CHAPTER 2

Health Bureau
Department of Health
Hospital Authority

Emergency dental services and elderly dental care support

Audit Commission
Hong Kong
28 March 2024

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.

Report No. 82 of the Director of Audit contains 8 Chapters which are available on our website (https://www.aud.gov.hk).

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EMERGENCY DENTAL SERVICES AND ELDERLY DENTAL CARE SUPPORT

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EMERGENCY DENTAL SERVICES AND ELDERLY DENTAL CARE SUPPORT

Executive Summary

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

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

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

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

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

Emergency dental services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Provision of elderly dental care support by the Department of Health

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

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

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

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

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

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

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

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

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

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

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

Implementation of the Elderly Dental Assistance Programme

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

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

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

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

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

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

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

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

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

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

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

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

Audit recommendations

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

Emergency dental services

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

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

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

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

Provision of elderly dental care support by DH

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

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

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

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

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

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

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

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

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

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

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

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

Emergency dental services

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

Implementation of EDAP

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

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

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

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

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

Response from the Government and the Hospital Authority

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

PART 1: INTRODUCTION

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

Background

1.2 ***Government policy on dental care.*** Proper oral health habits are key to the effective prevention of dental diseases. According to the World Health Organization, dental diseases include tooth decay, periodontal disease and tooth loss. Unlike many other diseases associated with old age, dental diseases are largely preventable through proper oral health self-care and professional care measures even at very old age (for achieving the goal of having at least 20 natural teeth at the age of 80). The Government's policy on dental care aims to raise public awareness of oral hygiene and oral health, and encourage proper oral health habits. Under the prevailing policy, the Government mainly undertakes publicity, education and promotion of oral health. Dental care services in Hong Kong are mainly provided by the private sector and non-governmental organisations (NGOs). According to the Government, when considering the strategy for oral health and dental care, and the provision of government-funded oral health measures and curative dental services, the long-term financial sustainability must be taken into account. It is more cost-effective to focus government resources on oral health measures and preventive dental services to achieve the goal of enhancing the overall level of citizens' oral health. At the same time, targeted assistance should be provided to individual under-privileged or disadvantaged groups who had difficulties in obtaining dental services, including persons with financial difficulties, persons with disabilities or special needs and the high-risk groups.

Emergency dental services

1.3 The Government provides emergency dental services for the public through designated sessions in government dental clinics (Note 1), and dental services for hospital in-patients and referred patients in public hospitals.

1.4 ***Emergency services provided in government dental clinics.*** Emergency dental services are provided by the Department of Health (DH) in designated sessions on designated days in 11 government dental clinics (hereinafter referred to as General Public (GP) sessions) (see Appendix A). The services cover only treatment of acute dental diseases, prescription for pain relief, treatment of oral abscess and teeth extraction. The dentists may also provide advice based on individual needs of patients while the patients have to seek dental care services provided by the private sector or NGOs. For eligible persons, emergency dental services are free of charge (Note 2). Table 1 shows the attendance of GP sessions in 2018-19 to 2023-24 (up to October 2023).

Note 1: *Under the civil service terms of appointment, the Government is obliged to provide dental benefits for civil service eligible persons (i.e. civil servants/pensioners and their eligible dependents). Government dental clinics under the Department of Health are established primarily for fulfilling this obligation. As of February 2024, the Department of Health operated 43 government dental clinics. These 43 government dental clinics are not for provision of comprehensive dental services for the general public. However, since 1947, the Government uses a small fraction (around 2%) of the service capacity of the dental clinics to provide a limited scope of supplementary emergency dental services to the general public.*

Note 2: *Eligible persons refer to holders of Hong Kong identity card. For non-eligible persons, emergency dental services are charged $1,190 per consultation.*

Table 1

Attendance of GP sessions
(2018-19 to 2023-24 (up to October 2023))

Year	Attendance (Number)
2018-19	37,027
2019-20	34,313
2020-21	23,317
2021-22	27,067
2022-23	20,035
2023-24 (up to October 2023)	11,229

Source: *DH records*

Remarks: *According to DH, due to the outbreak of coronavirus disease (COVID-19) epidemic and manpower shortage since January 2020, the attendance of GP sessions was generally lower than those in other periods.*

1.5 ***Emergency services provided in public hospitals (i.e. hospital dental services).*** Specialist oral maxillofacial surgery and dental treatment are provided for hospital in-patients, and patients with special oral health care and dental emergency needs at the Oral Maxillofacial Surgery and Dental Clinics (OMSDCs) of DH and the Hospital Authority (HA) in seven and six public hospitals (Note 3) respectively (see Table 2). Services are provided through referrals. Appointments will be arranged according to the urgency of the patients' conditions. Those with emergency needs, such as cases of dental trauma, will be provided with immediate consultation and

Note 3: *According to HA, general dental care services are also provided in 4 (i.e. the Alice Ho Miu Ling Nethersole Hospital, the Caritas Medical Centre, the Kwong Wah Hospital and the United Christian Hospital) of the 6 public hospitals for eligible staff working in the hospitals listed in Schedule 2 of the Hospital Authority Ordinance (Cap. 113) and their spouse.*

treatment. Patients may be charged a consultation fee (Note 4) and fees for treatments received (Note 5). Table 3 shows the attendance of hospital dental services in 2018-19 to 2023-24 (up to October 2023).

Table 2

List of public hospitals with OMSDCs
(October 2023)

Public hospitals with DH's OMSDCs	Public hospitals with HA's OMSDCs
1. North District Hospital	1. Alice Ho Miu Ling Nethersole Hospital
2. Pamela Youde Nethersole Eastern Hospital	2. Caritas Medical Centre
3. Princess Margaret Hospital	3. Hong Kong Children's Hospital (Note 1)
4. Prince of Wales Hospital	4. Kwong Wah Hospital (Note 2)
5. Queen Elizabeth Hospital	5. Tseung Kwan O Hospital (Note 2)
6. Queen Mary Hospital	6. United Christian Hospital
7. Tuen Mun Hospital	

Source: *DH and HA records*

Note 1: *According to HA, OMSDC of the Hong Kong Children's Hospital only provides services to its in-patients, referred paediatric cases from HA's Specialist Out-patient Clinics and referred patients of complicated paediatric cases from other public hospitals.*

Note 2: *According to HA, OMSDC of the Kwong Wah Hospital only provides services to its in-patients and patients referred by its Accident and Emergency Department, and OMSDC of the Tseung Kwan O Hospital only provides services to its in-patients, referred patients of minor and intermediate level surgical cases from other public hospitals, and patients referred by its Accident and Emergency Department and HA's Specialist Out-patient Clinics.*

Note 4: *As of January 2024, for hospital in-patients, no consultation fee is charged. For other patients, consultation fee is $135 for the first attendance and $80 for subsequent attendance for eligible persons (see Note 2 to para. 1.4) and $1,190 per consultation for non-eligible persons.*

Note 5: *Different fees are charged for different treatments provided by DH's and HA's OMSDCs. For example, as of January 2024, repairing of denture is charged at $73 for eligible persons (see Note 2 to para. 1.4) and $255 with additional charge for each tooth of $50 for non-eligible persons at DH's OMSDCs, while the treatment fees are determined by the dental officers attending the patients of HA's OMSDCs.*

Table 3

Attendance of hospital dental services
(2018-19 to 2023-24 (up to October 2023))

Year	Attendance (Number)		
	DH's OMSDCs (Note 1)	HA's OMSDCs (Note 2)	Total
2018-19	67,100	15,884	82,984
2019-20	60,400	14,669	75,069
2020-21	54,600	15,251	69,851
2021-22	58,200	18,865	77,065
2022-23	57,500	20,652	78,152
2023-24 (up to October 2023)	34,500	13,270	47,770

Source: *DH and HA records*

Note 1: *Attendance of DH's OMSDCs did not include the attendance of civil service eligible persons. According to DH, due to the outbreak of COVID-19 epidemic and manpower shortage since early January 2020, the attendance of DH's OMSDCs was generally lower than those in other periods.*

Note 2: *Attendance of HA's OMSDCs did not include the attendance of general dental care services provided to eligible staff and their spouse (see Note 3 to para. 1.5). According to HA, the emergency services at HA's OMSDCs were maintained during the outbreak of COVID-19 epidemic. However, non-emergency dental services (e.g. services provided to patients of stable cases) were suspended intermittently since January 2020. The increase in attendances since 2020-21 was mainly due to the opening of new OMSDCs in the Hong Kong Children's Hospital and Tseung Kwan O Hospital in 2019 and 2020 respectively.*

Remarks: *Audit Commission (Audit) examination covered the period during which there was COVID-19 epidemic.*

1.6 ***Expenditure.*** DH's hospital dental services and provision of services through GP sessions falls within the programme area "Curative Care"

of DH (Note 6). According to DH, it does not maintain a breakdown of expenditure for the provision of the aforementioned dental services. According to HA, in 2022-23, the expenditure for the provision of hospital dental services amounted to $45 million (Note 7).

Elderly dental care support

1.7 The Government provides dental care support to elderly persons under various initiatives, including the Outreach Dental Care Programme for the Elderly (ODCP) and the Elderly Health Care Voucher Scheme (EHVS) under DH's purview, and the Elderly Dental Assistance Programme (EDAP) administered by the Health Bureau (HHB) and funded under the Community Care Fund (CCF — Note 8). Details of these initiatives are shown in the ensuing paragraphs.

1.8 ***ODCP.*** The programme was implemented in October 2014 (Note 9) to provide eligible elderly persons in residential care homes for the elderly (RCHEs) or similar facilities (e.g. nursing homes for the elderly registered under DH) and day care centres for the elderly (DEs) (hereinafter referred to as RCHEs/DEs) with free

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Note 6: *In 2022-23, the expenditure of the programme area amounted to about $1.2 billion. The expenditure for the programme area "Curative Care" also included the expenditure of some other curative care services provided by DH such as services provided in the specialised outpatient clinics for patients with tuberculosis and chest diseases, skin diseases or human immunodeficiency virus infection.*

Note 7: *In 2022-23, the expenditure of HA amounted to $94.9 billion, mostly funded by subvention from the Government (i.e. $93.4 billion) under the programme area "Subvention: Hospital Authority" of the Health Bureau.*

Note 8: *CCF is a trust fund established in 2011 under the Secretary for Home and Youth Affairs Incorporation Ordinance (Cap. 1044) with the Secretary for Home and Youth Affairs Incorporated as its trustee (formerly known as the Secretary for Home Affairs Incorporation Ordinance (Cap. 1044) and with the Secretary for Home Affairs Incorporated as its trustee). Its objective is to provide assistance for people facing financial difficulties, particularly those who fall outside the social safety net or those within the safety net but are not covered by it because of special circumstances.*

Note 9: *The Government launched a three-year pilot project in April 2011 to provide free basic dental care for elderly persons residing in residential care homes for the elderly or receiving services in day care centres for the elderly through outreach dental teams set up by NGOs. In October 2014, it was regularised as ODCP.*

outreach dental services. DH has engaged NGOs to set up outreach dental teams to provide the services including on-site oral check-up for elderly persons and oral care training to caregivers of RCHEs/DEs. If the elderly persons are considered suitable for further curative treatments, dental treatments will be provided on-site or at the NGOs' dental clinics. DH enters into Funding and Service Agreements (FSAs) with NGOs, which typically run for a three-year service period. Under the current FSAs (for service period from 1 April 2021 to 31 March 2024), 10 NGOs have set up a total of 23 outreach dental teams. Table 4 shows the number of service users and expenditure of ODCP for the period 2017-19 to 2023-24 (up to December 2023).

Table 4

Number of service users and expenditure of ODCP
(2017-19 to 2023-24 (up to December 2023))

Service year	Service user (Number)	Expenditure (Note 1) ($ million)
2017-19 (since October 2017 — Note 2)	50,522	32
2019-20	45,353	44
2020-21	25,011	38
2021-22	37,245	42
2022-23	39,146	49
2023-24 (up to December 2023)	38,230	40

Source: *DH records*

Note 1: *The expenditure represented payments disbursed to NGOs in the respective years and might cover fees reimbursed for services provided to service users in previous year(s).*

Note 2: *The service period of the corresponding FSAs ran from October 2017 to March 2021 (i.e. 3.5 years). According to DH, the breakdown of the relevant figures for October 2017 to March 2018 and 2018-19 was not available and the expenditure only represented the amount disbursed in 2018-19.*

Remarks: *Audit examination covered the period during which there was COVID-19 epidemic. According to DH, services under ODCP were suspended intermittently due to the outbreak of COVID-19 epidemic in the period from early 2020 to early 2023. Hence, the number of service users and expenditure in the period were lower than those in other periods.*

1.9 ***EHVS.*** The Government has implemented EHVS to provide subsidies for eligible elderly persons aged 65 or above (Note 10) to choose private primary healthcare services that best suit their health care needs in their local communities. DH is responsible for administering the scheme. Vouchers under the scheme can be used for healthcare services, including private dental services. As of December 2023, the annual voucher amount for each eligible elderly person is $2,000 while the accumulation limit of vouchers is $8,000. Since July 2023, two elderly persons in spousal relationship and eligible to use vouchers can share their vouchers after pairing up their voucher accounts upon mutual consent. In November 2023, a three-year "Elderly Health Care Voucher Pilot Reward Scheme" has been rolled out under EHVS to promote primary healthcare and support the healthcare needs of elderly persons. Under the Scheme, within the same year, each eligible elderly person accumulating voucher spending of at least $1,000 on designated primary healthcare services will be allotted a $500 reward, for using towards disease prevention and health management services (including dental services). The number of voucher claim transactions and the amount of voucher claims under EHVS on dental services for the period 2018 to 2023 (up to October 2023) (Note 11) are shown in Table 5.

Note 10: *Elderly persons eligible for EHVS include those who hold valid Hong Kong identity cards or Certificates of Exemption issued by the Immigration Department. According to DH, elderly persons who obtained a Hong Kong identity card by virtue of a previous permission to land or remain in Hong Kong granted to him/her and such permission has expired or ceased to be valid are not eligible to receive and use the vouchers under EHVS. Also, elderly persons are provided with vouchers for using from the year in which they reach the age of 65. For example, an elderly person reaching the age of 65 in October 2023 will be provided with vouchers for using from 1 January 2023.*

Note 11: *In 2018 to 2023 (up to October 2023), the number of voucher claim transactions on dental services accounted for 6% to 8% of the total number of voucher claim transactions under EHVS every year, and amount of voucher claims on dental services accounted for 10% to 14% of the total amount of voucher claims under EHVS every year.*

Table 5

Number of voucher claim transactions and amount of voucher claims under EHVS on dental services (2018 to 2023 (up to October 2023))

Year	Voucher claim transactions (Note 1) (Number)	Amount of voucher claims ($ million)
2018 (Note 2)	294,950	287
2019 (Note 2)	310,306	313
2020	246,844	277
2021	308,343	355
2022	288,532	343
2023 (up to October)	282,870	351

Source: *DH records*

Note 1: *According to DH, due to the outbreak of COVID-19 epidemic in the period from early 2020 to early 2023, the number of voucher claim transactions was generally lower than those in other years.*

Note 2: *In 2018 and 2019, an additional one-off $1,000 worth of vouchers was allotted to each eligible elderly person each year.*

Remarks: *The Pilot Scheme for use of vouchers at the University of Hong Kong-Shenzhen Hospital was launched in October 2015 and regularised in June 2019. Eligible elderly persons may use the voucher to pay for services provided by the University of Hong Kong-Shenzhen Hospital, including dental services. According to DH, the University of Hong Kong-Shenzhen Hospital joined EHVS on a hospital basis, and the breakdown of the number of voucher claim transactions and amount of voucher claims by types of healthcare services (e.g. dental services) was not available.*

1.10 ***EDAP.*** EDAP was launched in September 2012 with funding provided under CCF to provide free removable dentures and related dental services (including oral examination, scaling and polishing, fillings, tooth extractions and X-ray examinations) to low-income elderly persons, namely, those aged 60 or above using the home care services subvented by the Social Welfare Department (SWD) and not receiving the Comprehensive Social Security Assistance (CSSA). Over the years, the

eligibility and service scope have been expanded several times. Since 2015, EDAP has been expanded to cover elderly persons receiving the Old Age Living Allowance (OALA) in the previous three consecutive months (see Appendix C). The Government has entrusted an implementing agent (i.e. Organisation A) to assist in implementing EDAP, including recruiting dentists/dental clinics and NGOs to participate in the programme, and processing claims of payments. Table 6 shows the number of cases and expenditure of EDAP for the period 2018-19 to 2023-24 (up to December 2023).

