A. Introduction

The Audit Commission ("Audit") conducted a review of the provision of public health services for the elderly by the Department of Health ("DH") and the Hospital Authority ("HA").

Background

2. According to the Census and Statistics Department, the population of elderly persons aged 65 or above is projected to increase from one million in 2013 to 1.45 million in 2021 and further to 2.2 million in 2031. The proportion of elderly persons will also increase from 14% of the whole population in 2013, to 19% in 2021 and further to 26% in 2031. The significant increase in the proportion and number of the elderly in the coming years poses great challenges and pressure to existing healthcare system.

3. Public health services for the elderly are mainly provided by DH and HA. Elderly healthcare services provided by DH are mainly primary care services which aim to improve self-care ability of the elderly, identify health risks and detect diseases for timely intervention. Health programmes launched by DH are as follows:

- Health assessment services and curative treatments for the elderly aged 65 or above provided by Elderly Health Centres ("EHCs") established in each of the 18 districts;

- Elderly Health Assessment Pilot Programme ("EHAPP") under which 10 000 elderly aged 70 or above recruited through participating non-governmental organizations ("NGOs") are provided with subsidized health assessments and follow-up consultations within the two-year pilot period. The Pilot Programme has started operation since July 2013;

- Educational health promotion activities ("HPAs") and advisory health services for the elderly and carers of residential care homes for the elderly ("RCHEs") and other elderly-related institutions ("non-RCHEs") provided by Visiting Health Teams ("VHTs") established in each of the 18 districts; and

- Elderly Health Care Voucher Scheme ("EHCVS") to subsidize the use of healthcare services in the private sector for elderly aged 70 or above.

The estimated expenditure for the above services in 2014-2015 amounted to $1,034 million.

4. HA provides primary care services through its 73 General Out-patient Clinics ("GOPCs"), while secondary and tertiary care services are provided through its hospitals and 47 Specialist Out-patient Clinics ("SOPCs"). Expenditure for the operation of HA in the financial year of 2013-2014 was $50 billion, of which the expenditure spent on elderly patients amounted to around 46% (i.e. $23 billion) of HA's total expenditure in the year.

The Committee's Report

5. The Committee's Report sets out the evidence gathered from witnesses. The Report is divided into the following parts:

- Introduction (Part A) (paragraphs 1 to 9);
- Elderly health assessment services of DH (Part B) (paragraphs 10 to 30);
- Educational and advisory health services provided by Visiting Health Teams of DH (Part C) (paragraphs 31 to 38);
- Administration of DH's Elderly Health Care Voucher Scheme (Part D) (paragraphs 39 to 47);
- HA's provision of Specialist Out-patient service to elderly patients (Part E) (paragraphs 48 to 61); and
- Conclusions and recommendations (Part F) (paragraphs 62 to 64).

Public hearing

6. The Committee held two public hearings on 16 December 2014 and 5 January 2015 to receive evidence from witnesses.

Opening statement by the Secretary for Food and Health

7. **Dr KO Wing-man, Secretary for Food and Health**, made a statement at the beginning of the public hearing. The full text of his statement is in ***Appendix 19***, the summary of which is as follows:

- DH would actively follow up on the review of the services of EHCs, enhance the service effectiveness of the provision of HPAs by VHTs, and improve the administration of EHCVS;

- HA would make every effort to shorten the waiting time for specialist out-patient services, optimize the appointment scheduling arrangements, extend the cross-cluster referral arrangements and provide community geriatric assessment team ("CGAT") service at more RCHEs; and

- in enhancing elderly healthcare services in a bid to tackle the challenges presented by the ageing population, HA had launched the General Outpatient Clinic Public-Private Partnership Programme piloted in a few districts to relieve the pressure on HA's out-patient services. Depending on feedback of the programme, the Administration would consider extending the programme to other districts progressively over the coming years.

Opening statement by the Director of Health

8. **Dr Constance CHAN Hon-yee, Director of Health**, made a statement at the beginning of the public hearing. The full text of her statement is in ***Appendix 20***, the summary of which is as follows:

- DH would take into account the Audit's recommendations in reviewing EHCs' capacity and strategic directions with a view to reducing the waiting time for enrolments for first-time health assessment. The review would take into account the experience gained from the implementation of EHAPP;

- a review on the reasons for the variations in waiting time of allied health counseling services in different EHCs and the reasons for no-show for the service would be undertaken so as to implement relevant improvement measures;

- a review on the mode of operation of VHTs in conducting HPAs would be undertaken with a view to introducing service improvements; and

- a comprehensive review of EHCVS would be conducted in mid-2015. DH would continue to encourage the elderly and healthcare service providers to participate in the programme.

Opening statement by Chief Executive of Hospital Authority

9. **Dr LEUNG Pak-yin, Chief Executive of HA**, made a statement at the beginning of the public hearing. The full text of his statement is in ***Appendix 21***, the summary of which is as follow:

- HA would continue to implement various measures to improve the waiting time at SOPCs, such as referring patients with stable and less complex conditions to the Family Medicine Specialist Clinics ("FMSCs") and GOPCs thereby alleviating the pressure of SOPCs; enhancing manpower at SOPCs to further increase its capacity and exploring the possibility of launching public-private partnership projects on SOPC services for those specialties with higher demand but of a non-acute nature;

- comprehensive, consistent and up-to-date waiting time information would be displayed in SOPCs and on HA's website to increase transparency;

- HA would consider extending the cross-cluster referral arrangement to other specialties where appropriate;

- HA would improve and coordinate the appointment scheduling of SOPC cases to enhance booking arrangement, such as adopting an over-booking mechanism to fill up cancelled and defaulted appointments to fully utilize service capacity; and

- HA would continue to review the service model of CGAT with a view to enhancing the quality of healthcare services for elderly residing in RCHEs, including the provision of CGAT service to more RCHEs as appropriate.

B. Elderly health assessment services of DH

10. As pointed out in paragraph 2.3 of the Director of Audit's Report ("Audit Report"), chronic diseases are taking up more and more of the capacity of Hong Kong's healthcare system. They are also the major causes of death. The Committee noted that the "Hong Kong Reference Framework for Preventive Care for Older Adults in Primary Care Settings" ("Reference Framework") published in 2012 by the Working Group on Primary Care[1] chaired by the Secretary for Food and Health affirmed that targeted, proactive and community-based preventive care was more cost-effective than downstream acute care. With a significant increase in the number of older people in the coming years, it was evident that the health assessment services provided by EHCs for the elderly played a vital role in the healthcare system in that it facilitated early and targeted intervention of various health risks at their early stage.

11. As stated in paragraphs 2.6 and 2.7 of the Audit Report, in the past 10 years, the elderly population increased from 831 000 in 2004 to 1 049 000 in 2013, but the 18 EHCs had still provided less than 40 000 health assessments a year to the elderly, and the manpower of the 18 EHCs had remained unchanged over the years. This indicated that the capacity of EHCs had not been expanded in a timely manner to align with the growth of the elderly population. Given the importance of health assessment services for the elderly in the healthcare system, the Committee enquired why DH had not expanded the capacity of EHCs in a timely manner to align with the growth in elderly population.

12. **Secretary for Food and Health** responded as follows:

- the Administration reckoned the challenges arising from increasing demand for elderly healthcare services due to an ageing population. The Government's policy in this regard was to ensure the provision of efficient and cost-effective healthcare services to the public, including the elderly, in a sustainable manner through a dual-track system comprising both the public and private sectors. It would not be feasible, if not impossible, to rely solely on DH to meet all the healthcare needs of the elderly. To this end, the Administration would

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

endeavor to maintain a proper balance between the public and private healthcare sectors in providing services to meet the long term healthcare needs of the population, including the elderly, through various healthcare policies and measures;

- as a matter of fact, the private sector was the major provider of primary healthcare services, with about 70% of out-patient consultations being taken care of by private medical practitioners. To encourage the elderly to use primary care services in the private sector, the Administration had launched a series of initiatives including EHCVS to subsidize the elderly to use private sector healthcare services; and

- the objective of setting up one EHC in each district was not purely for the purpose of service provision, but to set a reference benchmark for public health surveillance and quality assurance, and to become a role model at the community level for the provision of an integrated and multi-disciplinary primary care services for the private sector and NGOs to follow suit. Having said that, the Administration would seek to appropriately expand the capacity of EHCs, subject to the availability of public funding, to meet the growing demand for primary care services by the elderly.

