For information
on 20 June 2016

Legislative Council Panel on Health Services

Review of Elderly Health Assessment Pilot Programme

PURPOSE

This paper briefs Members on the findings of the Review of the Elderly Health Assessment Pilot Programme (the Pilot Programme) launched on a pilot basis for two years since July 2013.

BACKGROUND

2. In collaboration with nine non-governmental organisations (NGOs), the Government launched the two-year Pilot Programme in July 2013 to provide voluntary, protocol-based, subsidised health assessment service for up to 10,000 eligible elders. Under the Pilot Programme, an elder aged 70 or above who held a valid Hong Kong Identity Card and was not a member of the Elderly Health Centres (EHCs) of the Department of Health (DH) was eligible to receive health assessment service at the participating NGO's service centres. A list of the service centres is at **Annex A**. A subsidy of $1,200 for each elder was provided to NGOs for the health assessment service. Each participating elder was required to contribute a co-payment of $100, which could be met with the Elderly Health Care Vouchers. For elders having financial hardship[1], the co-payment was waived and borne by the Government.

3. With the aim of facilitating early identification of health risks as well as promoting health ageing, the services provided by NGOs under the Pilot Programme included three components –

[1] Defined as those who were receiving the Comprehensive Social Security Assistance or who were under the medical fee waiver mechanism of the medical social services unit of public hospital/clinic, or the Integrated Family Service Centres or Family & Child Protective Services Unit of the Social Welfare Department.

(a) Baseline health assessment

The scope of the health assessment was based on the "Hong Kong Reference Framework for Preventive Care for Older Adults in Primary Care Settings" (the Reference Framework). It aimed to systematically review and properly document the level of function and risk profile of an elder for formulating a personalized preventive care plan. Details of the major areas covered in the baseline health assessment are at **Annex B**.

(b) Follow-up consultations

Following the baseline health assessment, NGOs were required to arrange one or two follow-up consultations for each participating elder. During the first follow-up consultation, which was arranged within two months after the baseline health assessment, a medical practitioner would discuss with the elder the findings of his/her assessment results and the tailor-made preventive care plan that addressed the health issues identified. Where appropriate, a second follow-up consultation would be arranged within four months after the first follow-up consultation.

(c) Health promotion session

NGOs were required to provide health promotion sessions as part of the health assessment services to empower elders to manage their health risks / problems identified through the baseline health assessment. The sessions mainly focused on health topics relevant to lifestyle modification or chronic disease management.

4. Priority was given to elders who lived alone, who did not have health assessment before, or who did not have regular follow-up by medical services (hereunder referred to as "higher recruitment priority group"). To recruit these elders, targeted recruitment efforts were made by NGOs during the first six months of the pilot period, with enhanced promotional activities including reach-out activities through their community networks. At the same time, DH had also promoted the Pilot Programme through various channels.

THE REVIEW

5. DH has conducted a review to examine the experience gained and

to assess the effectiveness of the Pilot Programme. With the support of a research company, the review was conducted based on the feedback from participating elders collated through telephone survey, focus group study among the service providers, information collected by EHCs as well as statistical data submitted by NGOs and from the eHealth System(Subsidies)[2]. A summary of the findings of the review is set out in the ensuing paragraphs.

(a) Programme Participation

6. During the two-year pilot period, a total of 7 964 elders enrolled in the Pilot Programme. Among them, 6 093 (76.5%) belonged to the higher recruitment priority group as referred to in paragraph 4 above. The overall take-up rate was around 80%.

(b) Satisfaction with the Pilot Programme

7. It was reported that 91% of the participating elders were satisfied with the Pilot Programme, and the majority of them considered the Pilot Programme helpful in improving their health. However, some service users considered the health assessment items covered by the Pilot Programme inadequate, making the Pilot Programme less attractive to them.

(c) Early identification of health risks/problems and promotion of healthy ageing

8. Out of all the participating elders, 7 891 (99%) service users completed the Baseline Health Assessment while 7 665 (96%) completed all the clinical appointments arranged. Among those who had completed the Baseline Health Assessment, 2 914 (37%) were newly identified to have at least one problem related to blood pressure, blood sugar, or blood lipid. Further analysis revealed that 39% of the higher recruitment priority group as mentioned in paragraph 4 above were newly identified to have these health problems. In contrast, the corresponding percentage was lower (31%) for the elderly who did not meet any of the criteria for priority recruitment. The finding suggested that elders belonging to the higher recruitment priority group might be able to benefit more from the health assessment, as their health problems which otherwise would remain undetected could be identified and managed accordingly.

[2] The eHealth system(Subsidies) was purposefully designed for the Elderly Health Care Voucher Pilot Scheme to provide an electronic platform on which participating healthcare service providers could manage the registration of eHealth accounts for the elderly and handle reimbursement of health care vouchers. It has become an efficient platform to facilitate the development of public-private partnership, and has been enhanced and expanded to incorporate various vaccination subsidy schemes as well as the Pilot Programme.