Table 6

Number of cases and expenditure of EDAP
(2018-19 to 2023-24 (up to December 2023))

Year	Number of cases		Expenditure
	Application	Completed (Note)	($ million)
2018-19	17,035	17,198	194
2019-20	16,204	17,771	220
2020-21	14,909	14,414	202
2021-22	20,508	17,130	250
2022-23	29,675	19,691	292
2023-24 (up to December 2023)	21,484	18,987	287

Source: *HHB records*

Note: *Completed cases refer to cases with dental treatments completed and payments disbursed in the respective years, which may include applications received in previous year(s).*

Remarks: *According to HHB, the increase in the expenditure in general from 2018-19 to 2022-23 was in line with the increase in the number of applications, the expansion of service scope, as well as the adjustments in the service charge ceilings for the dental service items which were made in line with those under CSSA dental grant (see Note 52 to para. 4.27).*

Oral Health Surveys

1.11 According to the Government, before formulating policies and targets for oral health in Hong Kong, DH needs to collect pertinent information on the oral health status and related behaviour of people in Hong Kong for planning and evaluation of oral health programmes, and to plan for future oral health care development. The first territory-wide Oral Health Survey (OHS) was conducted in 2001 and DH undertook to carry out OHS every 10 years. According to the 2011 OHS, 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. However, the majority of the adult and older populations had various degrees of tooth decay and gum disease, and the Hong Kong population tended to ignore oral symptoms and delay the seeking of dental care even for severe problems. The 2021 OHS was commenced in November 2021. According to DH, due to COVID-19 epidemic, the survey work was delayed and was completed in late 2023. It will release the survey report within 2024.

Working Group on Oral Health and Dental Care

1.12 In December 2022, the Government established the Working Group on Oral Health and Dental Care (the Working Group — Note 12) to advise the Government on the long-term strategy for oral health and dental care, as well as matters including the enhancement of the scope and mode of services provided or subsidised by the

Note 12: *The Working Group is chaired by the Permanent Secretary for Health. Members include the Deputy Secretary for Health, the Commissioner for Primary Healthcare, the Director of Health or representative, representatives of the Education Bureau and the Labour and Welfare Bureau, and other non-official members from various sectors (e.g. dental and education). The tenure of the Working Group is two years from 31 December 2022 to 31 December 2024.*

Government (Note 13). An interim report was issued by the Working Group in December 2023. The Working Group will examine the result of the 2021 OHS and issue the final report before the end of its tenure by late 2024.

Responsible bureau/department and organisation

1.13 ***HHB.*** HHB is the policy bureau for DH. It is responsible for the overall health policies in Hong Kong including the oral health care policy, and providing subvention to HA. HHB also administers, implements and monitors EDAP on behalf of the Commission on Poverty (CoP) (see para. 1.10 and Note 38 to para. 4.2). Headed by a Consultant who is also responsible for oral health care policy, the team under HHB administering EDAP comprises 5 executive and clerical staff as at 31 December 2023.

1.14 ***DH.*** The Dental Services of DH provides a range of services including the provision of emergency dental services in government dental clinics with GP sessions (see para. 1.4), the hospital dental services in seven public hospitals (see para. 1.5) and the dental services under ODCP (see para. 1.8). The Health Care Voucher Division under the Elderly Health Branch of DH is responsible for the implementation of EHVS (see para. 1.9). An extract of the DH organisation chart (as at 31 December 2023) is at Appendix B. As at 31 December 2023, the staff establishment of the Dental Services was 1,501 (including 1,095 dental personnel and

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Note 13: *The terms of reference of the Working Group are to advise the Government on the following aspects of the development of oral health and dental care in Hong Kong, especially as part of primary healthcare:*

(a) the scope, efficacy and cost-effectiveness of the existing oral health measures and dental care services undertaken by the Government, having regard to local circumstances and experience as well as overseas practices and evidence;

(b) the long-term strategy for oral health and dental care in Hong Kong, especially as part of primary healthcare, including co-ordination of service programmes and manpower provision with a view to enhancing the oral health of the community; and

(c) priority areas for enhancements to oral health measures and dental care services, including the level of essential primary dental care services at different life stages, the scope of publicly-provided or funded dental care services, and the mode(s) of delivery and financing.

406 administrative and supporting staff) (Note 14), and that of the Health Care Voucher Division was 55.

1.15 ***HA.*** HA is responsible for the provision of hospital dental services in six public hospitals (see para. 1.5). As at 31 December 2023, HA had 14 dental officers and 21 ancillary dental personnel responsible for the provision of dental services in its establishment.

Impact of COVID-19 epidemic on DH's services

1.16 According to DH, as the Government's health adviser, it has been safeguarding the health of the people of Hong Kong with no exception in the outbreak of COVID-19 since early January 2020. Tasked with the responsibility of protecting Hong Kong against communicable diseases, during COVID-19 epidemic, DH has been fighting in the front line against COVID-19 epidemic since day one. Staff from various DH services, including the Dental Services, have been working behind-the-scene diligently to undertake various anti-epidemic initiatives, including health surveillance, contact tracing and epidemiological investigations, as well as port health and quarantine measures. To minimise the risk of infection, the Government announced that government departments are expected to provide basic public services, albeit of a limited scale. As such, public services under DH including dental services were adjusted or suspended during the epidemic period.

Audit review

1.17 In November 2023, Audit commenced a review to examine the provision of emergency dental services and elderly dental care support by the Government. The audit review has focused on the following areas:

Note 14: *The Dental Services of DH is also responsible for the provision of dental services to civil service eligible persons (see Note 1 to para. 1.3), the School Dental Care Service, dental regulatory and law enforcement, the administration of Government-subsidised programmes, and oral health education.*

(a) emergency dental services (PART 2);

(b) provision of elderly dental care support by DH (PART 3); and

(c) implementation of EDAP (PART 4).

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

Acknowledgement

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

PART 2: EMERGENCY DENTAL SERVICES

2.1 This PART examines the provision of emergency dental services, focusing on:

(a) dental services provided through GP sessions (paras. 2.2 to 2.17); and

(b) dental services provided in public hospitals (paras. 2.18 to 2.36).

Dental services provided through General Public sessions

2.2 According to DH, it uses a small fraction of the service capacity of the government dental clinics to provide emergency dental services for the public (see Note 1 to para. 1.3) through GP sessions on designated days in 11 government dental clinics (see Appendix A and Photograph 1). Services provided under GP sessions include:

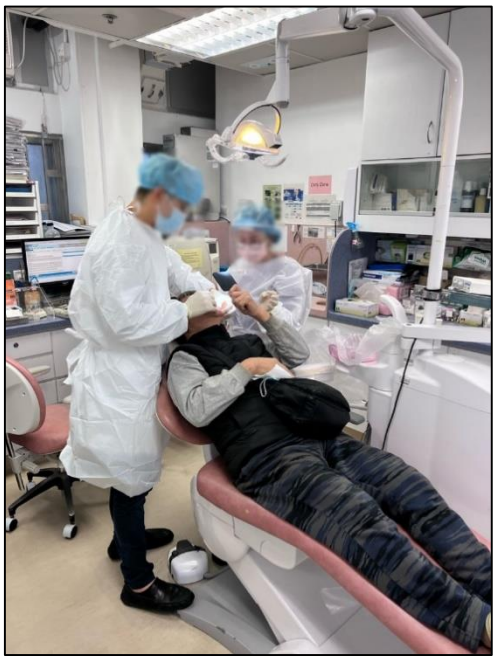
(a) treatment of acute dental diseases, prescription for pain relief, treatment of oral abscess and teeth extraction (Note 15); and

(b) provision of professional advice based on individual needs of patients.

Note 15: *According to DH, no services on filling, scaling and polishing, provision of dentures, removal of bridges, pre-orthodontic extraction, etc. would be provided, and only one tooth could be extracted for each patient per visit.*

Photograph 1

Provision of dental services through GP sessions (February 2024)



Source: *DH records*

2.3 A patient seeking emergency dental services provided at GP session is required to obtain a disc from the respective government dental clinic at the beginning of the session for receiving the services. Table 7 shows the number of attendances of GP sessions by age in 2018-19 to 2023-24 (up to October 2023).

Table 7

Number of attendances of GP sessions by age
(2018-19 to 2023-24 (up to October 2023))

Age group	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24 (up to October 2023)
18 or below	674 (2%)	1,345 (4%)	306 (1%)	312 (1%)	197 (1%)	102 (1%)
19 to 42	5,636 (15%)	7,008 (20%)	3,893 (17%)	4,775 (18%)	3,281 (16%)	1,786 (16%)
43 to 60	8,905 (24%)	6,870 (20%)	6,449 (28%)	7,559 (28%)	5,940 (30%)	3,203 (28%)
61 or above	21,812 (59%)	19,090 (56%)	12,669 (54%)	14,421 (53%)	10,617 (53%)	6,138 (55%)
Total	37,027 (100%)	34,313 (100%)	23,317 (100%)	27,067 (100%)	20,035 (100%)	11,229 (100%)

Source: *DH records*

Remarks: *According to DH, Audit examination covered the period during which there was COVID-19 epidemic, and the Government announced that public services were provided at a limited scale by opening only some but not all of its service centres, shortening the opening hours, etc., to avoid social gathering and minimise spreading of the infection.*

Need to enhance provision of emergency dental services to the public in need

2.4 According to DH, the maximum number of discs for allocation in each GP session is fixed (Note 16). Audit noted that:

(a) ***Decrease in number of discs for allocation (i.e. disc quota).*** From 2014-15 to 2018-19, the disc quota of the 11 government dental clinics was about 40,000 a year. The disc quotas decreased by 19,985 (50%) from 40,322 in 2018-19 to 20,337 in 2022-23. Based on the figure as of

Note 16: *The maximum number of discs for allocation in each GP session of the 11 government dental clinics varied from 32 to 84 (see Appendix A).*

October 2023, Audit estimated that the disc quota in 2023-24 would be about 50% of that in 2018-19; and

(b) ***Increase in disc allocation rate.*** The disc allocation rate (i.e. the percentage of disc quota allocated) increased from 92.3% in 2018-19 to 99.2% in 2022-23, and more than 99% of the discs allocated had been utilised (see Table 8).

Table 8

Allocation and utilisation of disc quotas
(2018-19 to 2023-24 (up to October 2023))

Year	Disc quota (a) (Number)	Disc allocated (b) (Number)	Allocation rate of disc quotas (c) = (b) ÷ (a) × 100% (%)	Disc utilised (d) (Number)	Utilisation rate of allocated discs (e) = (d) ÷ (b) × 100% (%)
2018-19	40,322	37,199	92.3%	37,027	99.5%
2019-20	37,133	34,505	92.9%	34,313	99.4%
2020-21	23,787	23,452	98.6%	23,317	99.4%
2021-22	28,101	27,310	97.2%	27,067	99.1%
2022-23	20,337	20,171	99.2%	20,035	99.3%
2023-24 (up to October 2023)	11,462	11,310	98.7%	11,229	99.3%

Source: *Audit analysis of DH records*

Remarks: *According to DH, unallocated or unutilised discs might be attributed to seasonal factors, such as weather conditions and traditional festivals.*

2.5 According to DH:

(a) the disc quotas have been reduced since January 2020 due to the outbreak of COVID-19 epidemic and manpower shortage. During COVID-19 epidemic, 75% of dental officers had been redeployed to various anti-epidemic functions, including but not limited to operations at the Temporary Specimen Collection Centre at the AsiaWorld-Expo to collect

deep throat saliva samples for all asymptomatic inbound travellers arriving at the Hong Kong International Airport, and the Holding Centre for Test Result in a hotel in Hong Kong. The associated dental services including dental services to civil service eligible persons and emergency dental services had to be reduced to avoid social gathering, and also the throughput of the remaining dental officers had lowered due to the need to undertake enhanced infection control measures. Meanwhile, the vacancy rates of dental officers working in the government dental clinics with GP sessions increased by 13 percentage points from 11% in 2018-19 to 24% in 2023-24 (up to October 2023) and the disc quota in 2023-24 could only be about 50% of that in 2018-19; and

(b) since 2021, DH has taken a number of proactive measures to address the problem of acute manpower shortage, including conducting year-round recruitment of dental officers and engaging dental officers under post-retirement service contracts and non-civil service contracts (Note 17).

2.6 According to the Working Group interim report issued in December 2023 (see para. 1.12), the Working Group noted the public demand for more disc quotas for GP sessions and for expansion of the scope of emergency dental services beyond pain relief and tooth extraction. After reviewing the arrangement for GP sessions, the Working Group recognised the inability to increase disc quotas for GP sessions due to the acute manpower shortage of dental officers in the Government. The expansion of tooth extraction service was also considered as not compatible with the goal of the Working Group to enhance the overall level of citizens' oral health through retention of natural teeth. To reduce the need for emergency dental treatment by promoting prevention, the Working Group considered that early identification and timely intervention of dental diseases would be a better strategy. A new service model should also be developed to enable targeted delivery of dental services to the under-privileged groups (see para. 2.14).

Note 17: *In July 2023, HHB informed the Legislative Council Panel on Health Services that in order to address the shortage of dentists and ensure adequate manpower to support public or subsidised dental care services in the long run, the Government was exploring to amend the Dentists Registration Ordinance (Cap. 156) to provide a new pathway for the admission of qualified non-locally trained dentists to practise in specified institutions and modernise the regulatory framework for dentists and ancillary dental workers.*

2.7 As mentioned in paragraph 2.4(a), the number of discs for allocation in 2022-23 was about 50% of that in 2014-15 to 2018-19. In view of the public demand for services provided at GP sessions, Audit considers that DH needs to keep under review the number of discs for allocation, the utilisation of discs for GP sessions and the measures to address the dentist shortage issue, and take measures to enhance provision of emergency dental services to the public in need (i.e. increase the service volume at least to pre-COVID-19 level (i.e. 40,000 service quota for the public a year) in government dental clinics or through a new service model).

Need to improve the disc distribution arrangement for GP sessions

2.8 Discs for GP sessions are distributed in the respective clinic on a first-come-first-served basis. Disc distribution stops when all discs for the upcoming GP session are given out. There had been public concerns on the disc distribution arrangements, in particular, the long queueing time and patients queueing up at clinics overnight in order to secure the discs.