Waiting time for enrolment and first-time health assessment at EHCs

13. The Committee noted that the elderly needed to wait for a long period of time to enroll as members of EHCs and receive first-time health assessment services. Audit's analysis of health assessments conducted by EHCs in 2013 revealed that the mix of first-time and subsequent health assessments of EHCs varied significantly. Assuming zero additional intake and attrition, it would take, averaging amongst the 18 EHCs, 3.7 years to clear the waiting list. In some districts such as Wan Chai and Yau Ma Tei, the waiting time[2] could be as long as over nine years. The Committee further noted from an analysis of over 38 900 health assessments cases conducted in 2012 that 32% of some 5 000 elderly who received first-time assessments in the year were found to have medical conditions, whereas only 7% of some 33 900 elderly who received their subsequent health assessments in the year had new medical conditions found (paragraph 2.10 of the Audit Report refers). In the light of the above, the Committee enquired:

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

- what measures DH had taken to address the problem of long waiting time for first-time assessments; and

- given the importance of first-time assessments in the identification of medical conditions, whether DH had devised a strategic direction in the mix of service provision of each EHC, such as allocating more manpower to conducting first-time assessments vis-à-vis subsequent assessments in districts that had long waiting time for first-time assessments.

14. **Director of Health** responded at the hearing and **Secretary for Food and Health** supplemented in his letter dated 24 December 2014 (in ***Appendix 22***) that:

- DH had kept the median waiting time for first-time assessments of EHCs under regular review. In 2007, DH undertook measures, such as the adoption of a simplified questionnaire for health assessments and streamlined procedures of health assessments for existing members, and allocated additional manpower and resources to meet the needs of elderly on the waiting list. As a result, the median waiting time decreased from 38.3 months in 2007 to 10.4 months in 2011;

- however, the median waiting time started to rise again from 2011 onwards, owing to the growing demand for the services. DH then decided to explore the feasibility of adopting alternative models of service provision, such as the introduction of EHAPP in 2013; and

- in order to cope with the service demands for EHCs, DH had successfully bid additional manpower for the creation of two clinical teams in Lek Yuen EHC and Wan Chai EHC in the financial years of 2014-2015 and 2015-2016 respectively.

As regards the suggestion of re-shuffling the mix of first-time assessments vis-à-vis subsequent assessments, **Director of Health** explained that service mix of individual EHCs was determined taking into account a number of factors, such as the rate of increase of elderly seeking to enroll as new members, the renewal rate of existing members, the number of members seeking curative treatments etc. Nevertheless, the Administration agreed with the Audit's recommendation of the need to review the mix of first-time and subsequent assessments of individual EHCs so that more sessions might be allocated to first-time assessments to solve the problem of long waiting time.

15. **Secretary for Food and Health** supplemented that:

- EHCVS was introduced as a pilot scheme in 2009 with the aim of offering a wider choice of primary care services to the elderly in addition to the existing available public healthcare services. The Administration considered that the pilot scheme allowed a more efficient use of healthcare resources in the market as it adopted the "money-follow-patient" concept under which an elderly was able to allocate healthcare resources flexibly to meet their own healthcare needs. An elderly could utilize health care vouchers for seeking health assessment services at private medical practitioners of their choices; and

- out of DH's estimated expenditure of $1,034 million for the provision of elderly healthcare services in the financial year of 2014-2015, the expenditure for the operation of EHCs accounted for $123 million while that of EHCVS accounted for $846 million. By converting EHCVS into a recurrent programme in 2014 and increasing the annual voucher amount to $2,000, the Administration hoped to tap healthcare resources in the private sector to meet the elderly's demand for primary care service and to lessen the pressure on the public health system.

16. On the specific measures to shorten the waiting time for first-time assessments, **Secretary for Food and Health** supplemented, after the public hearings, in his letter dated 24 December 2014 (in Appendix 22) that DH would:

- monitor the curative treatment attendance at EHCs and adding extra time slots for health assessments at those centres with lower attendance for treatment. Currently, nine EHCs had already employed this measure;

- review the justifications for the provision of curative treatments by EHCs and explore the feasibility of setting a quota for curative services each day, so that more time slots could be allocated for conducting health assessments;

- review the mix of first-time and subsequent health assessments in all EHCs to reduce the disparity among them and to shorten the waiting time for first-time health assessments; and

- display updated list of median waiting times for all EHCs on the Elderly Health Service website and at EHCs to increase transparency and

facilitate the elderly to choose enrolling at those centres with relatively shorter waiting time.

Efficient utilization of manpower of EHCs

17. Noting that EHCs would conduct curative treatments for the elderly in the afternoon, the Committee enquired about the justifications for the provision of curative treatments by EHCs, in view that HA was already providing similar services through its GOPCs. The Committee further enquired whether the review on the operation of the parallel systems in the provision of curative treatments by both EHCs and GOPCs mentioned at a meeting of Panel on Health Services of the Provisional Legislative Council held in 1997 (paragraph 2.15 of the Audit Report refers) had been conducted. **Chief Executive of HA** replied that GOPCs were managed by DH before 2003 and in 1997, there might be calls for reviewing the parallel systems which were by then operated under the same department. The management of GOPCs was then transferred to HA in July 2003. Since then, the mode of service provision of curative treatments under EHCs and GOPCs had been different. The focus of GOPCs in the provision of curative treatments was more from a risk management perspective, rather than on the basis of the age of the patients.

18. The Committee pointed out that the mix of first-time and subsequent assessments as well as the number of curative treatments conducted by EHCs varied significantly across different districts, implying that there might be a possibility of spare capacity for some EHCs in view of different service demand across districts. The Committee enquired whether DH had conducted any study to ascertain:

- the levels of service demand of different districts, taking into account demographic characteristics, socio-economic conditions and other relevant factors of each district; and

- the extent of spare capacity of each EHC,

so that the manpower resources could be adjusted or re-deployed among EHCs to meet the varying levels of service demand.

19. **Director of Health** responded that:

- each EHC was manned by a clinical team comprising a Medical and Health Officer and three nursing staff. Their capacity was more or less fully utilized as shown by the fact that total number of assessments conducted each year was roughly the same across the board;

- as there was only one clinical team in each district, it would not be possible to re-deploy the manpower of EHCs across districts lest the services provided for the districts would be adversely affected;

- taking on board the recommendations of Audit, the clinical team of each EHC would review its mode of service delivery and adjust its service mix where possible to better cope with service demand; and

- DH would explore how the two newly added clinical teams in Wan Chai EHC and Lek Yuen EHC in 2014-2015 and 2015-2016 respectively could be allocated to clear the long waiting list for first-time assessments of some EHCs. Apart from stationing at the respective EHCs, they might be deployed to provide additional sessions to EHCs with a long waiting list on a rotational basis.

20. The Committee enquired about the projected reduction in waiting time as a result of the deployment of the two additional clinical teams. **Secretary for Food and Health** replied to the Committee after the public hearings (in Appendix 22) that DH would monitor the statistics of all 18 EHCs closely and flexibly deploy the manpower having regard to the waiting list and physical environment (where space was available in EHC for accommodating an additional team) of each EHC. It was estimated that each additional clinical team would be able to conduct 2 125 health assessments every year. DH, however, considered it not possible to give a projection on the reduction in waiting time at this stage. DH would closely monitor the waiting time after improvement measures had been implemented.

21. In reply to the Committee's enquiry of whether DH had conducted any review or study to ascertain the demand for health assessment services in each district, **Secretary for Food and Health** supplemented after the public hearings (in Appendix 22) that two reviews were conducted in 2002 and 2007 respectively on the demand for health assessment services as well as measures to shorten the waiting time for enrollment to EHCs. The first review in 2002 concluded that the orientation of EHCs should be changed from mere service provision to that of

benchmarking and health monitoring, while the second review in 2007 recommended the implementation of measures to shorten waiting time for first-time assessments. To address the needs of various target groups in the community, the Administration was currently planning the establishment of locally-based community health centres in the districts, taking into account the priority of different districts, size and demographic characteristics of target population and health workforce of the district.