(d) Promoting the use of community-based preventive care and the concept of family doctor

9. Through the Pilot Programme, NGOs promoted preventive care to the elderly, including enhancing their understanding about the role of health assessment, providing counselling on modification of lifestyle risk factors and introducing other community-based services to the elders. The NGOs also opined that the multi-disciplinary and personalised preventive care services provided under the Pilot Programme could strengthen the primary care services for the elderly as well as promoting the family doctor concept. Apart from learning about the importance of health check, the participating elders were also provided with an opportunity to familiarise themselves with the community healthcare services provided by NGOs so as to broaden their choices for handling their health problems in the future.

(e) Impact on healthcare seeking behaviour

10. About 44% of the elders who had completed the Baseline Health Assessment needed to have further follow-up consultations/referrals after the Pilot Programme. Most of the referrals (74%) were made to the public sector as the elders preferred to be followed up in the public sector for managing their health problems. Moreover, amongst those elderly on the waiting list for enrolment at EHCs interviewed and found to have joined the Pilot Programme, over 70% continued to enroll for the EHC membership, suggesting that the Pilot Programme might not have a positive effect on alleviating the high demand for EHC membership.

(f) Other feedback from service providers

11. Most of the NGOs considered it very challenging to implement the Pilot Programme, particularly in the areas of recruitment of elders (especially those belonging to the higher recruitment priority group), employment of suitable healthcare professions to provide the services for the Pilot Programme, and high administrative, laboratory and manpower costs. According to the NGOs, common reasons for the elderly not joining the Pilot Programme included the lack of perceived need among the elderly and difficulties in accessing the service centres. The limited follow-up consultations provided by the Pilot Programme and elders' preference for getting follow-up consultations in the public sector also affected the attractiveness and the effectiveness of the Pilot Programme. There were thus suggestions that the Government should enhance the public health services for the elderly. Moreover, some of them suggested that the eligible age for the Pilot Programme should be lowered. While some considered that the Pilot

Programme was a duplication of EHCs' service, some also considered the health assessment services most beneficial to the elders belonging to the higher recruitment priority group, as they were frequently the needy/hidden elders whose health problems were not under proper care.

ELDERLY HEALTH ASSESSMENT SERVICE OF DH

12. Implemented through collaboration with NGOs on a public-private partnership, the Pilot Programme aimed to test out a new service model for enhancing primary care for the elderly. At present, the EHCs also provide similar primary health services in the public sector. EHCs adopt a multi-disciplinary approach in providing integrated primary health services including health assessment, counselling, health education and treatment to the elderly aged 65 or above on a membership basis. However, the heavily subsidised nature of EHCs' service, coupled with a rapidly ageing population, has created a huge demand for EHCs' services as reflected by the long waiting time for enrollment as members of EHC. DH has implemented a series of measures to shorten the enrollment waiting time, which include conducting extra health assessments at EHCs with lower attendance for curative treatment; allocating more quotas to first-time health assessments for new members at all EHCs; and encouraging cross-district membership to ensure resources could be fully utilised. In addition, the Government has allocated additional resources to DH to create two additional clinical teams in EHCs in 2015 and 2016 respectively. The median waiting time has been effectively shortened from 20 months in 2014 to 9 months in April 2016 through implementation of the abovementioned improvement measures. That said, it is noted that the enhanced service capacity of EHCs still falls short of the ever-increasing demand, with some 10 000 elders still on the waiting list as of April 2016.

13. Being cognisant of the fact that EHCs alone cannot meet the healthcare needs of all elders in Hong Kong, the Government has taken steps to explore new models of service delivery, including the Elderly Health Care Voucher Scheme and the current Pilot Programme under review, so as to tap into the resources of the private sector and allow elders to obtain primary health services in a more efficient and sustainable manner.

WAY FORWARD

14. The Pilot Programme has primarily met its objectives, particularly in the areas of application of the Reference Framework, detection

of previously unidentified health risks or problems, and promotion of community-based services. However, the lack of long-term curative and clinical follow-ups under the Pilot Programme has made it less attractive to some elderly, with only about 80% of the quotas (out of 10 000 quotas) used up at the end of the two-year pilot period. NGOs participating in the programme also need to tackle various operational issues under the Pilot Programme. We consider that this service delivery model should not be further pursued.

