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Health Care for Elderly People

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EXECUTIVE SUMMARY

1. The elderly population has been increasing steadily for the past few decades. However, longevity in most cases brings along poorer health. This implies an increased demand for the provision of health cares services for elderly people. Since two-thirds of the elderly population have limited or no monthly income, the younger generation will have to shoulder the financing of the provision of health care services for the elderly.

2. As 78% of the elderly population live either alone or with one family member only, the role played by the public sector as support and reinforcement to family care becomes significant.

3. Due to historical reasons, hospitals and acute treatment have expanded at the expense of primary health care. An efficient and effective primary health care to elderly people not only improves their general health status but also relieves the pressure on the secondary and tertiary health care services.

4. The findings of this research show that there still exists spare capacity in the services provided by Elderly Health Centres which are responsible for the provision of health promotion and preventive activities. The reasons for this low utilization, according to a survey conducted by an interest group, were poor publicity, poor accessibility and high annual fees of Elderly Health Centres.

5. There are limited oral health services provided for the elderly. There are also no oral health goals set for the elderly by the government. The general oral health conditions of the elderly in Hong Kong are poorer than that of the goals set by World Health Organization.

6. Long waiting time seems to be a common phenomenon in the General Out-patient Clinics (GOPCs). The Working Party on Primary Health Care (1990) has made a number of recommendations on the improvement of the services rendered by the GOPCs, yet, no reply from the government was received on the progress on the implementation of these recommendations.

7. The results brought about by the outreach medical services were positive: 10% reduction in unplanned hospital re-admission, accident and emergency attendance and geriatric out-patient attendance. At present, these outreach medical services are extended to elderly people living in residential care institutions, which is equivalent to about 10% of the total elderly population.

8. The old-old population, i.e., elderly people aged 80 years or above usually suffer a prevalence of chronic diseases and functional impairment. The rapid growth of this population segment, in turn, creates demand for both acute and long-term care services.

9. The findings of this research show that elderly patients account for more than 40% of the in-patients of hospitals. The average length of hospital stay of the elderly patients is more than 50% higher than that of general patients. This utilization of in-patient services by the elderly population and their length of hospital stay illustrate the great demand for secondary and tertiary health care services from the elderly population.

10. There is also a substantial demand for institutional services for the frail elderly. Elderly people at different points of old age may require different kinds of institutional care. Yet, no coordination is made among different institutions. This might affect the continuity of care received by the elderly.

11. There is a large number of applicants found on the central waiting list of infirmary beds and care and attention (C&A) places. Nursing homes are supposed to have been set up to relieve the pressure from the infirmaries and take care of the frail elderly whose health condition has deteriorated to a situation that C&A homes can no longer provide adequate care. Yet, the progress of completing nursing homes was delayed and none of them is in operation.

12. It is alleged that the growth of private homes for the elderly could help to relieve some pressure exerted upon the infirmary beds and the C&A places. Yet, the inadequate care provided by some of the private homes for the elderly would only exert pressure on the secondary and tertiary health care services for they are incapable of taking care of the frail elderly.

HEALTH CARE FOR THE ELDERLY PEOPLE

PART 1 - INTRODUCTION

1. Background

1.1 In September 1997, the Provisional Legislative Council (PLC) Panel on Health Services requested the Research and Library Services Division (RLS) to research on current health care system so as to facilitate their deliberation when the Secretary for Health and Welfare would complete a similar review in 1998. The focus on the elderly people was chosen as this group has become an increasingly significant consumer of public health care.

2. Objective and Scope

2.1 The objectives of this research are to review government policy on health care services for the elderly and to examine the adequacy of the existing health care services provided to the elderly people.

2.2 The scope of this research as agreed by the Panel is as follows:

(a) a brief description on the development of the health care policy for the elderly population;

(b) an overview of the elderly population;

(c) an estimate of the need of the elderly population for the health care services; and

(d) an analysis of the adequacy of the existing health care services provided for the elderly people.

3. Methodology

3.1 The study involves a combination of information collection, analysis and interviews.

3.2 Requests for information on the above subject were sent to various government departments and the Hospital Authority. However, only limited information was received as current data on various health care services for elderly people were not available from government sources or the Hospital Authority. As a result, data found on this paper were drawn from the research findings of local institutions or past government papers.

3.3 Several interviews were also held with academics, health care related professionals, government departments and the Hospital Authority to collect information and facts.

