中華人民共和國香港特別行政區政府總部食物及衞生局
Food and Health Bureau, Government Secretariat
The Government of the Hong Kong Special Administrative Region
The People's Republic of China

Your ref.: CB4/PAC/R63

Tel.: 3509 8913
Fax: 2840 0467

24 December 2014

By Fax : 2543 9197

Mr Anthony CHU
Clerk, Public Accounts Committee
Legislative Council Secretariat
Legislative Council Complex
1 Legislative Council Road
Central
Hong Kong

Dear Mr Chu,

Public Accounts Committee
Consideration of Chapter 2 of the Director of Audit's Report No. 63
Provision of health services for the elderly

I refer to your letter dated 17 December 2014 addressed to the Secretary for Food and Health regarding the captioned matter. Our responses to members' enquiries are set out at the Annex, please.

Yours sincerely,

(Wendy AU)
for Secretary for Food and Health

Encl.

c.c. Secretary for Financial Services and the Treasury (Fax : 2147 5239)
Director of Audit (Fax : 2583 9063)
Director of Health
Chief Executive of Hospital Authority

Annex

Public Accounts Committee (PAC)
Consideration of Chapter 2 of the Director of Audit's Report No. 63
Provision of health services for the elderly

The Administration's Response to the PAC's Enquiries

Elderly Health Assessment of the Department of Health

(a) The Department of Health ("DH") will review and monitor regularly the workload of each Elderly Health Centre ("EHC") with a view to implementing measures to enhance service efficiency and shorten the waiting time for first-time health assessments. These measures include –

- Monitoring 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 have already employed this measure.
- Reviewing the justifications for the provision of curative treatments and exploring the feasibility of setting a quota for curative services each day, so that more time slots can be allocated for conducting health assessments.
- Reviewing 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.
- Displaying updated list of median waiting times for all EHCs on the Elderly Health Service ("EHS") website (www.elderly.gov.hk) and at EHCs to increase transparency and facilitate elders to choose enrolling at those Centres with relatively shorter waiting time.

(b) By the end of 2013, the EHCs with the largest number of elders on the waiting list are Wan Chai EHC (1 760) and Lek Yuen EHC (1 426). The first additional clinical team will be posted to Lek Yuen EHC and the second to Wan Chai EHC. The Department will monitor the statistics of all 18 EHCs closely and flexibly deploy the manpower

having regard to the waiting list and physical environment (where space is available in the EHC for accommodating an additional team). It is estimated that each clinical team will be able to conduct 2 125 health assessments every year. Besides the number of first-time health assessments that can be conducted by the additional clinical teams, the waiting time is affected by many other factors including the rate of increase of elders seeking to enroll as new members, the renewal rate of existing members, the number of members seeking curative treatments, and the implementation of other enhancement measures mentioned in (a). It is therefore not possible to give a projection on the reduction in waiting time at this stage. Nevertheless, DH will closely monitor the waiting time as improvement measures are being implemented.

(c) DH conducted a review on the demand for health assessment service in 2002, which concluded that the orientation of EHCs should be changed from mere service provision to that of benchmarking and health monitoring (please see (d) below for details). A second review was conducted in 2007 and new measures to shorten the waiting time for EHC membership were implemented. These included the adoption of a simplified questionnaire for health assessment and streamlined procedures of health assessment for existing members, such that additional manpower and resources could be allocated to meet the needs of elders on the waiting list. To narrow the gap in waiting time between different EHCs, each EHC now provides information on those EHCs with shorter waiting time for enrolment as members. Individual elders may choose to apply for membership at these EHCs.

To address the needs of various target groups in the community, the Administration is planning the establishment of locally based community health centres in the districts. They aim to enhance health promotion activities, strengthen clinical services, improve co-ordination and continuity of care through enhancing allied health and multi-disciplinary services. A number of factors are taken into account in considering the priority of different districts, including size and demographic characteristics of target population and health workforce of the district.

(d) The heavily subsidised primary healthcare services, together with a rapidly ageing population, have created a huge demand for EHCs' services, and EHCs alone cannot meet the healthcare needs of all elders. In fact, upon the recommendation of a review of the EHS in 2002, the orientation of EHC services has changed from one of mere service provision to that of health information collation, benchmarking for the purpose of public health surveillance and quality assurance, and training. The EHCs serve as sentinel points in the 18 districts to collect important health information on the health status of the elderly, for the surveillance of health problems among them and the monitoring of change over time. Over the years, numerous epidemiological studies have been conducted to inform important public health actions. For instance, the cohort study conducted in collaboration with the School of Public Health of the University of Hong Kong since 2002 has accumulated health data on 120 000 clients of EHCs and has so far generated over 30 articles published in peer-reviewed journals.

Notwithstanding the above, we note the concerns about the long waiting time for first-time health assessments and will review the strategic directions of EHCs in light of the experience gained through new models of service provision including the Elderly Health Care Voucher Scheme ("EHCVS") and the Elderly Health Assessment Pilot Programme ("EHAPP").

(e) In the Hong Kong Reference Framework for Preventive Care for Older Adults in Primary Care Settings, independent elders with no known chronic diseases are recommended to have health assessment every one to three years, and those who also have chronic diseases or risk factors are recommended to be assessed at more frequent intervals e.g. on a yearly basis. In 2013, 96% of EHC members had chronic diseases, with 9%, 17%, 22% and 48% having one, two, three, and four or more chronic diseases respectively. EHCs, as model for continuous and comprehensive care for the elderly, have complied with this evidence-based recommendation. The only way to reduce the waiting time substantially is to expand the capacity of EHCs but it is 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.