Role of EHCVS in supplementing the services of EHCs

22. Taking note of the remarks made by Secretary for Food and Health that EHCs should not be regarded as the only source of primary care service provision, and that EHCVS was introduced to offer an alternative model of service delivery to meet the needs of the elderly, the Committee requested for the following statistics:

- how many elders on the waiting list for enrollment to EHCs to receive first-time health assessments had alternatively sought the service in the private sector by using health care vouchers; and

- on the use of health care vouchers by the elderly, the ratio of vouchers used for the purposes of health assessments and other preventive care as captured by the eHealth System[3].

23. **Director of Health** replied that DH did not have the relevant statistics. The eHealth System was purposely designed for capturing information relevant for the administration of EHCVS. Enrolled healthcare service providers could input some basic information into the system, such as the particulars of the elderly, the amount of vouchers used and the reasons of the visits by the elderly. It would not be possible for DH to extract insightful information from the eHealth System for determining whether the elderly on the waiting list for EHCs had actually used health care vouchers for conducting health assessment services in the private sector.

24. The Committee pointed out that as stated in paragraph 4.16 of the Audit Report, in the five years from 2009 to 2013, health care vouchers were mainly used by the elderly for settling medical fees for treating acute episodic conditions, with

3 The eHealth System was purposely designed for EHCVS, providing an electronic platform on which participating healthcare service providers can manage the registration of eHealth accounts for the elderly and to submit claims to DH on the vouchers used by the elderly

only a small percentage (less than 9%) of the vouchers being used for preventive care purposes. The Committee was doubtful whether EHCVS was of any help in alleviating the problem of long waiting time for enrollment to EHCs to receive first-time assessments. In response, **Director of Health** made the following remarks:

- the eHealth System only captured basic information on the reasons of visits for which health care vouchers were used by the elderly. No definite conclusion could be drawn from the existing data without a detailed analysis on how the health care vouchers were used for;

- nevertheless, DH recognized that the elderly mainly used the vouchers for medical treatments and preventive care was accorded a relatively low priority. More work needed to be done to encourage the elderly to use health care vouchers for primary care services including health assessments; and

- DH would conduct a comprehensive review of EHCVS in mid-2015 to collect relevant statistics and information conducive to the enhancement and further development of the Scheme.

25. **Secretary for Food and Health** added that it would also be conducive to the development of EHCVS to conduct a survey as to whether the elderly on the waiting list for enrollment to EHCs had sought primary care services by other means, such as using health care vouchers in the private sector. That said, he was of the view that the elderly should not be excluded from the waiting list even if they could meet their needs of primary care services by alternative means as EHCs could provide a comprehensive primary care services for them.

Plans and timetable for implementing the Audit's recommendations

26. The Committee noted that Director of Health had agreed to the Audit's recommendations as stated in paragraph 2.18 of the Audit Report and enquired about details of the follow-up actions. In reply, **Secretary for Food and Health** stated in his letter of 24 December 2014 (in Appendix 22) that:

- in response to paragraph 2.18(a), DH had introduced various measures and initiatives such as EHAPP and EHCVS to meet the various demands of the elderly for primary care services. As explained earlier, it would not be feasible to solely rely on the capacity of EHCs to cope with the

growth in elderly population. DH would conduct a comprehensive review of EHCVS in mid-2015 and an evaluation of EHAPP by end of 2015, and would make reference to the results of these studies when reviewing the strategic direction of EHCs;

- as regards paragraphs 2.18(b) and (c), DH would review on each EHC having regard to the number of elderly on the waiting list and the demand for subsequent assessments and curative treatments in the districts to see if the service mix of individual EHCs could be adjusted. In addition, two additional clinical teams were successfully bid in the financial years of 2014-2015 and 2015-2016. DH would explore the feasibility of setting a performance pledge in 2016 after the two additional clinical teams had been established and the experience of their operation had been reviewed; and

- with respect to paragraph 2.18 (d), DH would compile relevant statistics on a monthly basis for ongoing monitoring on the waiting list of elderly awaiting enrollment and first-time assessments in each EHC.

27. The Committee highlighted the importance that unless a performance pledge and a timetable for achieving the pledge could be given, the problem of long waiting time for enrollment for first-time health assessments in EHCs could not be effectively addressed. **Secretary for Food and Health** affirmed the reply of Director of Health in that DH would explore the feasibility of setting a performance pledge for the waiting time for enrollment and first-time assessments in EHCs after the two additional clinical teams were in service. He said that unless sufficient resources were provided for expanding the capacity of EHCs, it would be difficult to commit a performance pledge at this stage.

28. In reply to the Committee's further enquiry on why DH would provide subsequent health assessments for every EHC member once every 18 months, and yet no target or performance pledge was set on the waiting time for first-time health assessments, **Secretary for Food and Health** replied after the hearings (in Appendix 22) that in accordance with the Reference Framework, independent elderly with no known chronic diseases were recommended to have health assessment every one to three years, and those who also had chronic diseases or risk factors were recommended to be assessed at more frequent intervals, e.g. on a yearly basis. In 2013, 96% of EHC members had chronic diseases. EHCs, as a model for continuous and comprehensive care for the elderly, had complied with this evidence-based recommendation. The only way to reduce waiting time

substantially was to expand the capacity of EHCs but it was difficult to set a meaningful target without a firm commitment of additional resources and in light of the current severe shortage of healthcare manpower especially doctors.

29. The Committee enquired whether DH would conduct a comprehensive review on the mode of operation of EHCs to better cope with the growth in the elderly population in the coming decades. **Secretary for Food and Health** replied after the hearings (in Appendix 22) that EHCs, as benchmarks for the surveillance of health problems and quality assurance, had served as sentinel points in the 18 districts to collect important health information on the health status of the elderly. To address the concerns about the long waiting time for first-time health assessments, DH would review the strategic directions of EHCs in light of the experience gained through new models of service provision including EHCVS and EHAPP.

Effectiveness of EHAPP

30. The Committee was concerned about the low enrollment rate for EHAPP. **Director of Health** responded at the public hearing that there had been significant improvement in the enrollment of elderly for the programme in the past few months. The reason for the improvement in enrollment was that participating NGOs had used more effective channels in approaching eligible elderly. In reply to the Committee's enquiry on the DH's plan to enhance the elderly's enrollment in the programme, **Secretary for Food and Health** supplemented after the public hearings (in Appendix 22) that:

- DH had all along been working closely with NGOs in promoting EHAPP to eligible elderly. NGOs had conducted various publicity activities through their community network, including collaborations with other NGOs in providing services for the elderly, sending promotion letters and leaflets, conducting home visits and invitation calls to the elderly, conducting health talks in community centres, setting up promotional booths at public housing estates, and promotion through websites, television and radio programmes, newspaper and street banners;

- DH had also mounted publicity on EHAPP through the Department's website, District Elderly Community Centres, Neighbourhood Elderly Centres, Social Centres for the Elderly and GOPCs of HA. Besides, EHAPP had been actively promoted to the elderly on the waiting list of EHCs and those in various social centres through introductory talks

given by VHTs. To further enhance the publicity, DH had recently publicized EHAPP through RCHEs, newsletters for the elderly published by NGOs and radio programme; and

- given the enhanced promotional activities, the number of elderly registered with EHAPP had steadily increased. As at 8 December 2014, over 5 000 elderly had joined the programme.

C. Educational and advisory health services provided by Visiting HealthTeams of DH

Service efficiency of HPAs conducted by VHTs

31. The Committee noted that VHTs had been established since 1998 to conduct on-site health promotion and education activities to strengthen the healthcare of elderly at RCHEs and non-RCHEs so as to improve the elderly's self-care ability and health awareness. Estimated expenditure for the services for the financial year of 2014-2015 was $53.1 million.

32. As reflected in the examples stated in paragraphs 3.5 and 3.6 of the Audit Report, the Committee noted that the conduct of HPAs by VHTs was ineffective as the attendance of elderly and carers for some of the activities was low. Some RCHEs and non-RCHEs were being provided with a large number of HPAs in a year even though HPAs were poorly attended. The Committee enquired about reasons of low attendance for some HPAs and whether the resources allocated to VHTs could be more effectively utilized, say, by re-deploying the medical officers and nursing staff of VHTs to EHCs for conducting health assessments to shorten the waiting time for first-time assessments.