2.9 ***DH's initiatives for improving the disc distribution arrangement.*** Audit noted that DH has taken various measures for improving the disc distribution arrangement for GP sessions over the years, including:

(a) ***2014 survey on the use of telephone booking system.*** DH conducted a survey in 2014 to obtain views from patients using services of GP sessions on the use of telephone booking system (Note 18). According to the survey result, 26.9% of the respondents did not support the use of telephone booking system. The major reasons were "prefer waiting in the clinic" and "do not know how to use telephone booking";

(b) ***2016 study on the use of telephone booking system.*** In 2016, DH studied the use of telephone booking system by referencing to HA's experiences in the General Out-patient Clinics. In view of the limited disc quotas of GP

Note 18: *The survey was conducted in form of face-to-face personal interviews in May 2014 during GP sessions at the 11 government dental clinics and 1,278 patients were interviewed. Apart from views on the use of telephone booking system, it also collected other information, such as the profile of patients attending the GP sessions and the utilisation pattern of Government subsidisation for dental treatment in private sector.*

sessions, DH considered that the use of telephone booking system for GP sessions might lead to other problems, for example:

(i) if all discs were allocated through telephone booking system, the discs would be consumed in a short period of time due to the limited number in each GP session; and

(ii) if some discs were allocated through telephone booking system while others were distributed on-site, fewer discs would be available for on-site distribution, which might result in some patients (especially the elderly) queueing even earlier for securing the discs; and

(c) ***Trial use of self-service kiosks.*** In April 2020, DH set up self-service kiosks in two government dental clinics with GP sessions (i.e. the Tsuen Wan Dental Clinic and the Yan Oi Dental Clinic) on a trial basis. Patients could get queue tickets starting at 0:00 a.m. of the day of the GP session by inserting their identity proof (e.g. Hong Kong identity card) into the self-service kiosks (see Photograph 2). Patients can then return to the clinic at the beginning of the GP session for obtaining discs according to the priority indicated in the queue tickets. According to DH, the result of the trial was not promising due to operational difficulties and the kiosk services were ceased in August 2021 (Note 19).

Note 19: *The expenditure for setting up and operation of the self-service kiosks from April 2020 to August 2021 was about $280,000.*

Photograph 2

Self-service kiosk in the Tsuen Wan Dental Clinic (ceased operation in August 2021)

Source: Photograph taken by Audit staff in December 2023

2.10 ***Preliminary registration arrangement since 2022.*** Taking into account public views and operational experience, in September 2022, DH implemented the preliminary registration arrangement in 9 of the 11 government dental clinics with GP sessions (Note 20). According to DH, the objective of preliminary registration is to avoid overnight queueing at the clinics. Under the arrangement, DH commences registering patients' information at 0:00 a.m. of the day of the GP session (Note 21). Registration will stop when the number of preliminarily registered patients exceeds the number of disc quotas for the respective session. The registered patients can then return to the clinic before the commencement of the GP session for obtaining a disc.

Note 20: *According to DH, preliminary registration arrangement has not been implemented in the remaining 2 government dental clinics (i.e. the Cheung Chau Dental Clinic and the Tai O Dental Clinic) as overnight queueing was seldom observed.*

Note 21: *DH engaged contractors for conducting preliminary registration. The contractors' staff is responsible for registering the patients' information and maintaining order of the queue. In 2023, the related expenditure was about $1.1 million.*

2.11 In December 2023 and February 2024, Audit visited 5 of the 11 government dental clinics with GP sessions (Note 22) and noted that in 4 clinics, there were a few people queueing at about 5:00 p.m. for discs for the next day GP session with preliminary registration commencing at 0:00 a.m. (i.e. would need to wait for at least 7 hours). In mid-February 2024, Audit visited 3 of the 5 clinics at 10:00 p.m. and noted that the number of people queueing up at the clinics accounted for 36% to 57% of the disc quotas (see Photograph 3 for an example).

Photograph 3

People queueing for discs for GP session (February 2024)

Source: Photograph taken by Audit staff at about 10:00 p.m. on 21 February 2024

2.12 According to DH, in 2023-24 (up to October 2023), 98% of the discs were distributed to patients registered through preliminary registration. Audit noted that the number of people queueing up at 3 clinics accounted for 36% to 57% of the disc quotas at 10:00 p.m. in mid-February 2024 (see para. 2.11). This indicated that

Note 22: *The government dental clinics visited by Audit were the Kennedy Town Community Complex Dental Clinic, the Kowloon City Dental Clinic, the Tsuen Wan Dental Clinic, the Yuen Long Government Offices Dental Clinic and the Yan Oi Dental Clinic.*

although patients might start registering at 0:00 a.m. on the day of GP session, quite a number of people queued early for a few hours in order to secure a spot for the preliminary registration. Audit also noted that for one clinic (i.e. the Mona Fong Dental Clinic in Sai Kung) with GP session in the afternoon, registered patients needed to return to the clinic at 11:00 a.m. for obtaining the discs, and return to the clinic again at 1:30 p.m. when the GP session commences for obtaining the services (Note 23).

2.13 Audit noted that DH had explored different means for distributing the discs including conducting a survey in 2014 and a study in 2016 on the use of telephone booking system (see para. 2.9(a) and (b)). In view of the technology development, the wider use of electronic devices and improved accessibility of electronic government services (e.g. the launch of "HA Go" mobile application in December 2019 for managing booking in public hospitals) since the studies in 2014 and 2016, and the audit findings in paragraphs 2.11 and 2.12, Audit considers that there is merit for DH to review the disc distribution arrangement (e.g. conducting another user survey) for GP sessions with a view to facilitating the public in need in obtaining discs.

Way forward

2.14 The Government announced in the 2023 Policy Address that it will collaborate with NGOs to increase the emergency dental services targeting at the under-privileged groups (Note 24) with financial difficulties in 2025 through expansion of service capacity, service points and service scope under a new service model (i.e. enhanced emergency dental services).

Note 23: *For the remaining 8 government dental clinics with preliminary registration arrangement, registered patients may go to the clinics 30 minutes before the commencement of the GP sessions for obtaining the discs at the earliest. Dental services are provided in the order of the disc number.*

Note 24: *The Working Group (see para. 1.12) defined three categories of under-privileged groups for provision of more targeted dental services according to their specific needs, namely, persons with financial difficulties, persons with disability and special needs, and high-risk groups (e.g. patients with dementia, stroke and Parkinson's Disease).*

2.15 Audit noted that as of February 2024, DH was working on the implementation details and schedule for the enhanced emergency dental services (see para. 2.14) to enable targeted delivery of dental services to the under-privileged groups. Audit considers that DH needs to take measures to ensure that the enhanced emergency dental services are implemented according to schedule. Furthermore, Audit noted that DH had not compiled management information on the types of emergency services provided, types of patients served and the service utilisation pattern of GP sessions. To facilitate monitoring of the provision of emergency dental services, Audit considers that DH needs to compile such management information for reference. In implementing the enhanced emergency dental services, DH also needs to take into account the audit observations and recommendations in this Audit Report.

Audit recommendations

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

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

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

(c) **take measures to ensure that the enhanced emergency dental services targeting the under-privileged groups under the new service model are implemented according to schedule;**

(d) **compile management information on the types of emergency services provided, types of patients served and the service utilisation pattern of GP sessions to facilitate monitoring of the provision of emergency dental services; and**

(e) **take into account the audit observations and recommendations in this Audit Report in implementing the enhanced emergency dental services.**

Response from the Government

2.17 The Director of Health agrees with the audit recommendations. He has said that:

(a) in view of the persistent dentists manpower shortage in DH, the new service model of the enhanced emergency dental services suggested by the Working Group is considered to be the way out to recover the service volume of the emergency dental services to the public to the pre-COVID-19 level; and

(b) for the Mona Fong Dental Clinic in Sai Kung, with the present clerical manpower constraints, DH will consider moving the registration time 1 hour before the service begins (i.e. 12:30 p.m.) after modification of logistics arrangement.

Dental services provided in public hospitals

2.18 Hospital dental services are provided at DH's OMSDCs in seven public hospitals and HA's OMSDCs in six public hospitals (see Table 2 in para. 1.5). Services provided include specialist oral maxillofacial surgery and dental treatment to hospital in-patients, patients with special oral health care needs and patients with dental emergency needs (Note 25). Examples of dental problems of patients of OMSDCs include acute oral and maxillofacial infections, uncontrollable oro-facial pain, failed or anticipated difficult extraction.

2.19 Apart from in-patients of public hospitals, OMSDCs only accept patients through referrals (i.e. out-patients). In general, out-patients of OMSDCs include patients referred by other clinical departments of public hospitals (e.g. hospitals' Accident and Emergency Department), the HA's General/Specialist Out-patient Clinics, government dental clinics (including GP sessions) and private registered dental or medical practitioners (see Notes 1 and 2 to Table 2 in para. 1.5). With the referral letters, patients could register and obtain the first appointments (i.e. new case appointments) from OMSDCs according to clinical conditions of patients at the time

Note 25: *According to DH and HA, the breakdown of the number of patients with emergency or non-emergency needs was not available. Hospital dental services mentioned in this Audit Report included services provided to both kinds of patients.*

of referral (Note 26). Follow-up appointments will be arranged as appropriate after the patients attend OMSDCs for the first time.

Room for improvement in monitoring the services of DH's OMSDCs

2.20 ***Need to improve accuracy in reporting attendance of DH's OMSDCs.*** As performance indicators on the provision of dental services, DH reports the number of attendances of hospital patients (i.e. attendance figure) and the number of patients of the special needs group (i.e. headcount figure) in its Controlling Officer's Report every year. Audit noted that, in response to a question raised by a Member of the Legislative Council in examination of the estimates of expenditure in 2023-24, the Government reported the sum of the attendance figure and the headcount figure as the total numbers of attendances of hospital patients and special needs groups for 2018 to 2022 (see Table 9). Upon enquiry, DH informed Audit in January 2024 that the headcount figure had been included in calculating the attendance figure. In other words, the attendances of DH's OMSDCs reported to the Legislative Council had been overstated. Audit considers that DH needs to step up measures to improve the accuracy in reporting attendance of its OMSDCs.

Note 26: *According to DH, patients of government dental clinics (including patients of GP sessions) will only be referred to DH's OMSDCs and appointments will be given at the government dental clinics directly.*

Table 9

Reported attendance of DH's OMSDCs
(2018 to 2022)

	2018	2019	2020	2021	2022
	(Number)				
Numbers reported in Controlling Officer's Reports					
Hospital patients (Number of attendances) (a)	67,000	66,100	51,400	61,800	52,900
Special needs group (Number of patients) (b)	11,500	11,400	9,100	9,100	7,400
Numbers reported to the Legislative Council					
Total numbers of attendances of hospital patients and special needs groups (c)=(a)+(b)	78,500	77,500	60,500	70,900	60,300

Source: DH records

2.21 ***Need to maintain management information on the attendance rates of DH's OMSDCs.*** New case appointments at OMSDCs are arranged for patients according to clinical conditions of patients at the time of referral. Follow-up appointments will be arranged as appropriate after the patients attend OMSDCs for the first time (see para. 2.19). While the attendances of DH's OMSDCs ranged from 54,600 to 67,100 in 2018-19 to 2022-23 (see Table 3 in para. 1.5), DH informed Audit in December 2023 that it did not maintain management information on the number of new case and follow-up appointments arranged. As such, the attendance rates of DH's OMSDCs could not be ascertained. Upon enquiry, DH informed Audit in March 2024 that HA's assistance was required to generate the relevant data for compiling the management information on the attendance rates as the relevant data was kept in HA's information systems (Note 27). To facilitate the review of services provided by DH's OMSDCs, DH needs to maintain management information on the attendance rates of its OMSDCs. In this regard, DH and HA should collaborate to compile the required OMSDC attendance rate data. This may entail HA generating

Note 27: *According to HA, DH's OMSDCs are located in the public hospitals managed by HA and DH uses the HA's information systems for keeping appointment and attendance records of its OMSDCs.*

relevant data extracts or granting DH access to certain HA's information systems, as appropriate.

2.22 ***Need to improve monitoring of achievement of targets on waiting time for new case appointments at DH's OMSDCs.*** According to DH's guidelines for its OMSDCs, depending on the clinical conditions of patients, new case appointments shall be arranged according to the targets as shown in Table 10.

Table 10

Targets for arranging new case appointments at DH's OMSDCs (February 2024)

Type of case	Target for arranging new case appointment from date of receipt of referral
Case of in-patients referred by other medical specialities of the same hospital	Within 1 working day
Case warranting immediate attention	Same day
Urgent case	Within 2 weeks

Source: *DH records*

Remarks: *According to DH, no target has been set for arranging new case appointments for semi-urgent and stable cases.*

2.23 Upon enquiry, DH informed Audit in December 2023 and January 2024 that:

(a) it did not maintain information on the achievement of the targets for arranging new case appointments as shown in its guidelines (see Table 10 in para. 2.22); and

(b) waiting time for new case appointments for different types of cases was not available.

To enhance monitoring of the provision of services at DH's OMSDCs, Audit considers that DH needs to maintain information on the achievement of the targets for arranging new case appointments stipulated in its guidelines and the waiting time for different types of new case appointments. With reference to the target set on arranging new case appointments for semi-urgent cases by HA's OMSDCs (see para. 2.25), DH needs to consider setting similar target for semi-urgent cases to enhance transparency and accountability.

Room for improvement in monitoring the services of HA's OMSDCs

2.24 HA's OMSDCs provide hospital dental services to in-patients of public hospitals and out-patients referred from various sources (see para. 2.19). Audit examined the attendance rates of out-patients of HA's OMSDCs in 2018-19 to 2023-24 (up to October 2023) (Note 28) and noted that the attendance rates of new case appointments ranged from 80% to 88% and those of follow-up appointments ranged from 85% to 89% (see Table 11).

Note 28: *According to HA, the attendance rates of in-patients were very high as the patients were staying in the hospitals.*

Table 11

Attendance rates of out-patients of HA's OMSDCs
(2018-19 to 2023-24 (up to October 2023))

	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24 (up to October 2023)
New case appointments						
Appointment arranged (Number) (a)	3,989	3,950	4,173	4,869	5,273	3,321
Appointment attended (Number) (b)	3,297	3,158	3,460	4,154	4,662	2,858
Attendance rate (%) (c)=(b)÷(a)×100%	83%	80%	83%	85%	88%	86%
Follow-up appointments						
Appointment arranged (Number) (d)	11,311	10,662	10,716	13,773	14,891	9,900
Appointment attended (Number) (e)	9,894	9,106	9,331	12,121	13,257	8,755
Attendance rate (%) (f)=(e)÷(d)×100%	87%	85%	87%	88%	89%	88%
Overall						
Appointment arranged (Number) (g)=(a)+(d)	15,300	14,612	14,889	18,642	20,164	13,221
Appointment attended (Number) (h)=(b)+(e)	13,191	12,264	12,791	16,275	17,919	11,613
Attendance rate (%) (i)=(h)÷(g)×100%	86%	84%	86%	87%	89%	88%

Source: *Audit analysis of HA records*

Remarks: *According to HA, non-attendance of out-patients of HA's OMSDCs might be due to some of these patients opting for alternative dental care services provided by the private sector, or experiencing a reduction in symptoms and believing that clinical care was no longer required.*

2.25 ***Need to regularly report achievement of targets on waiting time for new case appointments for urgent and semi-urgent cases at HA's OMSDCs.*** According to HA, upon receipt of the patients' referral letters, the dental officers/ancillary dental

personnel of its OMSDCs will assess the patients' conditions and arrange the first appointments (i.e. new case appointments) according to a triage system. Under the triage system, patients of urgent cases (e.g. with uncontrolled hemorrhage or gross facial swelling) will be given the first appointments within 2 weeks from dates of receipt of the referral letters or treated immediately if considered very urgent, and patients of semi-urgent cases (e.g. with chronic severe pain or recurrent oral infection with swelling) will be given the first appointments within 8 weeks from dates of receipt of the referral letters.

2.26 Upon enquiry, HA informed Audit in January and February 2024 that:

(a) for 2018-19 to 2023-24 (up to October 2023), all OMSDC cases classified as urgent and semi-urgent had been given the first appointments within 2 and 8 weeks respectively; and

(b) there was no requirement on reporting the achievement of the targets on waiting time for new case appointments at its OMSDCs for these cases nor maintaining the relating supporting documentations.

To improve monitoring of services provided at HA's OMSDCs, Audit considers that HA needs to require its staff to report the achievement of targets on the waiting time for new case appointments regularly and maintain the relating supporting documentations for verification.

2.27 ***Need to keep under review the waiting time for stable cases of HA's OMSDCs.*** Upon enquiry, HA informed Audit in January 2024 that:

(a) information on the waiting time for stable cases as well as the number of stable cases waiting for the first appointments were not readily available; and

(b) the waiting time might vary among the six HA's OMSDCs and for different types of dental treatments. For example, the waiting time for surgical removal of wisdom teeth was about 23 months in 2022-23.

