due to changes of oral condition and treatment plans of the elderly persons concerned).

Source: Audit analysis of DH records

Audit recommendations

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

(a) **look into the reasons why many residential care homes/day care centres had declined the outreach dental services, and take measures to encourage their participation in the Outreach Dental Care Programme for the Elderly;**

(b) **ensure that each outreach dental team serves not less than 1,000 elderly persons as required by the Funding and Service Agreement;**

(c) **ascertain the underlying reasons why elderly persons who were physically fit had refused treatments under the Outreach Dental Care Programme for the Elderly;**

(d) **take measures (e.g. enhancing promotional activities) to encourage elderly persons to receive necessary dental treatments;**

(e) **closely monitor those cases for which treatments were yet to be provided under the Outreach Dental Care Programme for the Elderly, so as to ensure that necessary treatments are provided in a timely manner;**

(f) **remind NGOs of the need to accurately and promptly update records of dental services in the DCMS;**

(g) **consider making use of the DCMS-ORMS to substantiate NGOs' claims before making payments to them; and**

(h) **follow up closely the results of the claims review being carried out by the NGO concerned (see Case 1 in para. 4.22), and take prompt action to recover any payments for services that have not been provided.**

Response from the Government

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

(a) the DH will study the reasons for non-participation of residential care homes/day care centres in the Outreach Dental Care Programme for the Elderly and continue to promote their participation;

(b) the DH will encourage the NGOs concerned to provide comprehensive professional advice on the pros and cons of dental treatments to their service users, while respecting the international professional consensus in treating frail elderly persons which is to provide patient-centred dental services, and the informed decision of the patients to refuse treatment after comprehensive explanations; and

(c) the DH had commenced the verification of the NGOs' claims against records in the DCMS-ORMS since December 2016.

Elderly Dental Assistance Programme

4.25 In September 2012, the Elderly Dental Assistance Programme was launched under the CCF. The Programme provides free removable dentures and related dental services (including oral examinations, scaling and polishing, fillings, tooth extractions and X-ray examinations) to low-income eligible elderly persons. On behalf of the former Steering Committee on Community Care Fund (Note 25), the Government appointed Organisation A as the implementing agent of the Programme. Through organising seminars and exhibitions and sending invitation letters, Organisation A invited registered dentists in Hong Kong to join the Programme.

4.26 As at 30 September 2016, 415 private dentists and 98 dentists from dental clinics operated by NGOs participated in the Programme as service providers (i.e. providing dentures and other related dental services). Through Organisation A, the CCF reimburses participating dentists and NGOs for the services provided. Administratively, the FHB helps the CCF oversee the Programme implementation.

Need to encourage participation

4.27 When the Elderly Dental Assistance Programme was launched in September 2012, only recipients of Home Based Services (see Note 2 to Appendix E) were covered. Over the years, coverage of the Programme has been expanded:

Note 25: *In 2013, the CCF was integrated into the work of the Commission on Poverty which replaced the role of the former Steering Committee on Community Care Fund. The CCF Task Force, set up under the Commission on Poverty as chaired by the Chief Secretary for Administration, is responsible for advising the Commission on Poverty on the CCF's various arrangements (including investment, finance and administrative operations), as well as the formulation of assistance programmes, the coordination and overseeing of the implementation of assistance programmes and the evaluation of their effectiveness. Currently, the CCF Task Force comprises 7 members (including the Chairperson) of the Commission on Poverty, 1 vice-chairperson, 14 co-opted members and 6 ex-officio members. The ex-officio members are representatives from the Education Bureau, the FHB, the Home Affairs Bureau, the Home Affairs Department, the Labour and Welfare Bureau and the Social Welfare Department.*

(a) ***May 2013.*** In September 2012, the eligibility criterion was that the elderly persons were using the Home Based Services as at 31 December 2011 (the cut-off date). The cut-off date was extended to 31 December 2012 in May 2013;

(b) ***June 2014.*** The cut–off date was further extended to 31 December 2013;

(c) ***December 2014.*** The cut-off date was removed;

(d) ***September 2015.*** The Programme was expanded to include recipients of Old Age Living Allowance aged 80 or above; and

(e) ***October 2016.*** The age criterion for recipients of Old Age Living Allowance was relaxed from "80 or above" to "75 or above".

4.28 As at 30 September 2016, given the expanded coverage of the Programme, it was estimated that 134,000 elderly persons would be eligible for the Programme (Note 26). However, Audit noted that only 10,733 elderly persons had participated in the Programme, with an overall participation rate of 8% (see Table 12).