33. **Director of Health** explained that the setting up of VHTs was to conduct on-site HPAs, such as health talks and skills training, for the elderly and carers of RCHEs and non-RCHEs. As the nature of services provided by VHTs was different to that of EHCs, it would not be possible to allocate the manpower of VHTs to support the services provided by EHCs. In some situations, more HPAs which covered various different topics were needed to be conducted for RCHEs that had a smaller establishment and fewer resources so as to enhance the quality of services provided to the elderly. She however admitted that the situation as reflected in the examples was not satisfactory. In addressing the issue of low attendance of some of HPAs, greater efforts would be made to promoting the service to the elderly and

carers of RCHEs and non-RCHEs, and to remind carers and the elderly to take part in HPAs that had already been scheduled.

34. The Committee enquired what measures DH would implement to enhance the efficiency of VHTs and to effectively promote HPAs that had low attendance. **Director of Health** replied that in future, VHTs would choose to conduct more HPAs at those RCHEs/non-RCHEs with a larger establishment. It should be noted, however, that it might not be possible to reduce the number of HPAs and health advisory services for those RCHEs that had less manpower resources, as those RCHEs might need more assistance in identifying areas of improvements and enhancing service standards.

35. **Dr Teresa LI Mun-pik, Assistant Director of Health (Family and Elderly Health Services)** supplemented that:

- VHTs conducted reviews of RCHEs annually to assess their standard of services through an Integrated Assessment, by which VHTs would identify areas of improvement and formulate specialized training programmes for them; and

- for effective promotion of HPAs, VHTs would proactively approach RCHEs/non-RCHEs to ascertain their service needs and suitably adjust the frequency and content of HPAs to better suit their needs.

Advisory services provided by VHTs

36. Referring to paragraph 3.14 of the Audit Report, the Committee enquired whether DH agreed to extend the coverage of review of health records to all non-private RCHEs and those private RCHEs which had computerized their health records. **Director of Health** responded that owing to the fact that many private RCHEs did not have a proper health record system for their residents, VHTs would conduct review of health records of private RCHEs annually to assess their record keeping and to provide suitable advice and training. Taking on board the Audit's recommendations, DH would review the practice of not reviewing the health records of non-private RCHEs and those private RCHEs which had computerized their health records. DH might consider reviewing health records of such RCHEs on a risk-based approach and a longer time span, say, a five-year cycle.

37. Noting that DH agreed to review the mode of operation of VHTs in conducting HPAs with a view to introducing service improvements (paragraph 3.12 of the Audit Report refers), the Committee enquired about DH's plan in this regard. **Director of Health** said that:

- the Social Welfare Department would provide DH with an updated list of all non-RCHEs periodically. VHTs would initiate the conduct of HPAs for those non-RCHEs which received fewer visits in the past;

- contents of HPAs would be reviewed every three months to see if there was any need for revision; and

- VHTs would remind staff of RCHEs/non-RCHEs of the need to have carers accompanying the elderly in attending HPAs so that proper assistance could be provided to the elderly.

38. The Committee was of the view that DH should consider conducting some of HPAs on Saturdays, Sundays or public holidays as far as practicable to facilitate the attendance of family members and thus strengthening the family members' support for the elderly who prefer to age at home. **Director of Health** replied that DH would consider this suggestion.

D. Administration of DH's Elderly Health Care Voucher Scheme

39. The Committee noted that EHCVS was introduced in 2009 as a pilot programme and became a recurrent programme in January 2014. Elderly aged 70 or above were eligible to join EHCVS. The programme was aimed at subsidizing the elderly in their use of primary healthcare services in the private sector. Through providing partial subsidy, the programme implemented the "money-follow-patient" concept under which the elderly could choose within their local communities private healthcare services that best suit their needs. Under the programme, an elderly was provided, through his/her account in the eHealth System, annual voucher amount of $2,000. Unused vouchers could be accumulated up to $4,000. As at March 2014, 556 000 elderly (representing a joining rate of 75%) and some 4 100 private healthcare service providers had joined/enrolled in the programme. Estimated expenditure for settling voucher claims for 2014-2015 amounted to $846 million.

Participation of private healthcare service providers in EHCVS

40. Noting from paragraph 4.4 and Table 9 of the Audit Report that 93% of the voucher claims were related to the services provided by enrolled Medical Practitioners and enrolled Chinese Medicine Practitioners, and that their enrolment rate only accounted for 34% and 23% of the estimated number of service providers in private practice respectively, the Committee enquired how DH would enhance their participation in the programme, particularly Chinese Medicine Practitioners, who were popular among the elderly.

41. **Director of Health** replied that participation by private healthcare service providers in the programme was voluntary. In this regard, DH had stepped up the publicity of EHCVS, such as the use of television and radio announcements of public interest to raise the awareness of the programme. Secondly, DH had been appealing to the relevant professional bodies, such as the Chinese Medicine Council of Hong Kong, to solicit their assistance to encourage the enrollment of healthcare service providers, particularly Chinese Medicine Practitioners. Thirdly, enhancements had been made to the programme to increase its attractiveness, such as doubling the annual voucher amount from $1,000 per year in 2013 to $2,000 per year in 2014, changing the face value of each voucher from $50 to $1, and increasing the accumulation limit to $4,000. As a result of these measures, more healthcare service providers responded that they were more willing to take part in the programme than before.

42. In reply to the Committee's further enquiry on what concrete incentives could be provided to improve the enrollment of private healthcare service providers, such as the feasibility of introducing commendation schemes for private medical practitioners who have joined EHCVS, **Secretary for Food and Health** responded that:

- the increase in the voucher amount to $2,000 per year served as an attractive incentive for the private sector to join the programme, as it offered more convenience and a much wider choice for the elderly to seek healthcare services in the private sector;

- there existed a number of constraints that hindered the enrollment of certain types of private healthcare service providers. For instance, out of the some 5 000 Medical Practitioners in private practice, around 2 000 of them were providing specialist services. They had less motivation to join the programme because such services were usually

quite expensive and hence their patients were less likely to use health care vouchers to settle medical fees. Also, some traditional Chinese Medicine Practitioners who did not use computers were not eligible to join the programme as they were unable to install the eHealth System; and

- as regards the suggestion of introducing commendation scheme as an incentive for more private healthcare service providers to join the programme, **Secretary for Food and Health** cautioned that the suggestion needed careful consideration as the Medical Council of Hong Kong had promulgated Code of Professional Conduct setting out clear guidelines against doctors from advertising their services. DH would continue to work along with professional medical bodies to publicize EHCVS to their members and to encourage their participation.

Management of eHealth System and elderly voucher accounts

43. In response to the Committee's enquiry on whether DH would consider requesting enrolled healthcare service providers to input further information into the eHealth System so that detailed statistics could be compiled from the system for evaluating the effectiveness of EHCVS in promoting the use of private healthcare services and thus alleviating the pressure on the public healthcare system, **Director of Health** replied that enrolled healthcare service providers were only required to input relevant information into the eHealth System for the administration of EHCVS, including settling voucher claims. Requiring enrolled healthcare service providers to furnish further details into the system on each consultation case might pose extra administrative work on them and this would adversely affect their motivation to join the programme. DH might consider conducting a separate survey to gauge the views of elderly patients and private healthcare service providers on EHCVS.

44. The Committee noted from paragraph 4.20 of the Audit Report that the eHealth System would not close the deceased elderly's voucher accounts, but would continue issuing vouchers to the accounts. As a result, as at 31 March 2014, the system had accumulated unused vouchers of the 100 000 deceased elderly amounting to $262 million. Further, in making provision for EHCVS in the 2014-2015 Estimates of Expenditure, DH had inadvertently included the number of vouchers held by the deceased elderly, and the 2014-2015 provision had inflated by some $92 million as a result. The Committee enquired whether the unspent fund had been returned to the General Revenue Account or other funds of the Government, and the total amount of the unspent fund returned since the launch of EHCVS.

45. **Director of Health** responded that DH had started implementing changes to the eHealth System to manage the voucher accounts of deceased elderly so that they would be excluded when preparing the estimates for EHCVS. **Secretary for Food and Health** provided after the public hearings (in Appendix 22) that the unspent fund under EHCVS would not be allocated to DH for other purposes and would remain in the General Revenue Account. The estimated and actual expenditures of EHCVS since the scheme was launched in 2009 were provided in Appendix 22.