PART 2 - POLICY DEVELOPMENT

4. Background

4.1 From the 1970s to early 1990s, the provision of health and related services for the elderly was shared by different government departments. They were, namely, the Department of Health, the Social Welfare Department and the Hospital Authority. The policy bureau which was responsible for drafting the policy was the Health and Welfare Branch. In October 1994, the Elderly Services Division within the Health and Welfare Branch was set up to oversee and coordinate policy matters related to welfare, medical and health services for the elderly.

5 Policy Development

5.1 The government has issued a number of consultation and policy papers on health related issues for the whole community in the past few decades. (Please see Appendix I for details). However, there has been no comprehensive review of health care policy conducted by the government since 1974. Rather, a number of separate reviews was conducted: hospital care, primary health care, rehabilitative care, etc. Yet, no single independent policy paper on elderly health care was issued even though the elderly population is the major consumer of health care services. The guiding principles of the provision of health care services for the elderly could be found in reports on elderly care services in which health services formed *part* of the wide range of welfare services catered for the elderly people.

1960-70

5.2 In the 1960s and early 1970s, the objective of the health policy was to meet Hong Kong’s immediate requirements in medical and health services. The emphasis of the policy was building more clinics and hospitals. Long-term planning for health care for the community or for the elderly was not a major government concern at that time.

1970-90

5.3 Throughout the 1970s to the 1990s, the government has published a number of consultation and policy papers on various health issues. Although the elderly population was a group of major users of public health care services, those papers had limited discussion of health care services targeted for the elderly. The discussion of the provision of health care services for the elderly could only be found in papers on elderly welfare services.

5.4 In the papers on welfare services for the elderly, quite a considerable number of recommendations had been made to improve the provision of health care services for elderly people. For example, the government had drafted a detailed programme on the provision of the health services for elderly people in a green paper entitled "Services for the Elderly 1977". It contained programmes on preventive services, out-patient services, community support services and institutional care for the elderly people. Some recommendations suggested by this green paper were incorporated into the "White Paper on Social Welfare into the 1980s".

5.5 In 1988, the Central Committee on Services for the Elderly[1] reviewed the care services for the elderly population. The report emphasized the importance of the provision of primary health care services, community care services, institutional care services and rehabilitation services for the elderly population.

5.6 In 1994, the Working Group on Care for the Elderly[2] published a report which reviewed the care services for the elderly population. In this report, the Working Group recognized the inadequacy in the provision of medical and health care services for the elderly and recommended the government to increase primary health care services, community care services and institutional care services for the elderly.

5.7 The supply of elderly health care services has fallen short of their demand even though numerous recommendations were made to the government on the improvement of these services. Part 3 of this paper will give a more updated picture of the profile of the elderly population and an estimate of their need for health care services.

[1] In April 1987, the Welfare Services Panel of the Omelco recommended the government to set up a central committee on services for the elderly population. This Central Committee was set up in June 1987 whose membership comprised of government officials and representatives from the social welfare agencies.

[2] The Working Group on Care for the Elderly was set up in Nov. 1993 by the government. Members of the Working Group consisted of government officials and public members.

PART 3 - CHARACTERISTICS OF THE ELDERLY POPULATION

6. Introduction

6.1 This part looks at the size of the elderly population, their health conditions and financial conditions so as to identify their need for health care services.

7. Definition of the Elderly Population

7.1 For the planning of medical services, the government usually defines the elderly population as people aged 65 years or above. However, the prevailing retirement age among employees, such as civil servants, is at 60 years of age. Where applicable, this paper will follow the government's definition used for planning purposes, i.e., people aged 65 years or above.

8. Size of the Elderly Population

8.1 Table 1 and Figure 1 show the growth of elderly population in the period of 1977-1996. The elderly population (aged 65 years and above) accounted for 10% of the total population in 1996. This increased from 5.7% (261 100) to 10% (631 300) in the period 1977 to 1996 (19 years), representing a growth of 76% in the elderly population in the past two decades.

8.2 If we compare the increase in the over-75 population, i.e., people aged 75 years or above, the rate of increase is even more significant. The proportion of the over-75 population to total population rose from 1.7% in 1977 to 3.6% in 1996. The rate of increase in that period was 112%.