Note 26: *Persons eligible for the Programme are those aged 60 or above, being users of the Home Based Services (see Note 2 to Appendix E) who are not receiving assistance under the Comprehensive Social Security Assistance Scheme, or those aged 80 or above (with age criterion relaxed to 75 or above in October 2016) who are receiving Old Age Living Allowance.*

Table 12

Participants of the Elderly Dental Assistance Programme
(30 September 2016)

Target participant	Estimated no. of eligible elderly persons (a)	No. of elderly persons who had participated (b)	Participation rate (c) = (b)/(a) × 100%
Users of Home Based Services	14,000	1,743	12.5%
Recipients of Old Age Living Allowance	120,000	8,990	7.5%
Overall	134,000	10,733	8.0%

Source: Audit analysis of FHB records

4.29 Upon enquiry, the FHB informed Audit in February and March 2017 that:

(a) a number of factors had affected the participation of the Programme. According to the DH's Oral Health Survey conducted in 2011 (see para. 1.15), while about 25% of the elderly persons living in the community (i.e. non-institutionalised elderly persons) had the need to replace missing teeth, only 7% of them perceived the need. This tallied with the actual participation rate of the Programme, and might indicate that the participation rate of elderly persons depended much on their response and willingness to receiving denture services. Furthermore, the participation rate was also subject to other factors such as the service capacity of participating dentists and the matching of elderly persons requiring dental services with participating dentists;

(b) participation of elderly persons in the Programme was on a voluntary basis. The FHB had engaged around 180 district elderly centres/community centres/NGO dental clinics throughout the territory to publicise the Programme to eligible elderly persons on a targeted basis,

and to process applications from elderly persons who were interested in the Programme. Whether or not these elderly persons would eventually choose to participate in the Programme was entirely a personal choice; and

(c) similarly, participation of dentists in the Programme was also on a voluntary basis. Even for those who were willing to participate in the Programme to provide denture services, the caseload they were willing to take up was of their own accord.

4.30 To benefit more elderly persons, Audit considers that there is a need for the FHB to take measures to encourage participation of elderly persons in the Programme.

Need to improve documentation

4.31 Participating dentists and NGO dental clinics submit claims to the CCF for payments on dental services from time to time. Through Organisation A, the CCF pays the participating dentists and NGO dental clinics the dental fees on a reimbursement basis. Currently, the maximum subsidy is $14,390 per patient, which will be adjusted in accordance with the dental grant under the Comprehensive Social Security Assistance Scheme (see Note 7(a) to para. 1.11).

4.32 In September 2015, the Programme coverage was expanded to include recipients of Old Age Living Allowance (see para. 4.27(d)). The pool of beneficiary cases involved were relatively large. Organisation A, in consultation with the FHB, took the initiative to introduce new measures to enhance the verification of claims for payments. Audit noted that the following key measures had been implemented since March 2016:

(a) ***Surveys of elderly persons who had received services.*** A sample of patients (i.e. elderly persons) were surveyed by telephone to ascertain the dental services they had received; and

(b) ***Follow-up action.*** Survey results were compared with the dentists' claims to identify any discrepancies. If irregularities were detected, follow-up

action would be taken (e.g. prima facie cases with fraudulent claims would be referred to the relevant law enforcement authorities).

4.33 In the period March to September 2016, Organisation A conducted surveys in 155 cases. Of the 155 cases, potential discrepancies were identified in 45 cases (29%). Audit noted that of these 45 cases:

(a) for six cases, follow-up action had been taken; and

(b) for the other 39 cases, follow-up action had been considered not necessary. In four of these 39 cases, the justifications for not taking further action could be better documented.

Upon Audit's enquiry, in January and February 2017, Organisation A provided Audit with the justifications for not taking further action on the four cases. Audit considers that, to enhance public accountability, there is a need to improve the documentation of justifications for not taking further action on cases with discrepancies identified in telephone surveys of elderly persons.

High administration cost

4.34 As the implementing agent of the Elderly Dental Assistance Programme, Organisation A received reimbursements from the CCF for administration cost incurred for the Programme. The administration cost is for covering various expenditures, namely:

(a) disbursement of handling fees of $50 per case for processing applications by NGOs;

(b) staff costs incurred in implementing the Programme, such as verifying and arranging payments to participating dentists, handling complaints and enquiries, and conducting random check on claims (as at 30 November 2016, Organisation A employed 18 staff); and

(c) office expenses, such as maintenance of a dental appointment system and related computer services.