(f) For audit recommendation in paragraph 2.18(a) - please see the response to (d) above. A comprehensive review of the EHCVS will be conducted in mid-2015 and an evaluation of the EHAPP will be completed by the end of 2015. We will make reference to the results of these studies when reviewing the strategic directions of EHCs.

For audit recommendation in paragraph 2.18(b) – We will explore the feasibility of setting a performance pledge in 2016 after the two additional clinical teams have been established and the experience of their operation has been reviewed.

For audit recommendation in paragraph 2.18(c) – Please see responses to (a) and (b) above.

For audit recommendation in paragraph 2.18(d) – We are monitoring the waiting list of elderly awaiting membership enrolment and first-time health assessment in each EHC on a regular basis.

(g) DH has all along been working closely with the non-governmental organizations ("NGOs") in promoting the EHAPP to eligible elders. The NGOs have conducted various publicity activities through their community network, including collaboration with other NGOs in providing services for the elderly, sending promotion letters and leaflets, conducting home visits and invitation calls to elders, conducting health talks in community centres, setting up promotional booths at public housing estates, and promotion through websites, television and radio programmes, newspapers and street banners.

DH has also mounted publicity on the programme through the Department's website, District Elderly Community Centres, Neighbourhood Elderly Centres, Social Centres for the Elderly, and General Outpatient Clinics of the Hospital Authority. Besides, the EHAPP has been actively promoted to elders on the waiting list of EHCs and those in various social centres through introductory talks given by the Visiting Health Teams of EHS. To further enhance the publicity, DH has recently publicized the EHAPP through Residential Care Homes for the Elderly, newsletter for the elderly published by

NGOs and radio programme.

Given the enhanced promotional activities, the number of elders registered with the EHAPP has steadily increased. As of 8 December 2014, over 5 000 elderly have joined the programme. We will continue to work with the participating NGOs and other stakeholders to publicize the programme.

Administration of Department of Health's Elderly Health Care Voucher Scheme

(h) The unspent fund under the EHCVS would not be allocated to DH for other purposes and would remain in the General Revenue Account. The estimated and actual expenditures of the EHCVS since the Scheme was launched in 2009 are as follows -

Financial Year	**Estimated Expenditure ($ in million) (a)**	**Actual Expenditure ($ in million) (b)**	**Difference ($ in million) (a) - (b)**
2008-09 (Jan-Mar 2009 only)	27.6	6.6	21.0
2009-10	165.8	49.0	116.8
2010-11	168.6	72.0	96.6
2011-12	365.7	104.1	261.6
2012-13	298.0	196.0	102.0
2013-14	507.0	341.0	166.0
Total :	**1,532.7**	**768.7**	**764.0**

(i) In 2014, we implemented several enhancements to the EHCVS, including converting the EHCVS from a pilot project into a regular programme; doubling the annual voucher amount for each eligible elder from $1,000 to $2,000; and changing the face value of each voucher from $50 to $1. These measures are aimed to encourage more private healthcare service providers to participate in the EHCVS.

On publicity front, we plan to launch another round of promotional activities in 2015, which will include television and radio announcements of public interest (API) and appealing to the professional bodies again to solicit their assistance in publicizing the EHCVS to their fellow members and to encourage their participation in the EHCVS. We will also consider promoting the EHCVS through other popular media such as free newspapers. We will solicit the support from professional bodies to issue articles in their newsletters (such as the Chinese Medicine Council of Hong Kong) to encourage more private healthcare service providers, in particular Chinese Medicine Practitioners, to join the EHCVS.

We will undertake a comprehensive review of the EHCVS in mid-2015 and will take the opportunity to gauge the views of private healthcare providers and consider further measures to encourage them to join the EHCVS.

Hospital Authority's Provision of Specialist Outpatient Service to Elderly Patients

(j) The classification of specialty and subspecialty services in the Hospital Authority (HA) is generally based on that of the Hong Kong Academy of Medicine and respective Colleges.

In HA, the development of services for patients is based on healthcare needs instead of the mere factor of age of the patients. Building on this principle, HA provides care for elderly patients through different specialties and subspecialties having regard to the clinical conditions of individual patients (e.g. Geriatrics in outreach services to elderly homes, Psychogeriatrics in dementia care, Orthopaedics in joint replacement programmes, Ophthalmology in cataract services).

As our population ages, there will be an increasing proportion of elderly patients. Many of these patients will have multiple medical conditions and functional disabilities requiring treatment from various other specialties and subspecialties in addition to Internal Medicine or

Geriatrics. To better coordinate the care for the elderly, HA has established systems to provide platforms for joint input of relevant professionals. HA will integrate Geriatricians' inputs with the respective specialty care in treating an elderly patient whenever necessary to ensure the provision of appropriate and comprehensive services to the patients.

All in all, HA considers that elderly patients are better served under the current arrangement where the most suitable specialty would take the lead in providing care, while inputs from other specialties will be drawn in as appropriate, for the patients under a particular medical situation. Given the responsibility of our public healthcare system to serve both elderly and non-elderly, HA's current arrangement of focusing on integration in providing services is cost-effective from the overall perspective of serving the healthcare needs of the entire community.

Food and Health Bureau
Department of Health
Hospital Authority

December 2014