Audit examined the appointments arranged by HA for stable cases as at 25 January 2024 at its OMSDCs and noted that the latest appointments arranged were 8 to 63 weeks from that date among the six OMSDCs (see Table 12).

Table 12

Time lapse between 25 January 2024 and the latest appointments arranged for stable cases at HA's OMSDCs

HA's OMSDC	Time lapse (Week)
Alice Ho Miu Ling Nethersole Hospital	14
Caritas Medical Centre	63
Hong Kong Children's Hospital	9
Kwong Wah Hospital	8
Tseung Kwan O Hospital	14
United Christian Hospital	63

Source: Audit analysis of HA records

2.28 To improve monitoring of services provided at HA's OMSDCs, Audit considers that HA needs to maintain management information on the waiting time for stable cases and take measures to shorten the waiting time as appropriate.

2.29 ***Need to assess patients' conditions and arrange the first appointments for stable cases in a timely manner at HA's OMSDCs.*** Upon receipt of the patients' referral letters, the dental officers/ancillary dental personnel of HA's OMSDCs will assess the patients' conditions and arrange the first appointments accordingly (see para. 2.25). Audit noted that as at 25 January 2024, HA had not reviewed the referral letters and arranged the first appointments for 564 patients, and it had not maintained management information on the receipt dates of the concerned referral letters. Upon enquiry, HA informed Audit in January and February 2024 that:

(a) due to the emergency of patients requiring treatments and shortage in manpower for assessing the patients' conditions, some patients have not been assessed for arranging the first appointments; and

(b) for patients classified as urgent or semi-urgent cases, appointments have been arranged and/or treatments have been given timely. The 564 patients yet to be assessed and arranged with the first appointment were all categorised as stable according to the triage system (see para. 2.25).

To improve service provision, Audit considers that HA needs to take measures to ensure that patients' conditions are assessed and the first appointments are arranged at OMSDCs for stable cases in a timely manner (e.g. monitoring the time lapse between receipt of referral letters and arrangement of first appointments).

Way forward

2.30 Hospital dental services are provided at DH's OMSDCs in seven public hospitals and HA's OMSDCs in six public hospitals (see Table 2 in para. 1.5). In February 2023, the Government reported the latest development on primary healthcare to the Legislative Council Panel on Health Services. With a view to consolidating public primary healthcare services, the Government is reviewing the roles of key public healthcare service providers as follows:

(a) DH would focus on maintaining its public health functions and continue to serve as the Government's public health adviser in planning the overall public health strategy over the territory and executing its regulatory and enforcement roles; and

(b) HA would focus on its provision of public hospital and related medical treatment and rehabilitation services to the public in accordance with the Hospital Authority Ordinance (Cap. 113), whereas its primary healthcare services should focus to serve as an essential safety net for the population.

In this connection, HHB informed Audit in March 2024 that it was in the progress of migrating the hospital dental services (i.e. medical treatment) provided by DH to HA (i.e. merging DH's OMSDCs with HA's OMSDCs). Audit considers that HHB needs to take into account the audit observations and recommendations in this Audit Report in merging DH's and HA's hospital dental services.

Audit recommendations

2.31 **Audit has *recommended* that the Director of Health should, regarding OMSDCs:**

(a) **step up measures to improve the accuracy in reporting attendance;**

(b) **maintain management information on the attendance rates and collaborate with HA in compiling the relevant data as appropriate;**

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

(d) **consider setting a target on arranging new case appointments for semi-urgent cases to enhance transparency and accountability.**

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

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

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

(c) **take measures to ensure that patients' conditions are assessed and the first appointments are arranged for stable cases in a timely manner.**

2.33 **Audit has *recommended* that the Secretary for Health should take into account the audit observations and recommendations in this Audit Report in merging DH's and HA's hospital dental services.**

Response from the Government

2.34 The Secretary for Health agrees with the audit recommendation in paragraph 2.33. He has said that as part of DH's general exercise to streamline and rationalise its clinical functions, discussion between DH and HA is underway to consider how DH's current OMSDC service may be better merged with that of HA for operational synergy and efficiency. Audit's recommendations in respect of the monitoring and reporting systems will be taken into account in the process.

2.35 The Director of Health agrees with the audit recommendations in paragraph 2.31.

Response from the Hospital Authority

2.36 The Chief Executive, HA agrees with the audit recommendations in paragraphs 2.31(b) and 2.32.

PART 3: PROVISION OF ELDERLY DENTAL CARE SUPPORT BY THE DEPARTMENT OF HEALTH

3.1 This PART examines issues relating to provision of elderly dental care support by DH, focusing on the following areas:

(a) implementation of ODCP (paras. 3.2 to 3.34); and

(b) implementation of EHVS (paras. 3.35 to 3.39).

Implementation of the Outreach Dental Care Programme for the Elderly

3.2 According to the Government, elderly persons receiving long-term care services are generally frail and may be unable to take care of themselves and access conventional dental care services. As an initiative to enhance primary dental care for the needy elderly, the Government launched a three-year pilot project in April 2011 to provide free basic dental care (e.g. oral examination, scaling and polishing) for elderly persons residing or receiving services in RCHEs/DEs through outreach dental teams set up by NGOs. In October 2014, the project was regularised as ODCP. Over the years, the service coverage has been expanded (e.g. covering fillings, extractions and dentures). In 2022-23, under ODCP, dental services were provided to 39,146 service users and the expenditure amounted to $49 million.

3.3 The features of ODCP as of December 2023 were as follows:

(a) ***Eligibility criteria.*** Elderly persons holding valid Hong Kong identity cards and residing in RCHEs or similar facilities, or persons aged 60 or above in the relevant calendar year receiving services in DEs are eligible for using ODCP dental services;

(b) ***Mode of service provision.*** DH has engaged NGOs by entering into FSAs for ODCP. Outreach dental teams, consist of NGO staff including dentists and dental surgery assistants, are set up for providing outreach dental services to the eligible elderly persons in RCHEs/DEs. Services are mainly

provided on-site at RCHEs/DEs (e.g. oral health assessments and training activities). For further curative treatments that cannot be performed on-site, NGOs shall arrange transportation and escort services for the service users to receive treatments at the NGOs' dental clinics which are mainly in the same district (Note 29); and

(c) ***Objectives and service scope.*** ODCP aims to:

(i) provide free dental care services, including oral health assessment, oral care planning and further curative treatments (e.g. tooth extractions) which are considered by attending dentists as suitable for the eligible elderly persons;

(ii) promote the importance of oral hygiene and oral health to the eligible elderly persons, their family members and caregivers; and

(iii) provide oral care training to caregivers in RCHEs/DEs to enhance their ability and knowledge in providing daily oral care services to service users.

3.4 The current FSAs for ODCP run for a three-year period from 1 April 2021 to 31 March 2024. Audit examined the implementation of ODCP in two FSA periods (i.e. from 1 October 2017 to 31 March 2021, and from 1 April 2021 to 31 March 2024, both involving the same 10 NGOs and 23 outreach dental teams) to identify room for improvement.

Note 29: *Fees payable to NGOs for ODCP services included:*

(a) an annual grant, calculated based on number of service users, to cover recurrent operating costs of the outreach dental teams in running the services. The annual grant for the current FSA period (i.e. 1 April 2021 to 31 March 2024) was $720 per service user;

(b) reimbursement of costs of further curative treatments, making reference to the permissible items and service charge ceilings under CSSA dental grant, both of which are determined in consultation with DH; and

(c) claims of transport and escort subsidy if applicable.

Need to take further measures to enhance NGOs' performance in reaching their target numbers of service users

3.5 DH has engaged NGOs that operate dental services to participate in ODCP by invitation for proposals (see para. 3.27). According to the invitation for proposal document, an NGO shall operate ODCP mainly on a district basis. NGO should state in the proposal the district(s) and number of outreach dental team(s) it would like to operate (each team with a target to provide services to at least 1,000 or 2,000 service users in each service year). Upon award of FSAs, each NGO is assigned by DH a list of RCHEs/DEs (mainly in the same district) for provision of ODCP services. RCHEs/DEs and their respective service users may join the programme on a voluntary basis.

3.6 According to FSAs of the two FSA periods under examination, the 10 NGOs should operate 23 teams (Note 30) for providing ODCP services to a target of at least 43,000 service users per year (Note 31). Table 13 shows ODCP services provided for the period 2017-19 (see Note 2 to Table 4 in para. 1.8) to 2023-24 (up to December 2023).

Note 30: *The number of outreach dental teams set up by each NGO ranged from 1 to 10, and the number of RCHEs/DEs assigned to each NGO ranged from 19 to 385.*

Note 31: *According to DH, as at 31 March 2023, there were some 66,600 residents/users in RCHEs/DEs. The target of 43,000 ODCP service users represented approximately 65% of the eligible elderly persons.*

Table 13

ODCP services provided
(2017-19 to 2023-24 (up to December 2023))

Service year	Service users	Service users receiving dental treatments	Treatments performed	Training activities
	(Number)			
2017-19	50,522	28,790	45,682	1,024
2019-20	45,353	23,661	32,212	905
2020-21	25,011	14,412	16,169	180
2021-22	37,245	24,530	29,575	642
2022-23	39,146	29,956	32,766	771
2023-24 (up to December 2023)	38,230	26,677	36,690	625

Source: *Audit analysis of DH records*

Remarks: *The number of service users represented the number of elderly persons provided with oral health assessments by the outreach dental teams. Subsequent to the oral health assessments, further curative treatments were provided for those who required the treatments and were considered suitable by the attending dentists of the outreach dental teams (subject to consent of the service users). A service user could be provided with more than one dental treatment.*

3.7 Audit analysed the achievement on the target number of service users (i.e. the actual number of service users compared to the target proposed for each service year — see paras. 3.5 and 3.6) for the period 2017-19 to 2023-24 (up to December 2023) (see Table 14) and noted that:

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

(b) the number of NGOs that could not achieve the target ranged from 2 (in 2017-19) to 9 NGOs (in 2020-21). The numbers of service users for NGOs G and I were less than 50% of the proposed target numbers for

three consecutive years (from 2020-21 to 2022-23). Despite the resumption of services, some NGOs were still far from meeting the service users target in 2023-24 (up to December 2023).

Table 14

Achievement on target number of service users
(2017-19 to 2023-24 (up to December 2023))

NGO	2017-19	2019-20	2020-21	2021-22	2022-23	2023-24 (up to December 2023) (Note)
A	178%	157%	67%	113%	108%	157%
B	95%	87%	48%	65%	68%	124%
C	144%	102%	72%	123%	133%	190%
D	157%	127%	5%	37%	64%	98%
E	112%	103%	8%	98%	87%	114%
F	180%	166%	127%	141%	166%	213%
G	102%	89%	16%	34%	20%	60%
H	99%	96%	55%	82%	87%	123%
I	132%	95%	0.1%	28%	22%	32%
J	107%	99%	61%	86%	89%	101%
Overall	117%	105%	58%	87%	91%	119%

Source: *Audit analysis of DH records*

Note: *The achievement on target is calculated on a pro-rata basis, i.e. 9 months up to December 2023.*

Remarks: *The achievement on target for each NGO is calculated by comparing the actual number of service users against the target number of service users proposed by the NGO, i.e. 1,000 or 2,000 service users by the number of outreach dental team(s) in each service year (see para. 3.5). The overall achievement on target is calculated by comparing the total number of service users against the target of 43,000 service users for each service year (see para. 3.6).*

3.8 According to FSAs, for monitoring and evaluation purposes, an NGO shall prepare a monthly progress report to DH with information include service utilisation

(e.g. numbers of RCHEs/DEs and service users served) and other relevant indicators, and also an annual evaluation report (in a standardised format) to report the service performance (e.g. number of and names of RCHEs/DEs visited, number of service users receiving oral health assessments or dental treatments). If the NGO fails to conform to the required service quality standards and relevant requirements, it has to provide an explanation to DH and work out a plan to improve its services within a timeframe to be agreed with DH.

3.9 According to the annual evaluation reports of NGOs G and I, the reasons for not meeting the service users target in 2022-23 were:

(a) according to NGO G, due to the outbreak of COVID-19 epidemic, it had difficulties in meeting the target. It had suspended ODCP services until the relaxation of social distancing measures in early 2023; and

(b) according to NGO I, due to the outbreak of COVID-19 epidemic, RCHEs/DEs had turned down its requests to conduct ODCP services at the venues.

For improvement plans, both NGOs G and I stated that they would step up publicity of ODCP through phone calls, emails or site visits to RCHEs/DEs.

3.10 Upon enquiry, DH informed Audit in February and March 2024 that:

(a) the FSA periods under examination ran from October 2017 to March 2024 (see para. 3.4) during which there was COVID-19 epidemic and that the RCHEs/DEs refused NGOs for ODCP services in order to protect the elderly persons from infection;

(b) the number of service users set out in an FSA was the number of service users that an NGO seek to achieve and was for funding estimation purpose only. It was not designed to be restrictive;

(c) an NGO had to refund any overpaid amount to the Government if it could not achieve 50% of the proposed target number of service users and any surplus. As such, overpayment was never an issue;

(d) it was considered that NGOs were in the best position to assist the Government in the provision of ODCP services as they could use their social network and connection to reach RCHEs/DEs;

(e) it was understandable that NGOs had great difficulties in reaching RCHEs/DEs due to visit restrictions imposed by the Government and social-gathering restrictions during the service years in 2019-20 to 2022-23 under COVID-19 epidemic. Yet, DH understood that NGOs had tried their best to provide the service level they could. Also, different NGOs had different policies and governance in arranging work duties of their staff during COVID-19 epidemic;

(f) noting that NGO I had room for improvement, DH had a meeting with the administration team in June 2023. It was understood that NGO I had difficulties in resuming ODCP services due to professional manpower shortage, and had agreed to transfer one RCHE to another NGO for the provision of ODCP services. As for NGO G, it was a relatively much smaller NGO. DH fully appreciated its dedication to serve the public with its scarce resources, and had been tactfully encouraging it to make improvement but understandably it would take time; and

(g) in the 2023-24 service year, the number of ODCP service users up to mid-February 2024 was about 43,500 (i.e. exceeding the overall target of 43,000).

3.11 While noting DH's explanations, with a view to enabling more users to benefit from ODCP, Audit considers that DH needs to take further measures to enhance NGOs' performance in reaching their target numbers of service users under ODCP, in particular, providing assistance to those with difficulties in achieving the targets as needed.

Need to improve participation rate of RCHEs/DEs

3.12 According to the explanations provided by NGOs in annual evaluation reports, reasons for not meeting the target number of service users included refusal of RCHEs/DEs in participating in ODCP and that the elderly were not interested to receive the services. In addition, according to DH, there was a number of factors that would affect RCHEs'/DEs' interests in joining ODCP, including but not limited

to the premises size and setting, manpower of RCHEs/DEs, as well as individual medical and mental health conditions of the elderly persons. According to FSAs, an NGO is expected to approach and contact all RCHEs/DEs assigned to it (see para. 3.5) for promotion of participation in ODCP in each service year. Audit analysed the participation rates of RCHEs/DEs in ODCP for the period 2017-19 to 2023-24 (up to December 2023) (see Table 15) and noted that:

(a) the overall participation rate was 88% in 2017-19 and 68% in 2023-24 (up to December 2023) (Note 32);

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

(c) a further analysis by the 18 districts in Hong Kong in 2022-23 revealed that the participation rates of RCHEs/DEs in ODCP ranged from 47% (Sham Shui Po) to 94% (Yuen Long). Given the exceptionally low participation rate of the Sham Shui Po district, Audit further analysed the participation of RCHEs/DEs (totalled 93) in the district assigned to various NGOs. The results showed that while 37 (40%) RCHEs/DEs were assigned to NGO G, none of the RCHEs/DEs participated in ODCP. On the other hand, NGO J which was assigned 48 (52%) RCHEs/DEs in the same district achieved a participation rate of 81%, suggesting that the low participation rate might not be a district-specific issue.