4.35 As a general rule, the administration cost of a programme of the CCF is capped within 5% of the estimated total disbursement of the programme. The target is to limit the average administrative cost to less than 5% of the total disbursement on a long-term basis. In this regard, the Commission on Poverty had approved a budget for the Programme whereby the administration cost to be incurred by Organisation A was limited to 5% of the estimated total disbursement of the Programme.

4.36 Audit noted that in the period 2012-13 to 2015-16, the total administration cost spent by Organisation A amounted to $10,700,000, which was equivalent to 18.8% of the Programme's total disbursement of $56,916,000 for the period. Upon enquiry, the FHB informed Audit in February 2017 that:

(a) the administration cost spent by Organisation A as a percentage of disbursement exceeded 5% in the first few years because it included set-up costs (e.g. design and printing of publicity materials, procurement of office equipment, and staffing support for the planning and implementation). With the increase of the number of participants following expansion of the Programme, the share of the administration cost was substantially reduced; and

(b) the unique role played by Organisation A could not be replaced by other agents. As set out in the paper of the former Steering Committee on Community Care Fund, Organisation A, being a non-profit making professional organisation with a vast majority of locally registered dentists as members, was invited to serve as the implementing agent of the Programme. Organisation A was entrusted with the responsibility to co-ordinate with private dentists and NGO dental clinics for active participation in the Programme.

4.37 Nevertheless, given that the total administration cost for the Programme from 2012-13 to 2015-16 was equivalent to 18.8% of the total disbursement, Audit considers that there is a need to further reduce the administration cost with a view to meeting the requirement set by the CCF and improving the economy of scale.

Audit recommendations

4.38 **Audit has *recommended* that the Secretary for Food and Health should:**

(a) **take measures to encourage participation of elderly persons in the Elderly Dental Assistance Programme;**

(b) **improve the documentation of the justifications for not taking further action on cases with discrepancies identified in telephone surveys of elderly persons; and**

(c) **work with Organisation A to further reduce the administration cost with a view to meeting the requirement set by the CCF.**

Response from the Government

4.39 The Secretary for Food and Health generally agrees with the audit recommendations.

PART 5: ATTAINMENT OF ORAL HEALTH

5.1 This PART examines the attainment of oral health in the community.

Oral health goals of the Government

5.2 In March 1989, the Dental Sub-Committee of the Medical Development Advisory Committee was established (Note 27). The Dental Sub-Committee monitored and reviewed factors affecting the provision of oral health services in Hong Kong. In March 1991, the Dental Sub-Committee completed a review on oral health. Recommendations of the review included the setting of a range of oral health goals for different age groups of the community, namely, people who are 5-year-old, 12-year-old, 18-year-old and 35 to 44-year-old. Table 13 shows examples of the oral health goals recommended to be accomplished by 2010 and 2025.

Note 27: *The Medical Development Advisory Committee was appointed by the then Governor of Hong Kong to advise the Government on medical and health services. Members of its Dental Sub-Committee included academics, dentists and government representatives (e.g. officials of the DH).*

Table 13

Examples of oral health goals to be accomplished by 2010 and 2025

Age group	Goal for 2010	Goal for 2025
5-year-old	• 70% people are caries-free (i.e. the teeth show no evidence of decay) • A maximum of 10% people having more than 3 decayed, extracted, filled teeth	• 90% people are caries-free • A maximum of 10% people having more than 3 decayed, extracted, filled teeth
12-year-old	• 70% people are caries-free in their permanent dentition • Decayed, missing and filled teeth (DMF) index (Note) is 1 or less	• 85% people are caries-free in their permanent dentition • DMF index is less than 1
18-year-old	• 60% people are caries-free • DMF index is 2 or less	• 85% people are caries-free • DMF index is less than 1
35 to 44-year-old	• 20% people are caries-free • DMF index is less than 6	• 30% people are caries-free • DMF index is less than 5
Elderly persons (over 65-year-old)	No goals set	No goals set

Source: DH records

Note: The DMF index measures the prevalence of dental caries in an individual. The index is the sum of the number of decayed/missing/filled teeth. In general, the lower the index, the better the oral condition.

5.3 According to a Medical Development Advisory Committee paper issued in 1991 by the then Health and Welfare Branch of the Government Secretariat, the Government had agreed with the recommendations of the Dental Sub-Committee and had the implementation planned.