Monitoring of voucher claims

46. Noting the occurrences of unsatisfactory practices adopted by some enrolled healthcare service providers (paragraph 4.34 of the Audit Report refers), the Committee enquired what follow-up actions had been taken to address the issue, and the number of anomalous cases found. **Director of Health** replied that:

- DH had taken follow-up actions on the cases highlighted in the Audit Report, including making telephone calls to the elderly to ascertain whether healthcare services had been provided to them and reminding the problematic healthcare service providers to avoid making errors in future;

- as the face value of each voucher was adjusted to $1 per voucher effective from July 2014 onwards, the unsatisfactory practice of requiring an elderly to sign one consent form for each voucher used would be significantly reduced; and

- in the period from 1 January 2009 to 31 March 2014, DH had conducted some 7 700 inspections.

Assistant Director of Health (Family and Elderly Health Services) supplemented that around 1 950 claims were considered anomalous.

47. The Committee enquired what actions DH would take in response to the Audit's recommendations set out in paragraph 4.37 of the Audit Report on the monitoring of EHCVS. **Director of Health** stated that DH would:

- review the inspection protocol on monitoring voucher claims, such as avoiding the adoption of a standard pattern of routine checking and to consider conducting surprise checks;

- consider taking escalating measures against those malpractice healthcare service providers, such as issuing advisory letters or warning letters where warranted, after guidance had been given to them and no improvements were shown;

- DH had followed up the error/omission cases identified by Audit. No fraudulent practices had been discovered so far; and

- modeling on the methodology adopted in the interim review of EHCVS conducted in 2011, DH would conduct a comprehensive review of EHCVS in mid-2015 to fully gauge the feedback of the elderly and enrolled healthcare service providers on the use of the vouchers, scheme awareness and participation, satisfaction with the scheme and the impact of the scheme on healthcare seeking behaviour.

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

48. The Committee noted that there were 47 SOPCs providing specialist consultations for patients. As pointed out in paragraph 5.4 of the Audit Report, from 2009-2010 to 2013-2014, the attendance of elderly patients at SOPCs of the seven major Specialties (namely Ear, Nose and Throat; Gynaecology; Medicine; Ophthalmology; Orthopaedics and Traumatology; Psychiatry and Surgery) increased by 12% from 1.88 million to 2.11 million. In 2013-2014, elderly patients represented 37% of all attendances at SOPCs of the seven Specialties.

49. Unlike GOPCs under which consultation quotas will be reserved for elderly patients, SOPCs provide services to patients in accordance with the assessment of individual needs and clinical conditions, rather than solely on patients' age. Patients referred to SOPCs for first consultation are triaged into one of the three categories of Priority 1 (urgent), Priority 2 (semi-urgent) or Routine based on their clinical conditions. HA sets target median waiting time of two and eight weeks for Priority 1 and Priority 2 cases respectively. No target waiting time is set for Routine cases.

<u>Increase in elderly patients' waiting time for first SOPC consultation</u>

50. Noting from paragraph 5.9 of the Audit Report that waiting time for first consultation for Routine cases had generally increased in the past five years, the Committee enquired whether the improvement measures undertaken by HA to

shorten the waiting time as mentioned in paragraph 5.8 of the Audit Report were ineffective, and what further actions HA would take to effectively address the situation.

51. **Chief Executive of HA** responded at the public hearings and further supplemented in the letter dated 14 January 2015 (in ***Appendix 23***) that:

- due to ageing population and increasing prevalence of chronic diseases, the demand for SOPC services had been rising. On the other hand, the public healthcare sector was experiencing manpower shortage in recent years. As a result, waiting time for patients especially those with less severe and non-urgent conditions was lengthened over the years; and

- Nevertheless, HA had been implementing the following measures in order to address the issue of long waiting time for SOPC services:

  - enhancing primary healthcare services so that cases of stable and less complex conditions could be managed at FMSCs and GOPCs thereby alleviating pressure at SOPCs;

  - engaging part-time and "limited registration" doctors to improve manpower strength and paying out special honorarium for additional services to increase service capacity within HA;

  - exploring the possibility of launching public-private partnership projects to SOPC services which were in higher demand but of a non-acute nature to alleviate the pressure of public healthcare sector and provide more choices to patients; and

  - implementing specific programmes in 2013-2014 and 2014-2015 at different clusters to provide additional consultation sessions and to triage non-acute cases to FMSCs with the aim to clear the backlog of Routine cases.

<u>Cross-cluster arrangements</u>

52. In view of the disparity in elderly patients' waiting time at SOPCs of different clusters, the Committee was of the view that extending the cross-cluster referral arrangement to specialties that had a large number of elderly patients (i.e.

Medicine, Orthopaedics and Traumatology and Psychiatry) could reduce the disparity and alleviate the problem of long waiting time for some SOPCs.

53. **Chief Executive of HA** responded that a mechanism was in place to facilitate the referral of patients where there was disparity in waiting times in different clusters. However, specialties which had quite long waiting times across all clusters would not be suitable to adopt the cross-cluster referral arrangement despite that there might be difference in the waiting time among individual clusters. Also, patients who were mobility impaired or required long-term clinical support or follow-up within the community where they lived might have little incentive to receive service in another cluster. That said, HA would continue to review and monitor the disparity of waiting times in different clusters and extend the cross-cluster referral arrangement as far as possible.

54. Although patients were allowed to select an SOPC for first consultation in any cluster according to their preference under the "patient-initiated cross-cluster appointment booking", the Committee noted that some clusters did not allow patients from other clusters to book appointments in their SOPCs (paragraph 5.33 of the Audit Report refers). In reply, **Chief Executive of HA** said that HA would take measures to remind staff of SOPCs to allow patients to attend SOPCs of their choices whenever clinical condition and capacity warranted. He supplemented after public hearings in the letter dated 14 January 2015 (in Appendix 23) that HA would produce a poster on procedures and practices on the booking of first appointment at SOPC for the information of both the public and HA staff. The poster would be ready in the first half of 2015.

<u>Appointment scheduling practices of SOPCs and disclosure of waiting time information</u>

55. As pointed out in paragraphs 5.18 and 5.19 of the Audit Report, different SOPCs adopted different appointment scheduling practices, which contributed to less than optimal utilization of appointment slots and that slots from cancelled appointments were not put in the most efficient use. The Committee enquired what measures HA would take to increase the efficiency of the appointment system to better utilize the available appointment slots.

56. **Chief Executive of HA** responded that HA would conduct a comprehensive review on the appointment scheduling practices of SOPCs and issue relevant

guidelines to all clusters with a view to standardizing the practices of SOPCs. He supplemented after public hearings in the letter dated 14 January 2015 (in Appendix 23) that the following measures would be implemented to enhance the efficiency of appointment scheduling system:

- a SOPC Phone Enquiry System was implemented as a pilot initiative in the Kowloon Central cluster in 2011 for answering SOPC enquiries and other related functions, including allowing patients to give advance notice to cancel or reschedule their consultation appointments. SOPCs could thus fully utilize the released quotas to arrange appointments for other patients. HA planned to extend the pilot programme to the other six clusters in 2015-2016;

- a SOPC Operation Manual would be published in 2015-2016 to all clusters with a view to aligning different practices of SOPCs in scheduling appointments; and

- good appointment scheduling practices adopted by some clusters which had achieved optimal utilization of service capacity would be shared among clusters to encourage other SOPCs to adopt such good practices.

57. In response to the Committee's enquiry on the disclosure of waiting time information, **Chief Executive of HA** replied that at present, information regarding waiting time for five of the eight specialties, namely Ear, Nose and Throat, Gynaecology, Ophthalmology, Orthopaedics and Traumatology and Paediatrics had been uploaded onto the HA's website. HA planned to upload the waiting time information for the remaining three major specialties on its website in first half of 2015. In addition, HA would display comprehensive, standardized and updated waiting time information in SOPCs in first half of 2015 in order to facilitate patients' understanding of the waiting time situation for making informed decision on treatment choices.