Note 32: *In 2023-24 (up to December 2023), 715 (68%) out of the 1,051 RCHEs/DEs assigned to NGOs participated in ODCP.*

Table 15

Participation rates of RCHEs/DEs in ODCP
(2017-19 to 2023-24 (up to December 2023))

NGO	2017-19	2019-20	2020-21	2021-22	2022-23	2023-24 (up to December 2023)
A	95%	71%	42%	58%	74%	61%
B	83%	68%	44%	56%	57%	70%
C	83%	76%	44%	68%	69%	80%
D	96%	88%	4%	32%	36%	56%
E	83%	62%	8%	59%	63%	62%
F	95%	84%	88%	84%	92%	87%
G	58%	37%	8%	10%	5%	9%
H	83%	74%	57%	68%	78%	82%
I	86%	65%	3%	30%	19%	27%
J	94%	84%	53%	77%	84%	75%
Overall	88%	75%	45%	64%	68%	68%

Source: *Audit analysis of DH records*

3.13 According to FSAs, NGOs are expected to approach and contact all RCHEs/DEs assigned for promotion of participation in ODCP in each service year. The annual evaluation reports to be submitted to DH by NGOs under FSAs should be prepared in a standardised format (see para. 3.8), under which a list of RCHEs/DEs not served in the period (with reasons) should be attached. Audit noted that NGO G did not submit the lists for all service years under examination (i.e. from 2017-19 to 2022-23) in its annual evaluation reports. Upon enquiry, DH informed Audit in March 2024 that:

(a) information about RCHEs/DEs not served was input by NGOs and stored in DH's computer system, and that DH could retrieve such information for monitoring purpose; and

(b) in daily contact with NGO G, DH understood that NGO G did input the data into the computer system.

While noting DH's explanations, Audit considers that DH needs to take measures to ensure that NGOs submit the annual evaluation reports in accordance with FSA requirements, including the list of RCHEs/DEs not served in the period (with reasons) (see also Note 3 to Table 18 in para. 3.24). DH also needs to keep proper documentation on follow-up actions with NGOs.

3.14 According to DH, promotion efforts were made in collaboration with SWD from 2014 (i.e. the launch of ODCP) to 2018 to encourage RCHEs/DEs to participate in ODCP, such as arranging seminars to RCHEs/DEs, incorporating oral health requirements in the code of practice issued to RCHEs/DEs, and providing a list to SWD for its advice on the reasons for RCHEs/DEs not participating in ODCP. The promotion for ODCP was suspended during COVID-19 epidemic. In addition, it was not a standard practice for DH staff to follow up with non-participating RCHEs/DEs (e.g. enquire if they had been approached by NGOs for joining ODCP).

3.15 According to DH, the overall participation rate of RCHEs/DEs in ODCP for 2023-24 (up to February 2024) was 76%, which was highly comparable to that of the service year 2019-20. Furthermore, there were certain factors for RCHEs/DEs not participating in ODCP that were beyond DH's and NGOs' control (see para. 3.12). However, as one of the objectives of ODCP is to provide free dental care to the needy elderly in RCHEs/DEs, who may otherwise be unable to access conventional dental care services (see paras. 3.2 and 3.3(c)(i)), and the participation of RCHEs/DEs in the programme is essential for promoting and improving oral health of the elderly. In Audit's view, to enable more elderly to benefit from the programme, DH needs to step up efforts to ascertain the reasons for non-participation in ODCP of RCHEs/DEs (e.g. in collaboration with SWD), in particular individual NGOs having RCHEs/DEs with persistent low participation rates under their purview, and take measures to address the issue. DH also needs to strengthen the promotion work in encouraging RCHEs/DEs to join ODCP, including considering collaborating with SWD in related work.

Scope for improvement in monitoring NGOs' compliance with training requirements

3.16 The objectives of ODCP include promoting the importance of oral hygiene and oral health to the eligible elderly persons, their family members and caregivers, and also providing oral care training to caregivers in RCHEs/DEs (see para. 3.3(c)(ii) and (iii)). According to FSAs, an NGO needs to conduct at least one training activity

to caregivers (e.g. on-site visit, seminar and other appropriate training activity) to each participating RCHE/DE in each service year.

3.17 Audit analysed the number of training activities provided by NGOs to RCHEs/DEs for the period 2017-19 to 2023-24 (up to December 2023) based on DH's records and found that the percentage of RCHEs/DEs provided with training activities ranged from 25% (in 2020-21) to 93% (in 2017-19) (see Table 16). According to the annual evaluation reports submitted to DH and computer system records, NGO G did not provide any training activities to RCHEs/DEs since 2020-21.

Table 16

Percentage of participating RCHEs/DEs provided with training activities (2017-19 to 2023-24 (up to December 2023))

NGO	2017-19	2019-20	2020-21	2021-22	2022-23	2023-24 (up to December 2023)
A	100%	100%	70%	100%	93%	79%
B	100%	97%	57%	97%	97%	99%
C	97%	79%	65%	84%	100%	84%
D	100%	100%	100%	88%	100%	100%
E	52%	52%	67%	64%	49%	32%
F	86%	73%	3%	100%	97%	5%
G	69%	59%	0%	0%	0%	0%
H	94%	96%	83%	91%	94%	82%
I	98%	100%	0%	100%	100%	35%
J	96%	90%	0%	26%	89%	70%
Overall	93%	87%	25%	61%	89%	63%

Source: Audit analysis of DH records

3.18 Upon enquiry, DH informed Audit in March 2024 that:

(a) DH conducted physical meetings and phone interviews with individual NGOs to collect comments on ODCP and noted that RCHEs/DEs were not willing to accept training activities that involved group gatherings during COVID-19 epidemic and/or prevailing seasonal influenza periods. Therefore, outreach dental teams modified the mode of oral health education by providing individual elderly and his/her caregivers with personalised oral care plans to enhance the caregivers' ability in the provision of daily oral care to the elderly; and

(b) DH considered that the completion of personalised oral care plans had fulfilled the objective of ODCP in promoting oral hygiene, and was satisfied that with the completion of such plan for each elderly, 100% of the participating RCHEs/DEs had received oral health education from the outreach dental teams.

3.19 Audit noted that:

(a) the completion of personalised oral care plans (see para. 3.18) had been part of the oral health assessment and oral care planning provided to the elderly (see para. 3.3(c)(i)) by NGOs' outreach dental teams, which was an essential requirement for the provision of service by NGOs under ODCP. In other words, additional work was not required for providing such training; and

(b) according to DH's monitoring mechanism, NGOs are required to list out details of training activities in the annual evaluation reports, including dates, names of RCHEs/DEs, number of attendees and nature, provide training materials (e.g. powerpoint and video), and provide reasons for not being able to conduct at least one training activity for all RCHEs/DEs assigned. According to the annual evaluation reports submitted by NGOs, reported training activities mainly included group workshops, seminars and briefing sessions provided to caregivers. The completion of personalised oral care plans was not reported as training activities by NGOs in the annual evaluation reports/DH's computer system.

3.20 According to DH, promoting daily oral care is an important objective of ODCP and training of caregivers is a significant component of primary dental care services covered by the annual grant under ODCP. For NGOs which only delivered training through completion of the oral care plans (see also para. 3.19(a)), as the society returns to normalcy, to further enhance caregivers' knowledge on oral health care, Audit considers that there is merit for DH to keep under review the need for requiring NGOs to conduct other types of training activities in compliance with FSA requirements in addition to the completion of oral care plans.

Need to continue to ensure compliance with requirement on verification checks

3.21 According to DH's internal guidelines, DH shall conduct verification checks to RCHEs/DEs (Note 33). The purposes are to verify the eligibility of service users, if they had received the assessments/treatments as reported by NGOs, and if NGOs had kept proper documentation on the provision of services. According to DH, the checks were conducted on a random sampling basis and covered:

(a) all the participating NGOs (i.e. 10 NGOs for service years under examination);

(b) at least 36 RCHEs/DEs prior to 2022-23 and 5% of participating RCHEs/DEs since 2022-23; and

(c) for each RCHE/DE, 25 service users by on-site visits or 5 service users by telephone surveys.

3.22 Audit analysed the number of RCHEs/DEs and NGOs covered in verification checks conducted by DH (see Table 17) and noted that for the service years 2019-20 to 2021-22, the checks conducted did not cover the required number

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Note 33: *Prior to 2022-23, the verification checks were carried out by means of on-site visits to RCHEs/DEs. Since 2022-23, to lower the risk of infection to the elderly during COVID-19 epidemic, DH has introduced telephone surveys for carrying out the verification checks, under which staff of RCHEs/DEs were interviewed by telephone calls on the eligibility of the service users and ODCP services received, and the relevant supporting documents submitted to DH for inspection as appropriate.*

of RCHEs/DEs and all the participating NGOs. The shortfall ranged from 20 to 27 RCHEs/DEs and 1 to 2 NGOs respectively.

Table 17

Number of RCHEs/DEs and NGOs covered in DH's verification checks (2017-19 to 2023-24 (up to December 2023))

Service year	Number of RCHEs/DEs			Number of NGOs		
	required (a)	conducted (b)	shortfall (c) = (a) − (b)	required (d)	conducted (e)	shortfall (f) = (d) − (e)
2017-19	36	53	—	10	10	—
2019-20		9	27		8	2
2020-21		16	20		9	1
2021-22		14	22		8	2
2022-23	34	56	—		10	—
2023-24 (up to December 2023)	36	39	—		10	—

Source: Audit analysis of DH records

3.23 According to DH, verification checks by on-site visits to RCHEs/DEs were reduced due to the outbreak of COVID-19 epidemic. DH has introduced alternative measures (by means of telephone surveys — see Note 33 to para. 3.21) to conduct the verification checks. The required numbers of verification checks were met for 2017-19, 2022-23 and 2023-24 (up to December 2023). In Audit's view, DH needs to continue to take measures to ensure compliance with the requirement on the coverage of verification checks in the guidelines.

Need to step up monitoring of submission of reports by NGOs

3.24 NGOs are required under FSAs to submit reports, including annual evaluation reports and audited financial reports for ODCP within a specified timeframe after the close of the respective service year. The annual evaluation reports contain information for DH to monitor the performance of NGOs so as to ensure

provision of quality services to service users, while the audited financial reports help monitor the proper use of public money (e.g. amount of refund of surplus grant). Audit examined the submission of the reports for the period 2017-19 to 2022-23 (i.e. 5 service years) and noted non-submission and delays (see Table 18).

Table 18

Non-submission and delays in submission of reports for service years 2017-19 to 2022-23 (As of January 2024)

NGO	Annual evaluation report		Audited financial report	
	Non-submission/ delay (Note 1)	Number of reports	Non-submission/ delay (Note 2)	Number of reports
B	Not submitted	5	Delay	5
D	Delay	5	—	—
E	Delay	4	Delay	2
G	Delay (Note 3)	4	Not submitted Delay	1 4
H	—	—	Delay	1
I	Delay	4	Delay	1
J	—	—	Delay	1

Source: *Audit analysis of DH records*

Note 1: *Annual evaluation reports should be submitted within 3 months after the close of the service year. The delays ranged from 3 to 40 days.*

Note 2: *Audited financial reports should be submitted within 6 months after the close of the service year. The delays ranged from 5 to 336 days.*

Note 3: *In the annual evaluation reports submitted, NGO G did not attach a list of RCHEs/DEs not served (see para. 3.13).*

3.25 According to FSAs, late submission of annual evaluation reports or audited financial reports without prior approval from DH may be regarded as services not provided to the satisfaction of the Government, and may result in the Government recovering, withholding or refusing the payment of any part of the annual grant (see Note 29 to para. 3.3(b)) or termination of the agreement. Audit noted that as of

January 2024, NGO B had not submitted the annual evaluation reports for all the 5 service years despite repeated reminders by DH. DH withheld payments of the last instalments of the annual grant to NGO B for the relevant service years (totalling $290,570). However, reminders were not always sent to other NGOs for non-submission/delays in submission of reports (Note 34), and DH had not issued guidelines on follow-up actions on overdue reports to its staff.

3.26 Despite the measures taken by DH in paragraph 3.25, some NGOs did not timely submit the relevant reports in accordance with the FSA requirements. In Audit's view, DH needs to take further measures to ensure the timely submission of reports by NGOs and compliance with the FSA requirements. DH also needs to provide guidelines for staff on the follow-up actions on overdue reports.

Room for improvement in engaging NGOs for participating in ODCP

3.27 ***Need to further encourage NGOs to participate in ODCP.*** DH invited NGOs that operate dental services to participate in ODCP via an invitation for proposal exercise for each FSA period (see para. 3.5). According to DH, it intended to enter into contracts with about 16 to 20 selected NGOs which had the most suitable offers in response to the invitation for proposals. Under DH's assessment mechanism, NGOs must fulfil essential requirements and attain an overall passing score (see paras. 3.28 and 3.29) to be further considered for participating in ODCP.

3.28 Audit noted that for the invitation for proposal exercise for FSA period from April 2024 to March 2027, DH had identified 27 NGOs that met the essential requirements (e.g. must be a non-profit-making entity and was operating at least one dental clinic for the public) to attend a briefing session. A total of 11 NGOs had submitted proposal, i.e. one more NGO than the previous two invitation exercises. In other words, since the launch of ODCP in 2014 (see para. 3.2), the number of NGOs submitting proposals ranged from 10 to 11 (Note 35). In Audit's view, DH

Note 34: *According to DH, some NGOs communicated with DH's staff (e.g. by phones or emails) about delays in submission of reports. However, there were no evidence that prior approval had been given by DH in writing for the delays.*

Note 35: *All of the NGOs that submitted proposals were assessed to be suitable for the provision of ODCP services.*

needs to ascertain the reasons for non-participation in ODCP of NGOs and take measures to encourage more NGOs to submit proposals for participating in ODCP.

3.29 ***Need to consider service performance of NGOs in assessment.*** Under DH's criteria for assessing suitability of NGOs for providing ODCP services, NGOs must fulfil essential requirements, attain an overall passing score on particulars and experience of the NGOs as well as the quality of proposal (i.e. 50 out of a total score of 100) to be further considered for participating in ODCP. Past performance of the participating NGOs was not one of the assessment criteria.

3.30 Given that some NGOs did not achieve the service targets persistently and did not submit reports timely (see paras. 3.7, 3.17 and 3.24), DH needs to consider including past performance of NGOs as one of the criteria for assessing the suitability of NGOs for provision of services in future invitation for proposal exercises for ODCP as appropriate.

Need to formulate consolidated guidelines for monitoring implementation of ODCP

3.31 During the audit review, Audit requested for internal guidelines on the implementation of ODCP and DH provided a set of guidelines on verification checks (see para. 3.21). According to DH, various guidelines were available for staff's reference for monitoring the implementation of ODCP, including FSAs and general manuals, such as staff duty list, audit manual, computer system manual with guidelines on claims processing. However, there were no other specific and consolidated guidelines for monitoring the implementation of ODCP such as timeframe and authority for reviewing reports submitted by NGOs, and follow-up actions required on deviations from requirements in FSAs. In Audit's view, DH needs to promulgate a set of consolidated guidelines to staff on the monitoring of the implementation of ODCP and take measures to ensure compliance.