Oral health goals not totally attained

5.4 Government dental services are mainly provided through the DH (see para. 1.6). The DH leads and supports oral health education as well as oral health promotion in the territory (see para. 2.2). The DH last conducted an Oral Health

Survey in 2011. Audit noted that the survey results indicated that some oral health goals for 2010 had not been attained:

(a) ***5-year-old people.*** Of the 5-year-old people surveyed:

(i) 49.3% were caries-free, thereby not attaining the goal of "70% people are caries-free"; and

(ii) 26.2% had 4 or more "decayed, missing, filled teeth", thereby not attaining the goal of "a maximum of 10% people having more than 3 decayed, extracted, filled teeth"; and

(b) ***35 to 44-year-old people.*** Of the 35 to 44-year-old people surveyed:

(i) 3.9% were caries-free, thereby not attaining the goal of "20% people are caries-free"; and

(ii) the DMF index was 6.9 on the whole, thereby not attaining the goal of "DMF index is less than 6".

5.5 Upon enquiry, the DH informed Audit in February and March 2017 that:

(a) while the DH was aware of the recommendations regarding operational oral health goals proposed by the Dental Sub-Committee of the Medical Development Advisory Committee, the DH internally assessed in 1990 that among all recommendations, some would have direct resources implication which had to be costed. The DH recognised the fact that implementation of some of these proposals may contribute to some improvement in or achievement of the operational oral health goals, although the DH did not actively measure the effectiveness of programmes against the proposed oral health goals;

(b) the DH had focused only on comparing the results of the 2011 Oral Health Survey with those of the previous survey conducted in 2001. Given the change in social factors, it might not be meaningful to draw reference from the oral health goals set 20 years ago. The DH hence did not publish the level of attainment with reference to the oral health goals;

(c) a goal was only the direction whereas assessment of achievement could not rely on goals only because it involved provision of different services; and

(d) survey findings revealed that the oral health condition in Hong Kong was comparable to other developed countries.

Nevertheless, Audit noted that the existing oral health goals had yet to be reviewed and better set (see para. 5.6(a) and (b)).

Room for improving goal setting and evaluation

5.6 The 2010 and 2025 oral health goals were set in March 1991. Audit noted room for improving the setting and evaluation of oral health goals:

(a) ***Oral health goals not reviewed.*** In May 2001 and January 2003, the Legislative Council Panel on Health Services was informed that the Government would review and formulate long-term oral health strategies and goals for the community. As at 31 December 2016, 13 years had elapsed since January 2003, the oral health goals had still not been reviewed. In fact, these goals which were set some 26 years ago in 1991, were likely outdated;

(b) ***Oral health goals not set for elderly persons.*** While elderly persons are a key target group of dental programmes (see paras. 4.8 to 4.39), no oral health goals had been set for them (see Table 13 of para. 5.2). According to the DH, this could possibly be due to the difficulty in setting realistic goals for them (e.g. difficulty in collecting sufficient data from elderly persons might be anticipated at that time), and that there were so many factors which could not be controlled; and

(c) ***Long interval between surveys.*** The DH conducted the first oral health survey in 2001 and the second one in 2011 after an interval of 10 years. Subsequent to these surveys, new international guidelines were published in 2013, suggesting that surveys should be conducted every

five to six years (Note 28). According to the DH, the new international guidelines were only a suggestion and the frequency of surveys should vary depending on individual situations of different countries and territories. Nevertheless, in March 2017, the DH informed Audit that it was about to prepare and conduct the 2021 survey at the 10 years' interval as planned.

Audit recommendations

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

(a) **conduct a review of the oral health goals;**

(b) **review the conduct of oral health surveys in the future, taking into account the international good practices, the need to provide adequate coverage as well as other factors (e.g. availability of resources) relevant to the situation of Hong Kong; and**

(c) **to enhance public accountability and transparency, after reviewing the oral health goals, consider publishing the level of attainment against the goals.**

Response from the Government

5.8 The Director of Health generally agrees with the audit recommendations. She has said that the DH will consider publishing the level of attainment against goals in future.

Note 28: *According to the "Oral Health Surveys — Basic Methods" issued by the World Health Organization in 2013, oral health surveys should be conducted regularly every five to six years in the same community or setting.*

Appendix A
(paras. 1.7(a) and 2.2 refer)

Educational and publicity programmes of Department of Health's Oral Health Education Unit (Key programmes in 2015-16)