Services provided by CGATs

58. The Committee noted from paragraph 5.24 of the Audit Report that the outreach medical consultation services provided by CGATs to elderly residing in RCHEs were effective in reducing Accident and Emergency attendances and hospital admissions of elderly residents of the RCHEs. However, the service coverage of CGAT had remained unchanged in the past few years. The Committee enquired whether HA had plans to expand the service capacity of CGATs to benefit more

elderly residing in RCHEs. In reply, **Chief Executive of HA** said that in view of the current manpower shortage situation in the public healthcare sector, HA had to prioritize the use of the scarce resources to cope with the increasing service demand. HA would continue to monitor the demand for CGAT services, and through the annual planning exercise in 2016-2017 and forthcoming years, to meet the needs for CGAT service in areas where there were expansion of RCHEs.

Re-designating Geriatrics as a separate specialty

59. The Committee enquired whether HA would consider, from the perspective of efficient utilization of healthcare resources and to better cater for the needs of elderly patients, re-designate Geriatrics as a separate specialty.

60. In reply, **Secretary for Food and Health** and **Chief Executive of HA** said that:

- the classification of specialties and subspecialties in HA was generally based on that of the Hong Kong Academy of Medicine and respective Colleges;

- provision of services for patients was based on healthcare needs rather than on the age of patients;

- many of the elderly patients had multiple medical conditions and functional disabilities requiring treatments and care from various other specialties and subspecialties in addition to Medicine or Geriatrics having regard to the clinical conditions of individual patients;

- HA had established systems to provide platforms for joint input of relevant professionals from various specialties and subspecialties for patients under a particular medical condition; and

- the existing organization of specialties/subspecialties was cost-effective from the overall perspective of serving both elderly and non-elderly patients.

61. **Dr Derrick AU, Director (Quality and Safety), HA** supplemented that there were specialist teams within the Medicine Specialty to offer medical services for the elderly. HA would keep in view the healthcare needs of elderly patients in

the coming years and to revisit, when necessary, the need to re-designate Geriatrics as a separate specialty.

F. Conclusions and recommendations

Overall comments

62. The Committee:

- expresses serious concern that, although the Legislative Council had approved substantial expenditure to the Department of Health ("DH") for the provision of elderly healthcare services ($1,034 million in 2014-2015) and the Hospital Authority ("HA") for services on elderly patients (estimated at $23 billion out of HA's annual expenditure of $50 billion in 2013-2014), DH and HA had not managed these resources effectively and the considerable resources allocated were not optimally utilized to provide timely, efficient and value-for-money services for the elderly, as evidenced by the following unsatisfactory performances:

  (a) based on the assessment mix of first-time and subsequent health assessments in 2013 and assuming zero additional intake and attrition, and averaging amongst the 18 Elderly Health Centres ("EHCs"), it would take 3.7 years for all the elderly on the waiting list to enroll as members of EHC to receive first-time health assessment. In some districts, such as Wan Chai and Yau Ma Tei, the waiting time was even over nine years;

  (b) only 2 274 elderly (against a target of 10 000 elderly) had been enrolled in the Elderly Health Assessment Pilot Programme ("EHAPP") in its first year of operation. The programme's effectiveness to recruit frail elderly (i.e. no health assessment received before, not receiving regular follow-up by healthcare service providers and living alone), who is the priority target of the programme, is yet to be determined;

  (c) the service efficiency of health promotion activities ("HPAs") provided by Visiting Health Teams ("VHTs") was unsatisfactory as a number of HPAs provided to residential care homes for the elderly ("RCHEs") and other elderly-related institutions ("non-RCHEs") were poorly attended. VHTs should have made

sure that carers would accompany the elderly to attend those HPAs that required carers' attendance in order to provide needed assistance to the elderly;

(d) participation of private healthcare service providers in the Elderly Health Care Voucher Scheme ("EHCVS") as well as the usage of health care vouchers by the elderly were low. Also, there were management problems in monitoring voucher claims, as evidenced by a number of errors/omissions found in the Audit Commission ("Audit")'s examination of the consent forms[4] and the lack of guidelines issued by DH to healthcare service providers enrolled in EHCVS on the proper completion of consent forms. Voucher accounts of deceased elderly were still active which reflected the poor management of EHCVS; and

(e) elderly patients' waiting time for Routine cases[5] at Specialist Out-patient Clinics ("SOPCs") was increasing, and cross-cluster referral arrangement is limited to three Specialties only (i.e. Ear, Nose and Throat, Gynaecology and Ophthalmology);

- expresses serious concern that the elderly's health conditions might deteriorate during the long waiting time for healthcare services provided by DH and HA and considers that DH and HA should and could have done more to address the growing healthcare needs of the elderly;

- urges DH and HA to improve their service efficiency and to provide timely, value-for-money and elderly-oriented healthcare services that can best meet the needs of the elderly;

- recommends HA to explore, from the perspective of efficient utilization of healthcare resources and to better cater for the needs of elderly patients, the feasibility of setting up a Geriatrics Specialty or a dedicated unit for elderly patients at SOPCs to efficiently cope with the anticipated higher healthcare service demand arising from an ageing population;

4 An elderly is required to complete and sign a consent form after he/she receives healthcare service by using health care vouchers. DH will examine the propriety of the consent forms signed by the elderly to verify the validity of claims made by healthcare service providers enrolled in EHCVS.

5 Patients referred to SOPCs for first consultation are triaged into one of the three categories of Priority 1 (urgent), Priority 2 (semi-urgent) or Routine based on their clinical conditions. HA sets target median waiting time of two and eight weeks for Priority 1 and Priority 2 cases respectively. No target time is set for Routine cases.

Long waiting time for first-time health assessments at EHCs

- expresses serious concern that:

  (a) although the elderly population had increased by 26% from 831 000 to 1 049 000 in the past ten years, the 18 EHCs kept on providing less than 40 000 health assessments a year to the elderly in the same period. The capacity of EHCs had not been expanded in a timely manner to align with the growth of elderly population;

  (b) given the persistent long waiting time[6] for first-time health assessments at EHCs, DH has not recognized the extent of the demand and allocated sufficient resources to cope with the service demand, as evidenced by the following:

  - only two reviews were conducted in 2002 and 2007 respectively on the demand for health assessment services of EHCs and measures to shorten the waiting time;

  - no review has been conducted on the justifications for the provision of curative treatments by EHCs in parallel with the General Out-patient Clinics (" GOPCs") of HA;

  - DH has not ascertained the varying level of services demand arising from first-time and subsequent health assessments and curative treatments at EHCs and has not subsequently planned for the manpower resources among the EHCs accordingly; and

  - there was significant variation among EHCs in the waiting time for first-time health assessments, implying that there was room in re-allocating manpower among EHCs to help shorten the waiting time for EHCs with a relative larger number of elders on the waiting list;

  (c) despite the fact that more medical conditions are uncovered in first-time health assessments vis-à-vis subsequent assessments, DH

6 Waiting time refers to the duration between the date when an elderly applies for enrolment at an EHC to the date of enrolment (which is also the date of first-time health assessment).

has not reviewed the assessment mix of EHCs to provide more first-time assessments[7]; and

(d) DH has set a target of providing subsequent health assessment for every EHC member once about every 18 months. However, no such target or performance pledge is set for the waiting time for enrolment to EHCs to receive first-time assessments;

- does not agree with the remarks made by Secretary for Food and Health that EHCVS might have supplemented the assessment services provided by EHCs and that the elderly on the waiting list for enrolment to EHCs might have used health care vouchers to meet their needs for health assessments, as the Director of Audit's Report ("the Audit Report") revealed that, between 2009 and 2013, only less than 9% of the health care vouchers used by the elderly were spent on preventive care. Also, DH did not have any relevant statistics to substantiate such remarks;

- expresses serious concern about the following remarks made by Secretary for Food and Health and Director of Health at the public hearings in addressing the problem of long waiting time for enrolment to EHCs:

(a) in response to the Audit's recommendation stated in paragraph 2.18(a) of the Audit Report which suggested Director of Health to critically review the EHC capacity to ascertain if it had been aligned with the growth of the elderly population, the remark that it would not be possible to expand the capacity of EHCs to align with the growth of elderly population; the orientation of EHCs should not be that of mere service provision and EHCs alone could not meet the healthcare needs of all elderly; and