Audit recommendations

3.32 **Audit has *recommended* that the Director of Health should, regarding the implementation of ODCP:**

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

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

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

(d) **continue to take measures to ensure that NGOs record the training activities in DH's computer system and in annual evaluation reports;**

(e) **keep under review the need for requiring NGOs to conduct other types of training activities in compliance with FSA requirements in addition to the completion of oral care plans;**

(f) **continue to take measures to ensure compliance with the requirement on the coverage of verification checks in DH's guidelines;**

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

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

(i) **regarding the engagement of NGOs to participate in ODCP:**

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

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

(j) **promulgate a set of consolidated guidelines to staff on the monitoring of the implementation of ODCP and take measures to ensure compliance.**

Response from the Government

3.33 The Director of Health agrees with the audit recommendations. He has said that:

(a) fairly speaking, Audit's examination covered the two FSA periods of ODCP that were mostly affected by COVID-19 epidemic whereas protection of the elderly persons from infection was of utmost importance. With respect to the audit recommendation in paragraph 3.32(e), whilst there are merits of conducting other types of training activities to ensure compliance with FSA requirements, avoidance of social gathering by individualised oral care plans were considered to be the most appropriate training activity by that critical time;

(b) regarding the audit recommendations in paragraph 3.32(h) to (j), DH has worked out an operational manual by consolidating relevant parts of FSAs and existing manuals for ease of reference by staff in monitoring ODCP; and

(c) as a follow-up to the audit recommendation in paragraph 3.32(g), NGO B had submitted the five outstanding evaluation reports in mid-March 2024.

3.34 The Director of Social Welfare agrees with the audit recommendations in paragraph 3.32(b) and (c).

Implementation of the Elderly Health Care Voucher Scheme

3.35 Elderly persons aged 65 or above can make use of vouchers under EHVS for receiving private primary healthcare services that best suit their health care needs, including dental services (see para. 1.9). In 2022, the voucher amount claimed by elderly persons for private dental services was about $343 million (13% of the total

voucher amount claimed) and the average amount per claim transaction for dentists was $1,190. According to the Government, as of January 2024, the Government did not have plan to introduce vouchers under EHVS designated for dental services. However, the Government would explore ways to incentivise the elderly persons to receive regular dental check-ups by various measures, such as the promotion of dental check-ups in collaboration with the dental profession.

Need to remind dentists to inform DH timely of changes for updating information on EHVS website

3.36 Healthcare service providers in the private sector need to enrol in EHVS before eligible elderly persons can use the vouchers under the scheme for receiving services from them. DH publishes the list of dentists enrolled in EHVS with the clinic addresses and telephone numbers on EHVS website. Audit noted that:

(a) the percentage of dentists enrolled in EHVS to the number of dentists in the private sector actively practising in Hong Kong (Note 36) increased from 57% as at 31 December 2018 to 69% as at 31 December 2023 (see Table 19); and

Note 36: *The number of dentists in the private sector actively practising in Hong Kong refers to the number of dentists included in the general register of dentists under the Dentists Registration Ordinance, excluding dentists resident outside Hong Kong (i.e. who do not have any place of practice in Hong Kong), dentists who are economically inactive (e.g. retired) and dentists working in the public and academic sectors.*

Table 19

Number of dentists on EHVS dentist list
(2018 to 2023)

As at 31 December	Number of dentists in the private sector actively practising in Hong Kong (a)	Number of dentists enrolled in EHVS (b)	Percentage of dentists enrolled in EHVS (c) = (b) ÷ (a) × 100%
2018	1,843	1,047	57%
2019	1,892	1,171	62%
2020	1,920	1,219	63%
2021	1,980	1,296	65%
2022	2,055	1,331	65%
2023	2,141	1,477	69%

Source: DH records

(b) as at 31 January 2024, there were 1,472 dentists on the EHVS dentist list. In January 2024, Audit made anonymous enquiries to 20 private dental clinics involving 41 dentists on the EHVS dentist list (Note 37) as at 31 January 2024 and found that 4 (10%) dentists no longer allowed patients to use the vouchers under EHVS and 11 (27%) dentists no longer worked in the clinics (e.g. retired or resigned).

3.37 Upon enquiry, DH informed Audit in March 2024 that:

(a) healthcare service providers enrolled in EHVS are required under their agreements with DH to inform DH of changes (including retirement and resignation from the clinics) in any information or document submitted in relation to EHVS;

Note 37: *A private dental clinic may have one or more registered dentists. The dentists in a clinic may enrol in EHVS individually. Hence, a clinic may have some dentists enrolling in EHVS and some not enrolling in EHVS.*

(b) since 2015, DH has put in place a biennial database updating exercise to request updated information from enrolled healthcare service providers with the enrolment information appearing to be outdated (e.g. those could not be contacted via their previously provided correspondence addresses or having no active place of practice); and

(c) DH has been issuing annual reminders to enrolled healthcare service providers for updating their enrolment information.

To facilitate the public in using EHVS for dental services, Audit considers that DH needs to continue to encourage more dentists to enrol in EHVS and take measures to remind the dentists enrolled in EHVS to inform DH of the changes in their enrolment information in a timely manner for updating the information on EHVS website.

Audit recommendations

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

(a) **continue to encourage more dentists to enrol in EHVS; and**

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

Response from the Government

3.39 The Director of Health agrees with the audit recommendations.

PART 4: IMPLEMENTATION OF THE ELDERLY DENTAL ASSISTANCE PROGRAMME

4.1 This PART examines issues relating to the implementation of EDAP, focusing on the following areas:

(a) provision of services under EDAP (paras. 4.5 to 4.22);

(b) management and monitoring of service providers and implementing agent (paras. 4.23 to 4.42); and

(c) way forward (paras. 4.43 to 4.47).

Background

4.2 EDAP, funded by CCF (Note 38), was launched in September 2012 with an aim to provide low-income elderly persons with free removable dentures and related dental services (including oral examination, scaling and polishing, fillings, tooth extractions and X-ray examinations). Over the years, the eligibility and service scope have been expanded several times (see Appendix C). As of December 2023, elderly persons meeting the following criteria may apply for assistance under EDAP:

Note 38: *Prior to 2013, the work of CCF was overseen and coordinated by the Steering Committee on the CCF (chaired by the Chief Secretary for Administration). Following the re-establishment of CoP in December 2012 (chaired by the Chief Secretary for Administration), CCF has been integrated into the work of CoP. CCF Task Force, set up under CoP and chaired by the Secretary for Labour and Welfare, is responsible for advising CoP on CCF's various arrangements and the formulation of assistance programmes.*

(a) ***Eligibility criteria.***

(i) aged 60 or above using home care services subvented by SWD (Note 39) and paying level 1 or 2 fee charge for the services, and not a recipient of CSSA; or aged 65 or above receiving OALA (i.e. all OALA recipients);

(ii) have not benefitted from EDAP or for those aged 75 or above, have received dental services under EDAP at least 5 years ago (only applicable to "applicants for second time service"); and

(iii) have not benefitted from ODCP (see para. 1.8); and

(b) ***Suitability criteria.***

(i) have lost all/some of their teeth or suffer from dental illness; and

(ii) assessed to be in need of and suitable to have removable dentures and receive other related dental services.

4.3 With the expansion of service scope and eligibility, the number of applications for assistance under EDAP per year increased from 17,035 in 2018-19 to 29,675 in 2022-23, with the expenditure increased from $194 million to $292 million during the same period (see Table 6 in para. 1.10) (Note 40).

4.4 The Government, represented by the Secretary for Health, is responsible for administering, implementing and monitoring EDAP on behalf of CoP. HHB has entrusted Organisation A as the implementing agent to assist in the implementation of

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Note 39: *Home care services subvented by SWD include the Enhanced Home and Community Care Services and Integrated Home Care Services.*

Note 40: *In September 2023, an additional allocation of $1,258 million was approved by CoP to enhance and expand EDAP until end of September 2026. Since the launch of EDAP and up to October 2023, the approved allocation amounted to $3,517 million and the unused allocation was about $1,846 million.*

the programme since 2012. According to the service agreement (Note 41), Organisation A has set up a Project Office (Note 42) for carrying out the services set out in the agreement. An information technology system (i.e. Dental Appointment System) has been set up for dental appointment booking and management of claims for fees.

Provision of services under the Elderly Dental Assistance Programme

4.5 The major procedures involved in the provision of services under EDAP (as of December 2023) are as follows:

(a) ***Applications.*** Elderly persons who meet the application criteria (see para. 4.2) may apply for assistance under EDAP through the service units, i.e. SWD home care service teams (for SWD home care service users), or elderly/community centres or dental clinics operated by participating NGOs (for OALA recipients);

(b) ***Checking of eligibility and suitability.*** Staff of the service unit performs an initial screening on the eligibility (e.g. by checking supporting documents) and suitability (e.g. by completing a preliminary assessment questionnaire for assessing the need for dentures) of the applicant;

(c) ***Appointment with dentists.*** The applicant can indicate preference for a specific dentist/dental clinic on the application form. The staff will check

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Note 41: *A service agreement was signed in September 2012 with Organisation A, which sets out the terms and conditions as well as the service specifications for Organisation A to launch and implement EDAP (including setting up of a dedicated project team (i.e. a Project Office), recruitment and management of dentists/dental clinics and NGOs, verification and arrangement of payments, and submission of reports to the Government). According to the agreement, Organisation A should continue to implement the programme until the funding earmarked for the programme is fully disbursed or when the Government decides to end the programme, whichever is earlier.*

Note 42: *As at 31 December 2023, the Project Office was headed by a Project Manager and supported by 15 staff. In 2022-23, of the total expenditure of $292 million for EDAP, about $6 million was paid to Organisation A as administration fees (including staff costs of the Project Office).*

the Dental Appointment System if quota is available for the dentist (Note 43) and make an appointment for the first consultation session;

(d) ***Provision of dental services.*** Clinical assessments and necessary dental treatments are provided by the dentist to the applicant (Note 44);

(e) ***Payments to service units and dentists.*** The service unit and dentist/dental clinic submit claims for payment (e.g. administration fees and/or dental fees) to the Project Office. Payments are made to the service unit and dentist/dental clinic directly after verification; and

(f) ***Eligibility checks and verification checks.*** HHB, with the assistance of the Project Office, performs random checks on a sampling basis on applicants' OALA/CSSA status against SWD records. The Project Office also conducts post-treatment telephone surveys with beneficiaries (on a sampling basis) to ascertain if they have received the dental services according to the claims by the dentists/dental clinics, and gauge information on services provided and satisfaction towards the programme (Note 45).

A flowchart showing the procedures of provision of services under EDAP is shown in Figure 1.

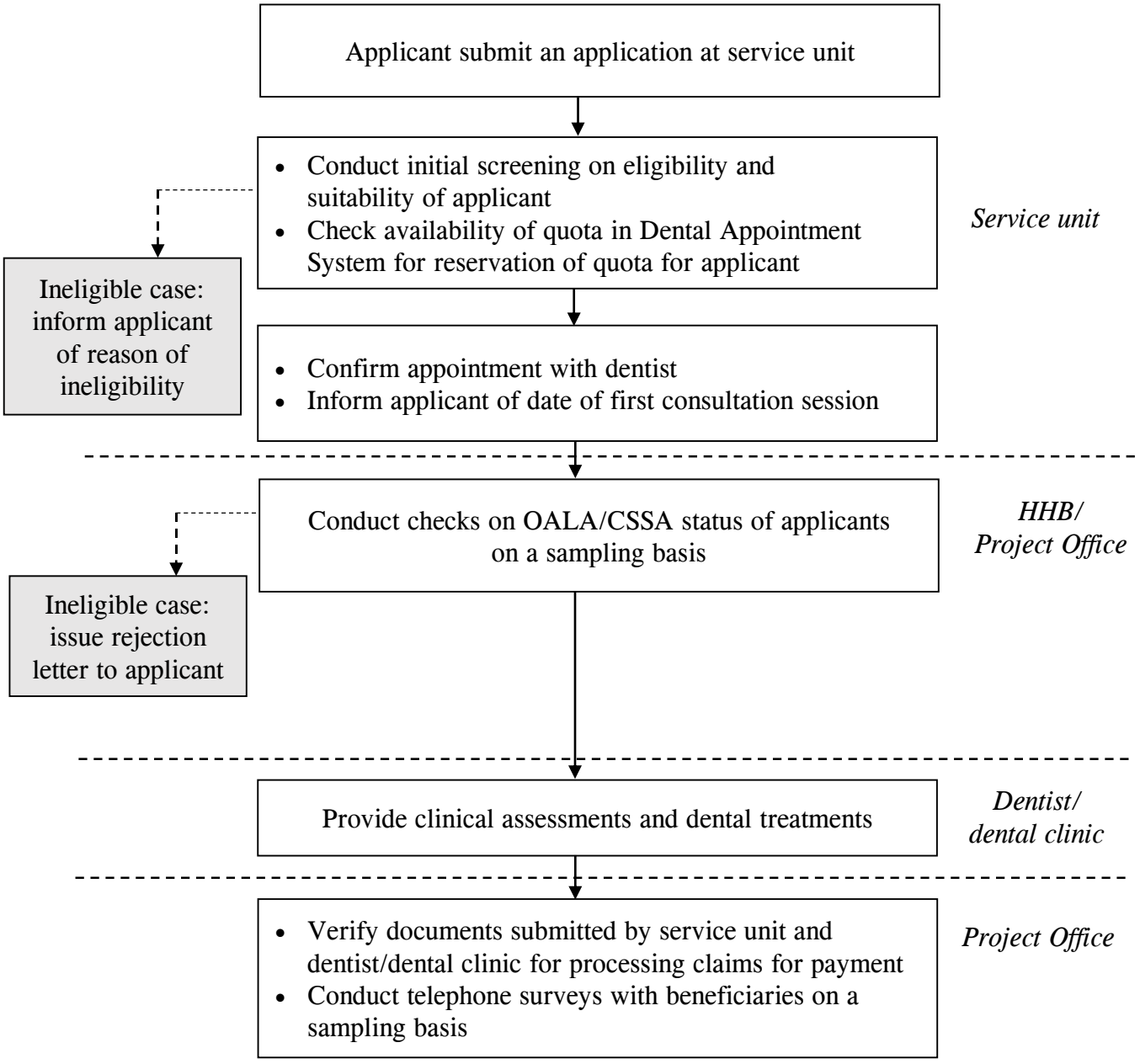
Note 43: *According to guidelines issued by Organisation A, participating dentists/dental clinics are required to inform the Project Office twice a year of the quota available for EDAP for each of the following 6 months. The Project Office will input the quota information in the Dental Appointment System.*

Note 44: *During the first consultation session, if the dentist considers that the applicant is not suitable to have removable dentures, the applicant will be provided with other dental services permissible for subsidy under EDAP (e.g. scaling and polishing). According to guidelines issued by Organisation A, no fees can be charged to the applicant by the dentists/dental clinics (including payment by EHVS — see para. 3.35).*

Note 45: *According to Organisation A, apart from the dental services received, the beneficiaries are also enquired about the satisfaction level towards EDAP, and any improvements in chewing with the installation of dentures. In 2022-23, 42% and 57% of the beneficiaries indicated that they were "very satisfied" and "satisfied" with EDAP respectively.*

Figure 1

Flowchart of provision of services under EDAP
(31 December 2023)



Source: *Organisation A records*

Need to further encourage eligible elderly persons to participate in EDAP

4.6 Audit analysis showed that the participation rates of eligible elderly persons in EDAP increased from 10% in 2018-19 to 20% in 2022-23 (see Table 20).