Target group	Programme	Detail
Pre-primary school students	Brighter Smiles for the New Generation	The programme helped children establish good tooth-brushing and smart diet habits for the prevention of dental disease. A wide range of education materials was developed and distributed to kindergartens and nurseries, including a cartoon DVD and picture books.
	Brighter Smiles Playland	The programme was specially designed for 4-year-old children (studying at Kindergarten 2/Nursery 3) to help them learn good oral care habits through interactive games and activities in the Playland.
Primary school students	Bright Smiles Mobile Classroom	A roving oral health education bus visited different primary schools. It served as an extra-curricular supplementary classroom to enrich the oral health knowledge of primary school students. It also helped enhance their ability to master oral care skills.
	Bright Smiles Campus Programme	This was a school-based oral health promotion programme for primary school students. Senior grade students (studying at Primary 4 to 6) were trained as "bright smiles ambassadors" to show the importance of clean teeth.
Secondary school students	Teens Teeth Programme	This was a school-based oral health promotion programme for secondary school students. A peer-led approach was adopted in promoting oral health to students of Secondary 1, with a view to reducing gum bleeding and nurturing flossing habits.
Special school students	Dandelion Oral Care Action	The programme promoted systematic tooth-brushing and flossing techniques. It was developed in collaboration with a special school for moderate intellectual disabled children.
All (including adults and the elderly)	Love Teeth Campaign	The Campaign, with a specific theme each year, promoted oral health to the public via mass media (e.g. television, radio and newspapers) and advertisement at MTR stations.

Source: DH records

Appendix B
(para. 1.7(b) refers)

School dental clinics

Clinic	Serving district	Name
1	Hong Kong and Islands	Tang Shiu Kin School Dental Clinic • 1/F, MacLehose Dental Centre • 5/F, MacLehose Dental Centre
2	Kowloon	1/F, Argyle Street Jockey Club School Dental Clinic
3	Kowloon	3/F, Argyle Street Jockey Club School Dental Clinic
4	Kowloon	Lam Tin School Dental Clinic
5	New Territories East	Fanling School Dental Clinic
6	New Territories East	Pamela Youde School Dental Clinic
7	New Territories West and Islands	Ha Kwai Chung School Dental Clinic
8	New Territories West	Tuen Mun School Dental Clinic

Source: DH records

Appendix C
(paras. 1.8 and 1.10 refer)

Charges for dentures and dental appliances payable by civil service eligible persons and the public (2016)

Payable by CSEPs

Partial/full dentures/dental appliances

Monthly salary (of Master Pay Scale)	New denture/ appliance (Each tooth)	Modification of existing denture/ appliance (Remodel, reline, repair, or each additional tooth)	Obturator	Maximum charge for restorations in both jaws	Maximum charge for restorations in one jaw	Bridge per retainer/ pontic (for Maryland bridgework charges are halved)
	($)	($)	($)	($)	($)	($)
Point 6 and below or equivalent	8	8	15	181	92	64
Points 7 to 21 or equivalent	37	17	92	273	138	102
Points 22 to 33 or equivalent	74	37	181	549	273	201
Points 34 or equivalent and over	147	74	365	1,097	549	412

Source: Civil Service Regulations

Appendix C
(Cont'd)
(paras. 1.8 and 1.10 refer)

Payable by the public

		($)
Eligible persons (see also Note 6 to para. 1.9)		
1	Acrylic denture, per tooth (Note)	43
	Maximum for one jaw denture of more than 5 teeth	375
	Minimum for one jaw denture of one to five teeth	190
2	Remodelling of denture	80
3	Repair/relining of denture	73
4	Addition of teeth, per tooth	43
	Maximum for one jaw denture	80
5	Obturator (Note)	43 per tooth plus 125
6	Maxillofacial prostheses	280 - 545
7	Other maxillofacial prostheses (Splints, applicators for radiotherapy, occlusion appliances, etc.)	No charge
Non-eligible persons		
1	Fixed appliance	
	Gold (Crown/Inlay/Onlay/Bridge) per unit	1,430
	Porcelain (Crown/Bridge) per unit	1,840
	Maryland Bridge	
	— Per porcelain unit	1,840
	— Per metal unit	520
2	Removable appliances	
	Chrome-Cobalt Denture - Metal Frame	2,420 plus 50 per tooth
	Acrylic Denture-Base	1,060 plus 50 per tooth
	Obturators - Base	1,260 plus 50 per tooth
	Repair/Reline/Addition	255 plus 50 per tooth
3	Implantology	
	Infrastructure – per implant	2,100
	Suprastructure	
	— Per crown unit	2,540
	— Per denture	4,180
4	Maxillofacial prostheses and other maxillofacial appliances	At cost as determined by the Dental Officer attending the patient

Source: DH records

Note: For chrome-cobalt appliances, the charges are doubled.