15. On the other hand, taking into account the experience gained through the Pilot Programme as well as the recommendations made by the Audit Commission (Chapter 2, Report 63) and the Public Accounts Committee on DH's provision of health services for the elderly, DH has critically reviewed the strategic direction of EHCs with a view to enhancing and deploying EHCs' service capacity to better serve the growing elderly population in Hong Kong. The enhancement measures to be introduced / being considered include –

(a) *A pilot collaborative model with NGOs to reach the "hard-to-reach" elders*

As pointed out in paragraph 11 above, one of the key observations from the Pilot Programme is that health assessment has proven to be more effective in detecting health problems among elders who belong to the "hard-to-reach" group (e.g. those who lack regular medical care). To reach out to the "hard-to-reach" elders, DH will implement a pilot collaborative model at EHCs with comparatively shorter waiting lists under which the EHCs concerned will collaborate with relevant NGOs which are experienced in reaching out to "hard-to-reach" elders. Certain quotas will be reserved and priority will be given to the "hard-to-reach" elders (e.g. those with poor social network and no regular medical care) identified and referred by social workers of the collaborating NGOs to receive primary health services at the EHCs. Subject to the experience from the pilot, the collaborative model may be rolled out to other EHCs in phases as appropriate.

(b) *Review the health assessment protocol to channel resources to first-time health assessments*

To enhance the coverage of EHCs, DH will review the health assessment protocol for re-visiting EHCs' members for possible ways to channel more resources into conducting first-time health

assessments for new members.

(c) *Enhance service capacity of EHCs*

The Government shall continue to actively seek additional resources to enhance the service capacity of the EHCs.

16. Besides, a comprehensive review of the Elderly Health Care Voucher Scheme is in progress. The strategic directions of the elderly health assessment service provided by DH will be reviewed taking into account the findings of the study.

ADVICE SOUGHT

17. Members are invited to note the findings and recommendations of the review of the Pilot Programme.

Food and Health Bureau
Department of Health
June 2016

Annex A

Elderly Health Assessment Pilot Programme

List of Participating NGOs and Their Service Centres' Location

Region	NGO (Service Centre Location)
Hong Kong	Hong Kong Sheng Kung Hui Welfare Council Limited (Central)
	Chai Wan Baptist Church Community Health Centre Limited (Chai Wan)
Kowloon	Evangel Hospital (Kowloon City and Cheung Sha Wan)
	Hong Kong Sheng Kung Hui Welfare Council Limited (Kwun Tong)[3]
	Po Leung Kuk (Prince Edward)
	Sik Sik Yuen (Wong Tai Sin)
	The Lok Sin Tong Benevolent Society, Kowloon (Kowloon City and Mong Kok)
	Tung Wah Group of Hospitals (Yau Ma Tei)
	United Christian Nethersole Community Health Service (Jordan, Lam Tin and Kwun Tong)
New Territories	Haven of Hope Christian Service (Hang Hau, Hau Tak, King Lam and Po Lam)
	United Christian Nethersole Community Health Service (Tai Po and Tin Shui Wai)

[3] The Kowloon centre of SKH was relocated from Ngau Tau Kok to Kwun Tong and the Kwun Tong centre commenced operation in January 2015.

Annex B

Elderly Health Assessment Pilot Programme

Major Components of Baseline Health Assessment

(a) **History-taking** –

- past medical history
- family history of significant illnesses
- current medications (including over-the-counter medicines and herbal remedies) and any medications that may cause dry mouth as a side effect
- lifestyle behaviour including smoking and drinking habit, diet pattern and physical activities
- dental health problems (e.g. difficulty in chewing or brushing teeth) and dry mouth
- vaccination history (especially seasonal influenza vaccination and pneumococcal vaccination)
- psychological status, e.g. mood and emotion status
- social history such as marital status, home environment, financial support, family support and social network
- functional status: current level of mobility, e.g. independent, walk with aids; current ability and needs in terms of activities of daily living, and any recent deterioration
- any significant change in lifestyle and mood
- history of fall

(b) Focused **physical examination** -

- check height, weight, body mass index and waist circumference
- measure blood pressure and check pulse
- assess patient's cognitive function to see if there is any clinical suspicion of dementia based on direct observation, with due consideration of information obtained by way of patient reports and concerns raised by family members, friends, caretakers or others if any
- functional status as indicated: hearing, vision, mobility, cognition, mood
- obtain other measurements deemed appropriate based on medical and psycho-social history

(c) **Investigation items** that are suggested in the “Hong Kong Reference Framework for Preventive Care for Older Adults in Primary Care Settings"; the “Hong Kong Reference Framework for Hypertension Care for Adults in Primary Care Settings"; and the “Hong Kong Reference Framework for Diabetes Care for Adults in Primary Care Settings” -

- Fasting blood glucose [(a)]
- Total cholesterol and HDL-cholesterol[(a)(b)(c)]
- Faecal occult blood[(a)]
- Cervical Smear[(a)]
- Triglyceride and LDL-cholesterol[(b)(c)]
- Renal function test[(b)(c)]
- HbA1c[(c)]
- Urine for routine and microscopy[(b)(c)]
- Uric acid[(b)]
- Resting ECG[(b)]

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Note :

(a) For early identification of diabetes mellitus, hyperlipidaemia, colorectal cancer and cervical cancer.
(b) For elders with known hypertension. Checking of uric acid is indicated if on diuretic. Resting ECG is indicated for newly diagnosed hypertensive patients to exclude left ventricular hypertrophy.
(c) For elders with known diabetes mellitus.