Table 20

Participation rate of EDAP
(2018-19 to 2022-23)

Item	2018-19	2019-20	2020-21	2021-22	2022-23
Number of eligible elderly persons (a) (Note 1)	542,066 (Note 3)	572,029	605,574	637,016 (Note 4)	687,331
Number of EDAP beneficiaries (b) (Note 2)	55,759	71,963	86,872	107,380	137,055
Participation rate (c)=(b)÷(a)×100%	10%	13%	14%	17%	20%

Source: *Audit analysis of SWD and Organisation A records*

Note 1: *In line with HHB's practice in reporting the participation rate of EDAP to the public, the number of OALA recipients was taken as the number of eligible elderly persons under EDAP because:*

(a) *elderly persons (aged 60 or above) using SWD home care services were required to pay a fee according to the fee scale based on their income levels (divided into 3 levels). Low-income elderly persons charged at levels 1 or 2 were eligible to apply for assistance under EDAP. The total number of SWD home care services users charged at levels 1 or 2 ranged from some 23,000 to some 29,000 for the period 2018-19 to 2022-23; and*

(b) *an elderly person aged 65 or above might be eligible for OALA, and at the same time using SWD home care services and charged at levels 1 or 2. As the number of such duplicate persons was not readily available, it was reasonable to gauge the participation rate based on the number of OALA recipients.*

Note 2: *This represents the cumulative number of applications since the launch of EDAP and up to 31 March of the respective year.*

Note 3: *With effect from 1 February 2019, the eligibility for EDAP has been expanded to include OALA recipients aged 65 or above (previously aged 70 or above).*

Note 4: *With effect from 1 July 2021, the eligibility for EDAP has been expanded to allow elderly person aged 75 or above and received EDAP services at least 5 years ago to apply for second time service.*

4.7 According to the Interim Report of the Working Group (see para. 1.12), the number of applicants for EDAP was rather low, indicating that some eligible elderly persons had not benefitted from the programme. According to HHB, the low participation rate was due to reluctance and unwillingness of the eligible elderly persons to accept dental treatments, or some of them had already had their own dentures. In this connection, Audit noted that Organisation A had estimated the numbers of beneficiaries under EDAP (Note 46) and the actual numbers of beneficiaries for the service years 2018/19 to 2022/23 were less than the estimated numbers by 13% to 53% (see Table 21).

Table 21

Comparison of estimated and actual numbers of beneficiaries
(For service years 2018/19 to 2022/23)

Beneficiary	2018/19	2019/20	2020/21	2021/22	2022/23
Estimated number (a)	36,000	19,776	21,600	24,000	27,000
Actual number (b)	16,829	17,117	14,781	17,440	22,494
Difference (c)=(a)−(b)	19,171	2,659	6,819	6,560	4,506
Percentage (d)=(c)÷(a)×100%	53%	13%	32%	27%	17%

Source: Audit analysis of Organisation A records

4.8 Under the service agreement, Organisation A is responsible for promoting EDAP to the public. According to Organisation A, promotional efforts for EDAP include arranging dentists to introduce and share information on the programme to the public through television and radio programmes, and through elderly/community centres to encourage participation (e.g. distribution of publicity materials).

Note 46: *According to the service agreement, Organisation A shall submit progress reports and financial reports to CCF Secretariat on a regular basis, and as and when required by the Government, which set out the latest position of the implementation of EDAP including statistical information. The estimates of number of beneficiaries are for budgeting purpose and prepared for each service year, i.e. September to August of the following year.*

4.9 The Government announced in the 2023 Policy Address that EDAP would be enhanced in the third quarter of 2024 to allow more eligible elderly persons to receive dental treatment services. The enhanced EDAP that will soon be implemented aims to provide dental services to benefit more eligible elderly persons (see para. 4.44). Given that the numbers of beneficiaries were less than those estimated by Organisation A in the past few years, HHB needs to, in collaboration with Organisation A, formulate further measures to encourage participation (e.g. step up promotion efforts on the benefits of EDAP to the elderly persons and address their concerns about joining the programme).

Room for improvement in vetting applicants' eligibility

4.10 Elderly persons who meet the eligibility criteria may apply for assistance under EDAP through the service units (see para. 4.5(a)). According to guidelines issued by Organisation A, initial screening on the eligibility of elderly person is performed by the service units at the time of application (e.g. checking of supporting documents — see para. 4.5(b)). Further eligibility checks are performed by HHB with the assistance of the Project Office (e.g. performs checks against SWD records for OALA/CSSA status of the applicants — see para. 4.5(f) and Note 47).

4.11 According to the eligibility criteria, elderly persons who have not benefitted from ODCP and EDAP previously (except those aged 75 or above and used EDAP services at least 5 years ago — see para. 4.2(a)(ii)) are eligible to apply for assistance under EDAP. Audit noted that:

(a) regarding the checking on applicant's participation in EDAP, service units would check the records in the Dental Appointment System; and

(b) with the imposition of an eligibility criterion that an EDAP applicant should not have benefitted from ODCP in September 2015 and up to December 2023, there was no random checking against DH records on whether the applicant had previously benefitted from ODCP. Upon enquiry, HHB informed Audit in February 2024 that:

Note 47: *According to HHB records, since launch of EDAP in September 2012 and up to December 2023, the rate of ineligible cases found in OALA/CSSA eligibility checks was 0.3%.*

(i) the proportion of ODCP users receiving removable dentures was very low over the years due to the frailty of ODCP users and associated difficulties to transport them to dental clinics for dental treatments. It appeared that the chances of receiving double benefits (i.e. benefitted under both EDAP and ODCP within a short period of time) were not extremely high; and

(ii) HHB started to carry out the relevant checks on a sampling basis since January 2024 and some ineligible cases were found.

4.12 In Audit's view, HHB needs to ensure that the eligibility checking mechanism on EDAP applicants covers all eligibility criteria (e.g. with expansion of eligibility criteria in the future).

Need to improve provision of information about service providers

4.13 According to the service agreement, Organisation A is required to maintain and update two lists of service providers, namely:

(a) list of participating service units (e.g. elderly/community centres), which is accessible by the public on the website set up by Organisation A for EDAP (List A); and

(b) list of participating dentists/dental clinics, which is distributed only to the NGOs operating the service units (List B).

4.14 According to guidelines issued by Organisation A, service units should not disclose information on List B (e.g. dentists' names and clinic addresses) to an applicant before receipt of his/her application for assistance under EDAP. In other words, information of the dentists/dental clinics is only disclosed at the time the applicant approaches a service unit to apply for assistance under EDAP, upon which he/she can indicate preference for a specific dentist/dental clinic to provide dental services. The service unit will then make an appointment with the dentist selected by

the applicant for first consultation session subject to the availability of service quota (see para. 4.5(c)) (Note 48).

4.15 Audit examination of HHB records revealed that there were comments from EDAP beneficiaries that the information of participating dentists/dental clinics (List B) should be made available earlier (so that they were allowed more time to consider the choice of dentist), instead of only disclosing to them by the service unit at the time of the application.

4.16 Audit also noted that:

(a) the Government launched the Primary Care Directory (the Directory) in 2011 with an objective to provide the public with an easily accessible web-based database of practice information (e.g. practice addresses, telephone numbers and service provisions) and professional qualifications of healthcare service providers (including dentists) in the community, as well as their participation in various government-subsidised programmes. In September 2023, HHB announced that as a move to tie in with the development of primary healthcare services, only doctors enlisted in the Directory would be allowed to take part in various government-subsidised primary healthcare programmes;

(b) for EHVS (see para. 3.35), members of the public can search for participating dentists in the Directory. DH also publishes on EHVS website the list of dentists enrolled in EHVS; and

(c) the Government plans to enhance EDAP to encourage elderly persons to receive preventive dental services (see para. 4.44).

4.17 In view of the beneficiaries' feedback and in line with the Government's practice in other government-subsidised programmes (e.g. EHVS) and promoting primary healthcare, HHB needs to consider publicising the list of dentists/dental

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Note 48: *The dentist concerned will provide all necessary dental services under EDAP for the beneficiary. Change of dentist will not be entertained after the first consultation session, unless under special circumstances with the approval from the Project Office.*

clinics participating in EDAP to the public (e.g. on the website set up by Organisation A for EDAP).

Room for improvement in making dental appointments for applicants without indication of preferred dentists

4.18 When an applicant submits an application at a service unit, he/she may indicate preference for a participating dentist/dental clinic in the district of his/her residence or in a different district for providing the dental services under EDAP (see para. 4.5(c)). If the applicant does not indicate any preference, the service unit will ask about his/her willingness to accept cross-district appointment if the service quota in the district of his/her residence is not available. According to guidelines issued by Organisation A, the service unit should make an appointment for the applicant based on the quota availability of the participating dentists as shown in the Dental Appointment System and with reference to his/her willingness to accept cross-district appointment or not. There are no other guidelines on circumstances in which quotas are available for multiple dentists.

4.19 Audit analysis revealed that in 2022-23, there was a significant variation in the number of new cases taken up by participating dentists under EDAP, ranging from 0 to 318 (averaging 32 cases). Audit examined the application forms of 60 new cases taken up by the 2 dentists (in 2 different districts) with the largest number of new cases (Note 49) and noted that:

(a) for 11 (18%) cases, 9 applicants did not indicate preference for a specific dentist/dental clinic on the forms, and 2 applicants just indicated preference for a specific dental clinic (with more than one dentist in the clinic);

(b) the reasons for making appointment with the 2 dentists for the 11 cases were not documented in the application forms; and

(c) the numbers of participating dentists in the 2 districts concerned were 27 and 45 respectively (based on List B as at 31 March 2023 — see para. 4.13(b)), and no appointments were made with 3 (11%) and 9 (20%)

Note 49: *In 2022-23, the 2 dentists handled 318 and 280 new cases respectively which represented 19% and 18% of the total numbers of new cases in their respective districts.*

of the dentists in 2022-23. Upon enquiry, HHB informed Audit in March 2024 that of the 12 dentists without any appointments, only 2 dentists provided quota for EDAP (see Note 43 to para. 4.5(c)) for 3 months in 2022-23.

4.20 To enhance transparency and accountability, HHB should require Organisation A to provide guidelines to service units on making appointments with dentists for applicants without indication of preferred dentists/dental clinics, and keep proper documentation on the considerations in making such appointments.

Audit recommendations

4.21 **Audit has *recommended* that the Secretary for Health should:**

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

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

(c) **consider publicising the list of dentists/dental clinics participating in EDAP to the public (e.g. on the website set up by Organisation A for EDAP); and**

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

Response from the Government

4.22 The Secretary for Health agrees with the audit recommendations.

Management and monitoring of service providers and implementing agent

Need to step up efforts in encouraging service providers to participate in EDAP

4.23 According to the service agreement, Organisation A shall liaise with dentists/dental clinics and NGOs and invite them to participate in EDAP. As at 31 December 2023, service providers under EDAP included 706 private dentists and 65 NGO dental clinics (with 105 dentists), 172 elderly/community centres and 81 SWD home care service teams operated by NGOs.

4.24 According to HHB, it regularly reviewed the number of participating dentists with Organisation A. Organisation A had also undertaken to recruit dentists to participate in EDAP (Note 50). Audit analysed the percentage of dentists in the private sector actively practising in Hong Kong (see Note 36 to para. 3.36(a)) participating in EDAP for the period 2018 to 2023. The results are shown in Table 22.

Note 50: *According to Organisation A, it had been promoting EDAP to dentists by releasing the latest information of the programme through its newsletter, organising monthly briefing sessions for interested dentists about operational processes and key points of the programme, and setting up booth in the annual Hong Kong International Dental Expo and Symposium.*

Table 22

Number of dentists participating in EDAP
(2018 to 2023)

As at 31 December	Number of dentists in the private sector actively practising in Hong Kong (a)	Number of dentists participating in EDAP (b)	Percentage of dentists participating in EDAP (c) = (b) ÷ (a) × 100%
2018	1,843	634	34%
2019	1,892	663	35%
2020	1,920	671	35%
2021	1,980	681	34%
2022	2,055	718	35%
2023	2,141	811	38%

Source: Audit analysis of DH and Organisation A records

4.25 On the other hand, Audit noted that the number of dentists withdrawn from EDAP had increased from 1 to 18 from 2018-19 to 2022-23, and then dropped to 7 in 2023-24 (up to December 2023). While a dentist who wish to withdraw from EDAP is required to submit to the Project Office a notification form (i.e. in a standard template), the dentist is not required to provide the reasons for withdrawal (Note 51).

Note 51: *According to Organisation A, the withdrawal numbers were higher during COVID-19 epidemic period (ranged from 18 (in 2022-23) to 24 (in 2020-21)). While the reasons for withdrawal were not required to be stated in the notification forms, from daily contacts with dentists/dental clinics, the withdrawals were mainly due to:*

(a) being too occupied in handling their own patients;

(b) personal grounds (e.g. migration and sickness); and

(c) avoiding administrative work involved in making claims.

4.26 While the number of dentists participating in EDAP had increased in the last few years, it accounted for about 38% of the dentists in the private sector actively practising in Hong Kong as at 31 December 2023. With the enhancement to EDAP (see para. 4.44), it was expected that the number of beneficiaries would increase. To cope with the increased demand, HHB needs to, in collaboration with Organisation A, step up efforts in encouraging dentists to participate in EDAP. Also, to facilitate evaluation of EDAP, there are merits for Organisation A to collect reasons for withdrawal from dentists (e.g. requiring dentists to provide the relevant information in the notification forms).

Need to expedite handling of long outstanding cases

4.27 Claims for payments of fees are submitted to Organisation A by service providers, which mainly include administration fees by service units, and dental fees by dentists/dental clinics (Note 52). According to guidelines issued by Organisation A to dentists/dental clinics, the claim forms for payment of dental fees should be submitted to the Project Office within 4 months upon delivery of dentures to the beneficiaries (Note 53). The Project Office verifies the claims for payments and arranges payments directly to service providers (e.g. dentists/dental clinics) twice a month (see para. 4.5(e)). According to Organisation A, the vetting of claims started upon submission of claim forms by the service providers. During the vetting process, the Project Office might need to contact the service providers to confirm/verify information, request them to provide explanations and/or supporting documents, and make corrections if necessary. Under normal circumstances, if all information is checked and in order, it will take around 2 to 4 months for release of payment.

4.28 Audit noted that the outstanding cases of claims for payments were categorised into two types for monitoring purpose in Organisation A's financial reports, and as at 31 December 2023 (see Table 23):

Note 52: *As at 31 December 2023, the maximum amount of subsidy per beneficiary included an administration fee of $50, a referral fee of $50, dental fees of $27,335 and an accompanying service fee of $70 per hour. The service charge ceilings for dental service items were referenced to those under CSSA dental grant, which were determined in consultation with DH.*

Note 53: *Organisation A's guidelines had not set a timeframe for the completion of dental treatments for installing dentures. According to Organisation A, the average completion time was around 3 months.*

(a) for cases with claim forms received from dentists/dental clinics (i.e. upon completion of dental treatments), the time lapse for 533 (4%) of the cases was over 1.6 years from the EDAP application dates; and

(b) for cases with claim forms not yet received from dentists/dental clinics, the time lapse for 654 (5%) of the cases was over 1.6 years from the EDAP application dates.

Table 23

Ageing analysis of outstanding cases of claims for payment (31 December 2023)

EDAP application date	Time lapse from application date (Note 2) (Year)	Number of cases with claim forms		Total
		received	not yet received	
30 May 2015 to 31 May 2016 (Note 1)	>7.6 to 8.6	24	3	27
1 June 2016 to 31 May 2018	>5.6 to 7.6	533 (4%) 11	654 (5%) 18	1,187 (4%) 29
1 June 2018 to 31 May 2020	>3.6 to 5.6	40	58	98
1 June 2020 to 31 May 2022	>1.6 to 3.6	458	575	1,033
1 June 2022 to 31 December 2023	≤1.6	13,407	12,023	25,430
	Total	13,940	12,677	26,617

Source: *Audit analysis of Organisation A records*

Note 1: *According to Organisation A, the payments for all cases with application dates on or before 29 May 2015 were completed.*

Note 2: *According to Organisation A, the time lapse included the time from application to first consultation, as well as for completion of dental treatments, submission of claim forms by dentists/dental clinics, verification of claims and arrangement of payments.*

Remarks: *The analysis was based on Organisation A's financial reports prepared for budgeting purpose. The period starts on 1 June each year to align with the annual adjustments in the ceiling amounts for dental treatment items payable for the dental grant under CSSA scheme (see Note 52 to para. 4.27).*

4.29 Audit examination of 200 long outstanding cases (i.e. over 1.6 years from the EDAP application dates; 100 cases with claim forms received and 100 cases without) found that:

(a) ***Claim forms received from dentists/dental clinics.*** According to Organisation A, under normal circumstances, if all information is checked and in order, it will take around 2 to 4 months for release of payment (see para. 4.27). Of the 100 cases examined:

(i) 73 (73%) cases had been outstanding for over 4 months (counting from the dates of receipt of claim forms), ranging from 123 to 2,984 days (i.e. about 8.2 years), averaging 771 days (i.e. about 2.1 years); and

(ii) for 48 (66%) of the 73 cases, there was no documentation on the reasons for the long processing time or follow-up actions (e.g. contacting dentists/dental clinics for supplementary information); and

(b) ***Claim forms not yet received from dentists/dental clinics.*** According to guidelines issued by Organisation A to dentists/dental clinics, claims for payments could be made if the beneficiaries could not be contacted by the dentists/dental clinics after 3 months of the last appointment. Of the 100 cases examined, it was noted that:

(i) for 54 (54%) cases, the Project Office had taken follow-up actions (e.g. contacting the dentists/dental clinics to enquire the status of cases). However, the follow-up actions for some cases were only taken an average of about one year after the first consultation sessions (Note 54); and

(ii) for the remaining 46 (46%) cases, there was no evidence of follow-up actions by the Project Office.