Appendix D
(paras. 1.8 to 1.10 and 4.2 refer)

Government dental clinics, orthodontic clinics and Oral Maxillofacial Surgery and Dental Units

Clinic	District	Name	Dental services provided for			
			CSEPs		Public	
			General	Specialised (Note)	Emergency	Specialised (Note)
Government dental clinics						
1	Central and Western	Harbour Building Dental Clinic	✓			
2	Central and Western	Kennedy Town Community Complex Dental Clinic	✓		✓	
3	Central and Western	Queensway Government Offices Dental Clinic	✓			
4	Central and Western	Sai Ying Pun Dental Clinic 3/F	✓			
5	Central and Western	Sai Ying Pun Dental Clinic 8/F	✓	✓		
6	Central and Western	Victoria Road Dental Clinic	✓			
7	Central and Western	Western Dental Clinic	✓	✓		
8	Eastern	Chai Wan Government Dental Clinic	✓			
9	Eastern	Tang Shiu Kin Dental Clinic	✓			
10	Islands	Cheung Chau Dental Clinic	✓		✓	
11	Islands	Tai O Dental Clinic	✓		✓	
12	Islands	Tung Chung Dental Clinic	✓			
13	Kowloon City	Kowloon City Dental Clinic	✓		✓	
14	Kwai Tsing	Ha Kwai Chung Government Dental Clinic	✓			
15	Kwai Tsing	Kwai Chung Hospital Dental Clinic	✓			

Appendix D
(Cont'd)
(paras. 1.8 to 1.10 and 4.2 refer)

Clinic	District	Name	Dental services provided for			
			CSEPs		Public	
			General	Specialised (Note)	Emergency	Specialised (Note)
16	Kwai Tsing	Sheung Kwai Chung Government Dental Clinic	✓			
17	Kwun Tong	Kwun Tong Dental Clinic	✓		✓	
18	Kwun Tong	Kwun Tong Yung Fung Shee Dental Clinic	✓			
19	North	Fanling Health Centre Dental Clinic	✓		✓	
20	Sai Kung	Mona Fong Dental Clinic	✓		✓	
21	Sai Kung	Tseung Kwan O Dental Clinic	✓			
22	Sha Tin	Ma On Shan Dental Clinic	✓			
23	Sha Tin	Pamela Youde Government Dental Clinic	✓			
24	Sham Shui Po	Cheung Sha Wan Government Offices Dental Clinic	✓	✓		
25	Southern	Aberdeen Jockey Club Dental Clinic	✓			
26	Southern	Hong Kong Police College Dental Clinic	✓			
27	Tai Po	Tai Po Wong Siu Ching Dental Clinic	✓		✓	
28	Tsuen Wan	Tsuen Wan Dental Clinic	✓			
29	Tsuen Wan	Tsuen Wan Government Offices Dental Clinic	✓		✓	
30	Tuen Mun	Castle Peak Hospital Dental Clinic	✓			
31	Tuen Mun	Yan Oi Dental Clinic	✓		✓	
32	Wan Chai	MacLehose Dental Clinic 2/F	✓	✓		
33	Wan Chai	MacLehose Dental Clinic 6/F	✓			

Appendix D
(Cont'd)
(paras. 1.8 to 1.10 and 4.2 refer)

Clinic	District	Name	Dental services provided for			
			CSEPs		Public	
			General	Specialised (Note)	Emergency	Specialised (Note)
34	Wan Chai	Wan Chai Dental Clinic	✓			
35	Yau Tsim Mong	Li Po Chun Dental Clinic	✓			
36	Yau Tsim Mong	Yau Ma Tei Dental Clinic	✓			
37	Yuen Long	Yuen Long Jockey Club Dental Clinic	✓		✓	
38	Yuen Long	Yuen Long Madam Yung Fung Shee Dental Clinic	✓			
Orthodontic clinics						
1	Central and Western	Harbour Building Orthodontic Clinic		✓		
2	Yau Tsim Mong	Yau Ma Tei Orthodontic Clinic		✓		
OMSDUs						
1	Eastern	Pamela Youde Nethersole Eastern Hospital OMSDU		✓		✓
2	Kwai Tsing	Princess Margaret Hospital OMSDU		✓		✓
3	North	North District Hospital OMSDU		✓		✓
4	Sha Tin	Prince of Wales Hospital OMSDU		✓		✓
5	Southern	Queen Mary Hospital OMSDU		✓		✓
6	Tuen Mun	Tuen Mun Hospital OMSDU		✓		✓
7	Yau Tsim Mong	Queen Elizabeth Hospital OMSDU		✓		✓

Source: DH records

Note: Specialised dental services include Endodontics, Oral & Maxillofacial Surgery, Orthodontics, Paediatric, Periodontology, Prosthodontics and Restorative Dentistry.