(b) in response to the Audit's recommendation stated in paragraph 2.18(b) of the Audit Report that Director of Health should explore the feasibility of setting a performance pledge for waiting time for enrolment to EHC, the remark that DH would only explore the feasibility of setting a performance pledge based

7 EHCs provide first-time and subsequent health assessments to the elderly. The allocation of assessment sessions to first-time vis-à-vis subsequent assessments by EHCs is not identical across the board. Some EHCs allocate more sessions to first-time assessments while others do not.

on the experience gained in the operation of the two clinical teams which would be established in 2014-2015 and 2015-2016[8];

- urges Director of Health to expedite measures to resolve the problem of long waiting time for enrolment to EHCs to receive first-time health assessments, and to set a performance target on the waiting time and a timetable in achieving the target;

- recommends Director of Health to:

  (a) conduct a comprehensive review on EHCs' mode of operation to better cope with the growth in service demand arising from an ageing population in the coming decades; and

  (b) collect relevant statistics to ascertain the demands for elderly healthcare services, and the extent of how such demands have been/are to be met by the various initiatives introduced, such as EHCVS and EHAPP;

Effectiveness of EHAPP

- expresses serious concern about the effectiveness of EHAPP as evidenced by the low enrolment rate of the elderly;

- considers that DH should explore ways to enhance the elderly's enrolment in EHAPP, especially frail elderly, by working more closely with collaborating non-governmental organizations and stepping up publicity for the programme;

Efficiency of services provided by VHTs

- expresses grave concern and finds it unacceptable that the service efficiency of VHTs was far from satisfactory, as evidenced by the following:

  (a) a large number of HPAs were conducted for some RCHEs/non-RCHEs even when the attendance by the elderly and their carers were low;

8 Two additional clinical teams would be created in the Lek Yuen EHC in 2014-2015 and in the Wan Chai EHC in 2015-2016 respectively.

(b) many of the contents of HPAs have not been updated;

(c) attendance of the elderly's family members to HPAs was extremely low; and

(d) health records of non-private RCHEs and those private RCHEs which have computerized their health records were not reviewed by VHTs;

- acknowledges that DH will implement measures to enhance service efficiency of VHTs, such as to proactively approach RCHEs/non-RCHEs to ascertain their service needs and suitably adjust the frequency and content of HPAs to better suit their needs, and will review the mode of operation of VHTs in conducting HPAs with a view to introducing service improvements;

Administration of EHCVS

Participation of healthcare service providers and the use of vouchers by the elderly

- expresses grave concern that:

(a) despite the services of enrolled Medical Practitioners and enrolled Chinese Medicine Practitioners are most in demand by the elderly as their services had accounted for 93% of the voucher claims made by healthcare service providers enrolled in EHCVS, their enrolment rate only accounted for 34% and 23% respectively of the estimated number of service providers in private practice;

(b) the non-enrolment of private healthcare service providers near the residing place of the elderly might discourage the use of health care vouchers by the elderly;

(c) as at December 2013, nearly 75% (or 415 000) of the enrolled elderly had vouchers which remained unused, of which 10% (or 41 844) of them had never used any of the vouchers issued to them. The value of unused vouchers of the 415 000 elderly amounted to $491 million;

(d) as at January 2014, nearly 10% (or 53 000) of the elderly had their vouchers forfeited because the value of their unused vouchers had

exceeded the accumulation limit of $3,000. The value of vouchers forfeited amounted to $9.6 million; and

(e) the elderly mainly use the vouchers to settle medical fees for treating acute episodic conditions rather than for preventive care purposes;

- acknowledges the following measures implemented by DH to enhance the participation of healthcare service providers and promote the wider use of vouchers by the elderly:

  (a) enhancing the attractiveness of the programme by doubling the annual voucher amount for each eligible elderly from $1,000 per year in 2013 to $2,000 per year in 2014, changing the face value of each voucher from $50 to $1, and increasing the accumulation limit to $4,000;

  (b) stepping up the publicity of EHCVS, such as the use of television and radio announcements of public interest and other effective channels to raise public awareness of the programme; and

  (c) appealing to medical professional bodies to solicit their support to encourage the enrolment of their members;

Management problems of EHCVS

- expresses grave concern and finds it unacceptable about DH's inefficacy and laxity to manage and administer EHCVS to ensure proper governance of the programme, as evidenced by the following:

  (a) voucher accounts of deceased elderly had not been closed and DH continued issuing vouchers to the accounts. As at March 2014, the deceased elderly had accumulated unused vouchers amounting to $262 million;

  (b) the number of vouchers held by deceased elderly was inadvertently included in making provision for EHCVS in the 2014-2015 Estimates of Expenditure, and the provision had been inflated by $92 million as a result; and

  (c) inadequacy in the conduct of routine and follow-up inspections by DH to deter the occurrences of unsatisfactory practices adopted by

some enrolled healthcare service providers, such as requiring an elderly to sign excessive and blank consent forms for one consultation;

- expresses serious concern about the limited features of the eHealth System[9] for EHCVS which does not capture essential information and statistics for evaluating the effectiveness of the programme;

- acknowledges that DH will take the following actions for improvement:

  (a) review the inspection protocol on monitoring voucher claims, such as conducting surprise checks;

  (b) consider taking escalating measures against those malpractice healthcare service providers, such as issuing advisory letters or warning letters where warranted, after guidance has been given to them and no improvements are shown;

  (c) follow up on the cases of errors/omissions identified in the consent forms, such as missing and incorrect information as well as unsatisfactory practices adopted by healthcare service providers including requiring an elderly to sign excessive and blank consent forms as identified by Audit. No fraudulent practices have been discovered so far; and

  (d) conduct a comprehensive review of EHCVS in mid-2015 to fully gauge the feedback of the elderly and enrolled healthcare service providers on the use of the vouchers, scheme awareness and participation, satisfaction with the scheme and the impact of the scheme on healthcare seeking behaviour for programme enhancements;

- recommends DH to consider making enhancements to the eHealth System so that more detailed statistics could be compiled for assessing the effectiveness of the programme;

9 The eHealth System was purposely designed for the EHCVS providing an electronic platform on which participating healthcare service providers can manage the registration of eHealth accounts for the elderly and to submit claims to DH on the vouchers used by the elderly.

HA's provision of specialist out-patient services to elderly patients

- notes that:

  (a) the attendance of elderly patients at the seven major specialties of SOPCs, namely, Ear, Nose and Throat; Gynaecology; Medicine; Ophthalmology; Orthopaedics and Traumatology; Psychiatry; and Surgery increased by 12% from 1.88 million to 2.11 million between 2009-2010 and 2013-2014. In 2013-2014, elderly patients represented 37% of all attendances at the seven specialties; and

  (b) the Medicine Specialty has the highest attendance of elderly patients. The subspecialty of Geriatrics is currently under the Medicine Specialty;

- notes the following justifications given by HA for not designating Geriatrics as a separate specialty in providing healthcare services for elderly patients:

  (a) provision of services for patients is based on healthcare needs instead of the mere factor of age of the patients;

  (b) many of the elderly patients have multiple medical conditions and functional disabilities requiring treatments and care from various other specialties and subspecialties in addition to Medicine or Geriatrics having regard to the clinical conditions of individual patients;

  (c) HA has established systems to provide platforms for joint input of relevant professionals from various specialties and subspecialties for patients under a particular medical condition; and

  (d) the existing organization of specialties/subspecialties is cost-effective from the overall perspective of serving both elderly and non-elderly patients;

- urges HA to consider measures to better cater for the increasing healthcare needs of the elderly patients; to keep the situation under constant review and to revisit, when necessary, the need to re-designate Geriatrics as a separate specialty;

Waiting time for first SOPC consultation and cross-cluster arrangements

- expresses grave concern that:

  (a) despite HA has implemented measures to shorten the waiting time for first SOPC consultation, waiting time for Routine cases at SOPCs has generally increased;

  (b) cross-cluster referral arrangement is currently available for three specialties (namely, Ear, Nose and Throat, Gynaecology and Ophthalmology) only and elderly patients' waiting time for Routine cases varied significantly across different clusters, implying that there might be room for expanding the cross-cluster referral arrangement;

  (c) although HA allows patients to select an SOPC for first consultation in any cluster according to their preference, some clusters do not allow patients from other clusters to book appointments in their SOPCs; and