Note 54: *The average time lapse between the follow-up actions taken by the Project Office and the first consultation sessions was 362 days. However, as the Project Office did not have readily available information on the status of these cases (e.g. whether treatments were still in progress or completed), Audit could not ascertain whether the follow-up actions were taken timely by the Project Office.*

4.30 Audit noted that Organisation A's guidelines on vetting of payments did not stipulate a timeframe for the follow-up actions on long outstanding cases. To enhance the payment process and facilitate the monitoring of service provision, Audit considers that HHB needs to require Organisation A to strengthen its efforts in monitoring long outstanding cases, including formulating guidelines on the follow-up actions and the relevant timeframes, and keeping track of the treatment status of long outstanding cases.

Need to continue to take measures to monitor the implementing agent's performance

4.31 The Government has entrusted Organisation A as the implementing agent since the launch of EDAP (Note 55) and entered into a service agreement in 2012 (see Note 41 to para. 4.4). According to the service agreement, Organisation A is required to, among others, submit management reports to HHB on a monthly basis for monitoring purpose, which should set out statistical information (e.g. number of cases completed or in progress, and profile of beneficiaries including gender and age groups).

4.32 Audit examination found that monthly management reports were not submitted by Organisation A to HHB for the period from August 2018 to November 2023.

4.33 Upon enquiry, HHB informed Audit in December 2023 to March 2024 that:

(a) Organisation A had submitted the monthly management reports for the period from August 2018 to November 2023 in December 2023 and January 2024. Since then, the management report had been submitted on a monthly basis (e.g. the management report for December 2023 was submitted to HHB on 2 January 2024);

Note 55: *In February 2012, the former Steering Committee on CCF (see Note 38 to para. 4.2) endorsed that Organisation A, being a local non-profit-making professional organisation with a vast majority of locally registered dentists as members, was entrusted to be the implementing agent for EDAP. As such, it had not invited other organisations to implement the programme.*

(b) while the monthly management reports had not been provided from August 2018 to November 2023, the more prominent statistical information had been reported regularly (either quarterly or half-yearly) when HHB made progress report to CoP; and

(c) the implementation of EDAP had been under effective and continuous monitoring by CoP and CCF Task Force (see Note 38 to para. 4.2), with HHB submitted reports on the implementation progress which included the statistical information and financial status of the programme.

4.34 In Audit's view, HHB needs to continue to take measures to monitor the performance of the implementing agent of EDAP, including ensuring the timely submission of management reports.

Room for improvement in management of service agreements

4.35 Since entering into the service agreement with Organisation A in 2012 (see Note 41 to para. 4.4), supplementary agreements/amendment letters had been issued for expanding the scope of the programme, changing the ceiling amounts of subsidy or extending the service period of the programme (see Appendix C). Service units and dentists/dental clinics are required to register with Organisation A and abide by the terms and conditions therein to become EDAP service providers.

4.36 ***Need to incorporate clauses on safeguarding national security in service agreement.*** The Law of the People's Republic of China on Safeguarding National Security in the Hong Kong Special Administrative Region was implemented on 30 June 2020. The Law stipulates that it is the constitutional duty of the Hong Kong Special Administrative Region to safeguard national security. Audit examined the service agreement and the supplementary agreements/amendment letters (the latest one was issued to Organisation A in December 2023) and noted that there was no specific clause concerning safeguarding national security.

4.37 ***Need to issue supplementary letters timely.*** From time to time, CoP endorsed changes and enhancements to EDAP upon recommendations by CCF Task Force. According to the service agreement, it was agreed that the service specifications shall be amended to be consistent with any amendments to the

programme approved by CoP. The Government shall notify the implementing agent in writing of any such amendments and the consequential changes. The implementing agent agrees to accept such notification as evidence of such amendments and consequential changes as notified by the Government.

4.38 Audit examined the supplementary letters issued in the period from May 2013 to December 2023 and noted that the time lapse between the endorsement by CoP for the amendments and the issuance of the supplementary letters by HHB ranged from 8 to 376 days (averaging 122 days).

4.39 According to HHB, the Government has obtained agreement from Organisation A that any further changes to EDAP endorsed by CoP will not have to specifically seek the consent of Organisation A to such, and the parties shall not need to enter into any further agreement or other instrument in writing. That said, it has issued supplementary letters to Organisation A as evidence of such amendments. While noting HHB's view, as a good management practice, Audit considers that HHB needs to expedite actions in issuing supplementary letters.

4.40 In Audit's view, HHB needs to enhance the management of service agreements with the implementing agent, including incorporating specific clauses concerning safeguarding national security, and expediting actions in issuing supplementary letters upon endorsement of amendments to EDAP by CoP.

Audit recommendations

4.41 **Audit has *recommended* that the Secretary for Health should:**

(a) **in collaboration with Organisation A, step up efforts in encouraging dentists to participate in EDAP, and collect reasons for withdrawal from dentists (e.g. requiring dentists to provide the relevant information in the notification forms);**

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

(c) **continue to take measures to monitor the performance of the implementing agent of EDAP, including ensuring the timely submission of management reports; and**

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

Response from the Government

4.42 The Secretary for Health agrees with the audit recommendations.

Way forward

4.43 According to HHB, beneficiaries under EDAP should have lost all or some of their teeth or should be suffering from dental illness and encountering difficulties in eating or chewing. Although not explicitly expressed as the programme goal, the provision of removable dentures should be targeted at improving eating and chewing.

4.44 The Interim Report of the Working Group (see para. 1.12) stated that about 10% of EDAP users had reported no improvement in chewing or eating after the denture treatment. The Working Group was of the opinion that the priority of subsidising removable dentures should be reconsidered in order to make better use of limited resources. As such, according to the Interim Report, the essential requirement of fixing removable dentures for EDAP would be lifted, encouraging more eligible elderly persons to receive preventive dental services (e.g. dental check-ups, scaling, extraction and filling) without applying for removable dentures, with a view to encouraging elderly persons to identify and treat dental diseases at an early stage and to retain natural teeth as far as possible. According to HHB, it was estimated that an additional 88,630 elderly persons would be benefitted under the enhancement. In the long run, HHB would review the priority of giving out subsidies targeted only for denture cases having regard to the policy objectives of retaining natural teeth.

4.45 With the review on the target beneficiaries and service scope, and the expansion of EDAP, HHB needs to take into account the audit observations and recommendations in this Audit Report in implementing enhancements to EDAP.

Audit recommendation

4.46 **Audit has *recommended* that the Secretary for Health should take into account the audit observations and recommendations in this Audit Report in implementing enhancements to EDAP.**

Response from the Government

4.47 The Secretary for Health agrees with the audit recommendation. He has said that taking into consideration that the fitting of removable denture is a treatment category to address tooth loss which is a very advanced stage of dental diseases, the Working Group opined that the priority of subsidising removable dentures should be reconsidered in order to make better use of limited resources, and that it may be more appropriate to put the emphasis on primary dental services such as dental check-ups and scaling. In the long run, HHB will review the priority of giving out subsidies targeted only for denture cases having regard to the policy objectives of retaining natural teeth.

Appendix A
(paras. 1.4, 2.2 and Note 16 to para. 2.4 refer)

List of government dental clinics with General Public sessions

	Government dental clinics with GP sessions	Service session (Note 1)	Maximum disc quota (Note 2) (Number)
Hong Kong Island			
1.	Kennedy Town Community Complex Dental Clinic	Monday morning	84
		Friday morning	84
Kowloon			
2.	Kowloon City Dental Clinic	Monday morning	84
		Thursday morning	42
3.	Kwun Tong Dental Clinic	Wednesday morning	84
New Territories			
4.	Tsuen Wan Dental Clinic	Tuesday morning	84
		Friday morning	84
5.	Yuen Long Government Offices Dental Clinic	Tuesday morning	42
		Friday morning	42
6.	Fanling Health Centre Dental Clinic	Tuesday morning	50
7.	Mona Fong Dental Clinic (Note 3)	Thursday afternoon	42
8.	Tai Po Wong Siu Ching Dental Clinic	Thursday morning	42
9.	Yan Oi Dental Clinic (Note 3)	Wednesday morning	42
Islands			
10.	Cheung Chau Dental Clinic	First Friday morning of each month	32
11.	Tai O Dental Clinic	Second Thursday morning of each month	32

Source: *DH records*

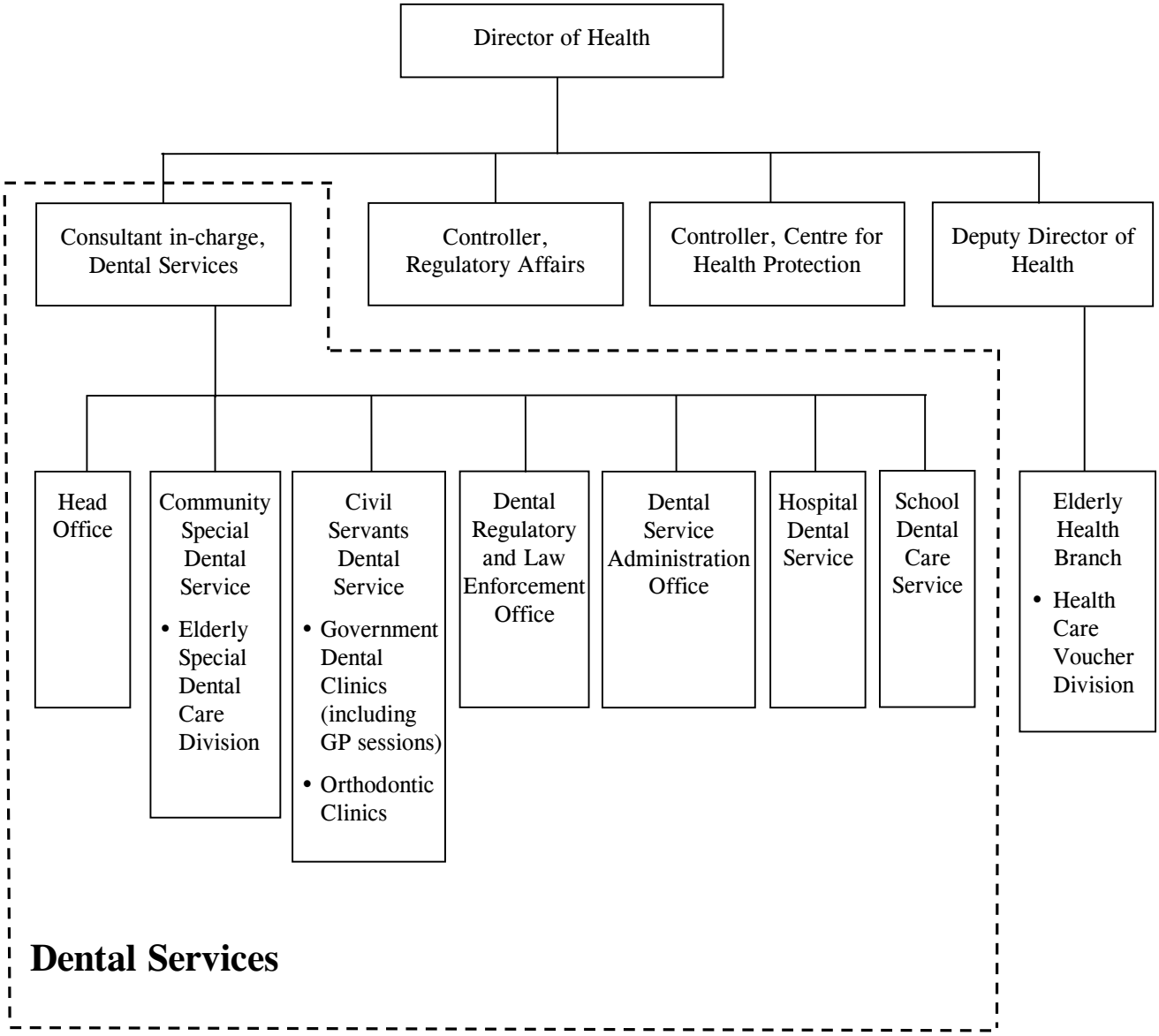
Note 1: *"Morning" service session runs from 8:45 a.m. to 1:00 p.m., and "afternoon" service session runs from 1:30 p.m. to 5:00 p.m.*

Note 2: *According to DH, disc quotas have been reduced by 25% or 50% since January 2020 due to COVID-19 epidemic and manpower shortage.*

Note 3: *The Mona Fong Dental Clinic and the Yan Oi Dental Clinic are located in Sai Kung and Tuen Mun respectively.*

Appendix B
(para. 1.14 refers)

Department of Health: Organisation chart (extract) (31 December 2023)



Source: *DH records*

Appendix C
(paras. 1.10, 4.2 and 4.35 refer)

Major changes on eligibility and service scope under the Elderly Dental Assistance Programme (September 2012 to December 2023)

Date	Eligibility	Service scope
September 2012 (launch of EDAP)	Elderly persons using home care services subvented by SWD (i.e. Enhanced Home and Community Care Services and Integrated Home Care Services) as at 31 December 2011 (i.e. cut-off date)	– Oral examination – Dentures for arches – Scaling and polishing – Fillings – Tooth extractions
June 2013	Cut-off date of home care services extended to 31 December 2012	—
October 2013	—	Added: – X-ray examinations
June 2014	– Expanded to include elderly persons using Home Help Service subvented by SWD – Cut-off date of home care services extended to 31 December 2013	—
December 2014	Removed the cut-off date requirement	
September 2015	Expanded to include OALA recipients aged 80 or above	
October 2016	Expanded to include OALA recipients aged 75 or above	
July 2017	Expanded to include OALA recipients aged 70 or above	
February 2019	Expanded to include OALA recipients aged 65 or above	
September 2020	Home Help Service ceased operation	
July 2021	Expanded to allow second time application for elderly persons aged 75 or above who received services under EDAP at least 5 years ago	Added: – Removal of bridges/crowns – Root canal treatments

Source: Audit analysis of HHB records

Acronyms and abbreviations

Audit	Audit Commission
CCF	Community Care Fund
CoP	Commission on Poverty
CSSA	Comprehensive Social Security Assistance
DE	Day care centre for the elderly
DH	Department of Health
EDAP	Elderly Dental Assistance Programme
EHVS	Elderly Health Care Voucher Scheme
FSA	Funding and Service Agreement
GP	General Public
HA	Hospital Authority
HHB	Health Bureau
NGO	Non-governmental organisation
OALA	Old Age Living Allowance
ODCP	Outreach Dental Care Programme for the Elderly
OHS	Oral Health Survey
OMSDC	Oral Maxillofacial Surgery and Dental Clinic
RCHE	Residential care home for the elderly
SWD	Social Welfare Department