Appendix E
(paras. 1.11, 4.8, 4.27 and 4.28 refer)

Dental services for people with special needs (30 September 2016)

Eligibility	Services provided	Payment to participating organisation
DH: Outreach Dental Care Programme for the Elderly		
Elderly persons aged 60 or above holding a Hong Kong identity card who are residing in Residential Care Homes or using services in day care centres (Note 1)	• On-site primary dental care services • Further curative treatments carried out on-site or at dental clinics operated by NGOs • On-site training for caregivers, the elderly and their families on oral care	• Annual grant of $550 per elderly person served • Reimbursement of curative treatments cost based on dental grant under Comprehensive Social Security Assistance Scheme • Escort subsidy of $200 per session of actual service • Transport subsidy of $300 per session of actual service • Dental equipment and facilities grant capped at 50% of the costs and not more than $180,000 per outreach dental team
CCF: Elderly Dental Assistance Programme		
• Elderly persons aged 60 or above, being users of the Home Based Services (Note 2) who are not receiving Comprehensive Social Security Assistance • Elderly persons aged 80 or above who are receiving Old Age Living Allowance	• Removable dentures and other related necessary dental services (scaling and polishing, fillings, tooth extractions and X-ray examination)	• Actual administration costs of the Programme paid to Organisation A • A maximum subsidy of $14,390 for each beneficiary reimbursed to the participating dentists and NGO dental clinics

Eligibility	Services provided	Payment to participating organisation
FHB: Pilot project on dental service for patients with intellectual disability		
Persons with intellectual disabilities aged 18 or above, who are also receiving Comprehensive Social Security Assistance, Disability Allowance or Waiver for medical fees issued by the Hospital Authority	Dental services supplemented with special support measures	• Actual administration costs of the project paid to Organisation A • A maximum subsidy of $19,000 for each beneficiary reimbursed to the participating organisations

Source: DH and FHB records

Note 1: Day care centres are run by NGOs, including those with subventions of the Social Welfare Department. The centres provide care and support services during daytime to frail and demented elderly persons. The centres also provide various kinds of support and assistance to carers of the elderly persons.

Note 2: Home Based Services include:

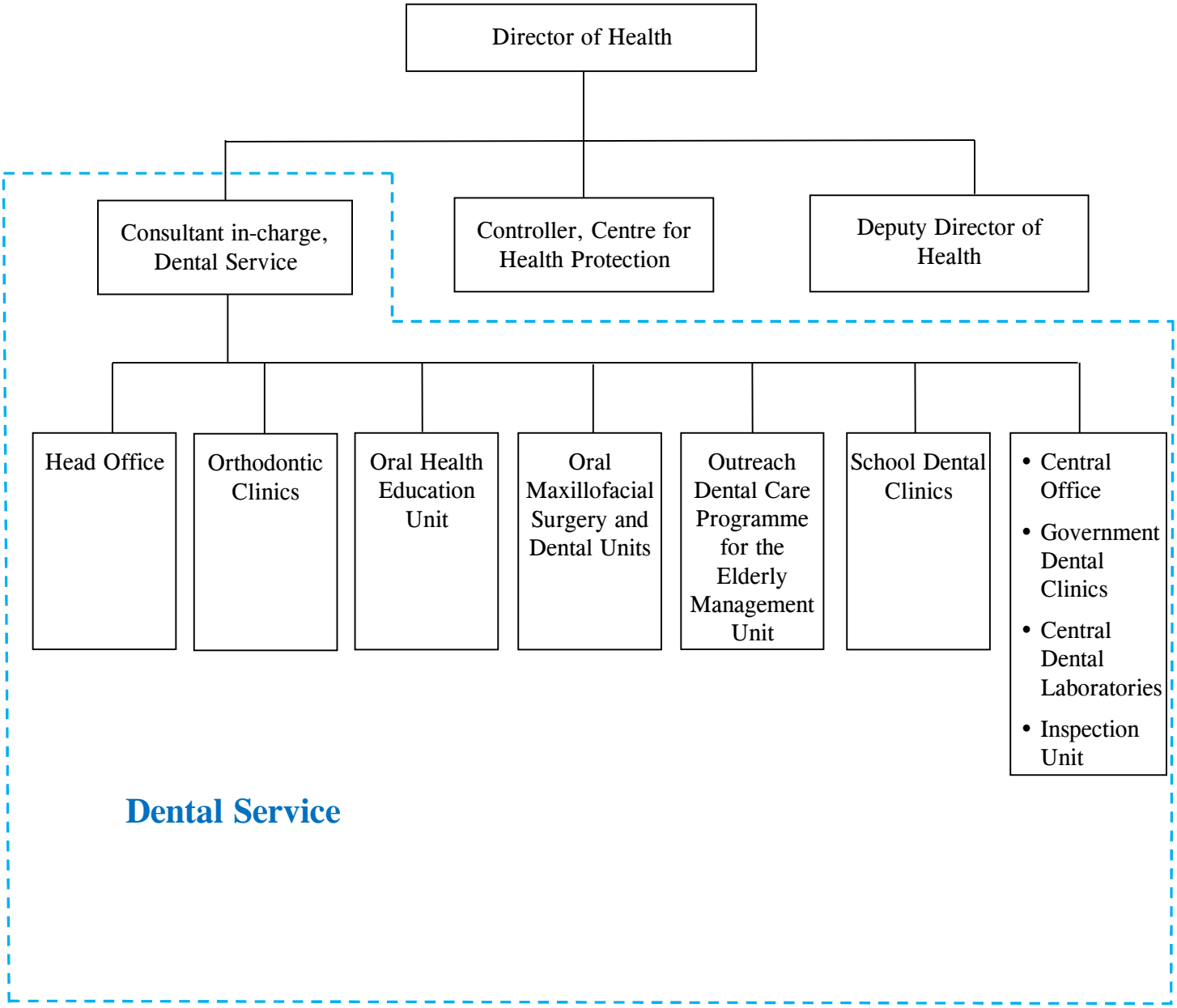
(a) enhanced home and community care services which provide integrated services to enable frail elderly persons aged 60 or above to receive nursing and care services in their familiar home and community environment and to maintain their maximum level of functioning;