  (d) the display of waiting time information at SOPCs and on HA's website is not updated, comprehensive and consistent;

- urges HA to devise effective measures to shorten the waiting time for Routine cases at SOPCs, and to extend the cross-cluster referral arrangement to more specialties as far as possible to enable efficient utilization of healthcare resources to benefit more elderly patients;

- notes that the possibility of introducing cross-cluster referral arrangement hinges on a number of factors, such as preference of patients and the existence of significant disparity in waiting time among clusters;

- acknowledges that HA will take steps to remind staff of SOPCs in all clusters to allow patients to attend SOPCs of their choices whenever clinical condition and capacity warranted and disclose comprehensive and updated waiting time information as appropriate in a timely manner;

Appointment scheduling practices of different SOPCs

- expresses serious concern that:

  (a) some SOPCs adopted different appointment scheduling and booking practices, resulting in varying levels of unscheduled appointment slots reserved for unforeseeable cases among the clinics. This might lead to less than optimal utilization of available appointment slots; and

  (b) some appointment slots from cancelled appointments are not released in a timely manner for re-booking;

- urges HA to conduct a comprehensive review on the appointment scheduling practices and the appointment systems of SOPCs to better utilize available appointment slots;

Outreach consultation service provided by CGATs

- notes that the outreach medical consultation services provided by CGATs to elderly residing in RCHEs are effective in reducing Accident and Emergency attendances and hospital admissions of elderly residents of RCHEs;

- expresses serious concern that:

  (a) although the services of CGATs are effective, service coverage of CGATs has remained unchanged in the past few years;

  (b) as at March 2014, some 4 500 elderly residing in 77 RCHEs had not received CGATs' services; and

  (c) a review of the service of CGATs conducted in 2012 by a working group under the Geriatrics Subcommittee[10] concluded that the coverage of CGATs would not be expanded unless additional resources were available; and

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

- urges HA to expand the service coverage of CGATs to include more RCHEs with a view to enhancing the healthcare quality of elderly residing in RCHEs.

Specific comments

63. The Committee:

Elderly health assessment services of DH

- expresses serious concern that:

  (a) despite the rising trend of the elderly population in the past ten years, the 18 EHCs had kept on providing less than 40 000 health assessments a year to the elderly. The EHC capacity had not been expanded in a timely manner to cope with the demand for health assessment services by the elderly;

  (b) the number of elderly waiting for first-time health assessments at EHCs has been rising in the past few years. Unless the mix of first-time and subsequent health assessments is adjusted or capacity is added, it would take 3.7 years, and over 9 years for some EHCs, to clear the backlogs of first-time health assessments;

  (c) there is significant disparity in the number of curative treatments conducted among EHCs (ranging from an average of 16 to 33 curative treatments per day from 2009 to 2013), suggesting that some EHCs might have spare capacity for conducting more health assessments;

  (d) curative treatments are provided by both EHCs of DH and GOPCs Clinics of HA. Nonetheless, no review has been conducted on the justifications for the provision of curative treatments by EHCs;

  (e) there is significant disparity among EHCs in the waiting time for allied health counseling services, ranging from 1.1 to 11 weeks; and

  (f) up to mid-July 2014, against a target of 10 000 elderly, only 2 274 had enrolled in EHAPP in its first year of operation;

- notes that DH:

  (a) has introduced a number of initiatives, such as EHAPP and EHCVS, to act as alternative models of service delivery to meet the demand of the elderly for health assessment services;

  (b) will review and monitor regularly the workload of each EHC with a view to implementing measures to enhance service efficiency and shorten the waiting time for first-time assessments;

  (c) will explore the feasibility of setting a performance pledge on waiting time in 2016 after the two additional clinical teams have been established and the experience of their operation has been reviewed;

  (d) will review the strategic directions of EHCs in the light of experience gained through new models of service provision including EHCVS and EHAPP;

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

  (f) has agreed with the Audit's recommendations in paragraphs 2.18, 2.26 and 2.32 of the Audit Report;

<u>Educational and advisory health services provided by VHTs</u>

- expresses grave concern and finds it unacceptable that:

  (a) VHTs do not maintain a full list of non-RCHEs and as a result, elders and carers in some non-RCHEs might not have the opportunities to receive health education;

  (b) some RCHEs and non-RCHEs are provided with a large number of HPAs even though HPAs were poorly attended;

  (c) no review has been conducted to evaluate the effectiveness of HPAs provided by VHTs; and

(d) VHTs do not review the health records of non-private RCHEs, and those private RCHEs the health records of which have been computerized;

- notes that Director of Health has agreed with the Audit's recommendations in paragraphs 3.11 and 3.16 of the Audit Report;

Administration of EHCVS

- expresses grave concern and finds it unacceptable that:

(a) the services of enrolled Medical Practitioners and enrolled Chinese Medicine Practitioners are in great demand by the elderly, and yet their enrolment only accounted for 34% and 23% of the estimated number of service providers in private practice;

(b) the ratios of medical practitioners enrolled in EHCVS to eligible elderly were uneven among the 18 districts. The non-enrollment of healthcare service providers in some districts might affect the usage of health care vouchers by the elderly;

(c) as at end of 2013, there were 415 000 elderly who had vouchers remained unused (the value of which amounted to $491 million). About 10% of these elderly (i.e. 41 844 elderly) had never used the vouchers issued to them;

(d) about 10% (i.e. 53 000) of the elderly who joined the programme had their vouchers forfeited with the accumulation limit having been exceeded;

(e) as the voucher accounts of 100 000 deceased elderly under the eHealth System had not been closed, vouchers would continue to be issued to them. As a result, the deceased elderly accounts had accumulated unused vouchers amounting to $262 million, and the 2014-2015 Estimates of Expenditure had also been inflated by $92 million;

(f) DH has all along been adopting a standard pattern of routine checking. In an examination of the consent forms of 5 031 claims, Audit identified 704 errors/omissions and a number of unsatisfactory practices adopted by some service providers, such as requesting an elderly to sign excessive and blank consent forms;

(g) in the five years from 2009 to 2013, less than 9% of the vouchers were used for preventive care purpose; and

(h) a comprehensive review of EHCVS has not been conducted after it has been converted into a recurrent programme;

- notes that DH:

(a) has stepped up the publicity of EHCVS and has encouraged the participation of private healthcare service providers through professional medical bodies;

(b) has started to implement changes to the eHealth System to manage the voucher accounts of the deceased elderly such that they will be excluded when preparing the estimates for EHCVS;

(c) will avoid adopting a standard pattern of routine checking and take escalated actions such as issuing advisory letters and warning letters to problematic healthcare service providers where warranted;

(d) will conduct a comprehensive review of EHCVS in mid-2015; and

(e) has agreed with the Audit's recommendations set out in paragraphs 4.9, 4.21, 4.37 and 4.40 of the Audit Report;

<u>Provision of specialist out-patient services to elderly patients</u>

- notes that:

(a) 46% of HA's operating expenditure in 2013-2014 was spent on elderly patients; and

(b) the number of elderly patients at the seven major specialties of SOPCs (excluding Paediatrics) increased by 12% from 1.88 million to 2.11 million between 2009-2010 and 2013-2014;

- expresses grave concern that:

(a) in the five years from 2009-2010 to 2013-2014, the waiting time of Routine cases of elderly patients for first consultation at SOPCs had generally increased;

(b) the 90th percentile waiting time for Routine cases of elderly patients varied significantly among different clusters;

(c) the appointment scheduling practices among SOPCs are different. There is room for improvement in the monitoring and booking of appointment slots in SOPCs;

(d) the cross-cluster referral arrangement is only available for three Specialties (namely, Ear, Nose and Throat, Gynaecology and Ophthalmology). Some clusters do not allow patients from other clusters to book appointments in their SOPCs; and

(e) the display of waiting time information at SOPCs and on the website of HA is not comprehensive, timely and up-to-date; and

- notes that the Chief Executive, HA has agreed with the Audit's recommendations in paragraphs 5.13, 5.22, 5.27, 5.35 and 5.41 of the Audit Report.

Follow-up action

64. The Committee wishes to be kept informed of the progress made in implementing the various recommendations made by the Committee and the Audit Commission .