(b) integrated home care services which provide enhanced support, care and rehabilitation services to enable elderly persons aged 60 or above, people with disabilities, and individuals with social needs to continue living in the community; and

(c) home help service which provides general personal care service, escort service and household cleaning services to elderly persons aged 60 or above, people with disabilities, and individuals living in Tung Chung areas who are incapable of looking after themselves.

Appendix F
(para. 1.13 refers)

Department of Health
Organisation chart (extract)
(30 September 2016)



Source: DH records

Appendix G
(para. 1.13 refers)

Department of Health
Staff for the provision of dental services
(30 September 2016)

Rank	Staff strength (No.)
Dental personnel	
Consultant	8
Principal Dental Officer	1
Senior Dental Officer	57
Dental Officer	250
Senior Dental Technologist	1
Dental Technologist	2
Dental Technician I	31
Dental Technician II	13
Tutor Dental Therapist	1
Senior Dental Therapist	27
Dental Therapist	240
Senior Dental Surgery Assistant	54
Dental Surgery Assistant	284
Dental Hygienist	13
Sub-total	982
Administrative and supporting staff	337
Total	1,319

Source: DH records

Appendix H
(para. 4.2 refers)

Quotas of General Public Sessions (2015-16)

Clinic	Available sessions	Quota per session (No. of discs)
Cheung Chau Dental Clinic	1st Friday of the month (AM)	32
Fanling Health Centre Dental Clinic	Tuesday (AM)	50
Kennedy Town Community Complex Dental Clinic	Monday (AM)	84
	Friday (AM)	84
Kowloon City Dental Clinic	Monday (AM)	84
	Thursday (AM)	42
Kwun Tong Dental Clinic	Wednesday (AM)	84
Mona Fong Dental Clinic	Thursday (PM)	42
Tai O Dental Clinic	2nd Thursday of the month (AM)	32
Tai Po Wong Siu Ching Dental Clinic	Thursday (AM)	42
Tsuen Wan Government Offices Dental Clinic	Tuesday (AM)	84
	Friday (AM)	84
Yan Oi Dental Clinic	Wednesday (AM)	42
Yuen Long Jockey Club Dental Clinic	Tuesday (AM)	42
	Friday (AM)	42

Source: DH records

Acronyms and abbreviations

Audit	Audit Commission
CCF	Community Care Fund
CSEPs	Civil service eligible persons
DCMS	Dental Clinic Management System
DCMS-ORMS	Dental Clinic Management System — Outreach Reporting Management Service
DH	Department of Health
DMF	Decayed, missing and filled teeth
FHB	Food and Health Bureau
FSTB	Financial Services and the Treasury Bureau
K2	Kindergarten 2
NGOs	Non-governmental organisations
N3	Nursery 3
OMSDUs	Oral Maxillofacial Surgery and Dental Units