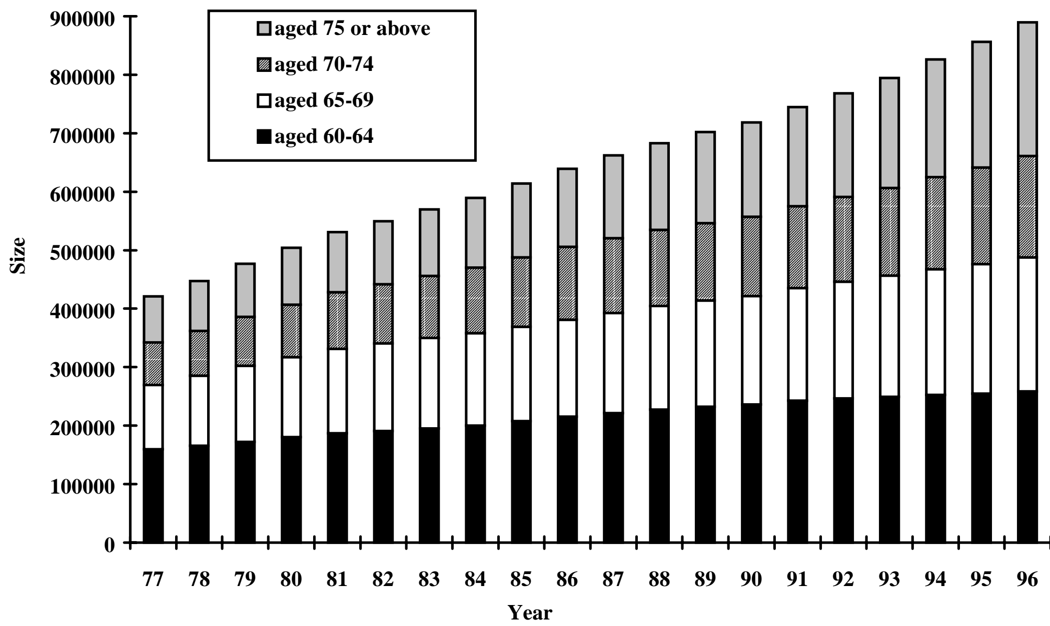
8.3 Figure 2 compares the growth rate of the elderly population with that of the total population in the period 1977-1996. It can be seen that in the past two decades, the elderly population grew much faster than the total population.

Table 1 - The Elderly Population, 1977-1996

Year	60--64 years	65--69 years	70--74 years	75 years or above	Total Population	60+ / total pop.	65+ / total pop.	75+ / total pop.
1977	159 800	109 600	73 000	78 500	4 577 200	9.20%	5.70%	1.72%
1978	165 600	119 600	76 800	85 200	4 660 800	9.59%	6.04%	1.83%
1979	172 500	129 600	83 700	91 200	4 863 600	9.81%	6.26%	1.88%
1980	180 300	136 900	89 700	97 300	5 016 700	10.05%	6.46%	1.94%
1981	187 000	144 300	96 800	102 800	5 154 800	10.30%	6.67%	1.99%
1982	190 700	149 900	101 200	107 900	5 245 300	10.48%	6.84%	2.06%
1983	195 200	154 700	106 200	113 400	5 323 500	10.70%	7.03%	2.13%
1984	200 200	158 200	112 000	119 200	5 376 800	10.97%	7.24%	2.22%
1985	207 700	161 500	118 600	126 100	5 436 800	11.29%	7.47%	2.32%
1986	215 700	165 500	124 300	133 900	5 508 100	11.61%	7.69%	2.43%
1987	221 700	171 000	127 800	141 500	5 564 500	11.90%	7.91%	2.54%
1988	227 600	177 000	130 000	148 500	5 602 400	12.19%	8.13%	2.65%
1989	232 200	181 800	132 400	155 400	5 631 400	12.46%	8.34%	2.76%
1990	236 200	185 400	135 400	161 600	5 642 900	12.73%	8.55%	2.86%
1991	242 900	192 400	139 900	169 700	5 683 900	13.11%	8.83%	2.99%
1992	246 500	199 500	144 900	177 500	5 740 000	13.39%	9.09%	3.09%
1993	249 100	207 200	150 300	188 000	5 854 000	13.57%	9.32%	3.21%
1994	252 600	215 000	157 400	201 200	6 002 700	13.76%	9.56%	3.35%
1995	254 700	221 600	165 000	214 700	6 130 900	13.96%	9.81%	3.50%
1996	258 500	229 000	173 500	228 800	6 292 000	14.14%	10.03%	3.64%
% increase in the elderly pop. Over total pop. from 1977 -1996 (19 years)						53.70%	75.96%	111.63%

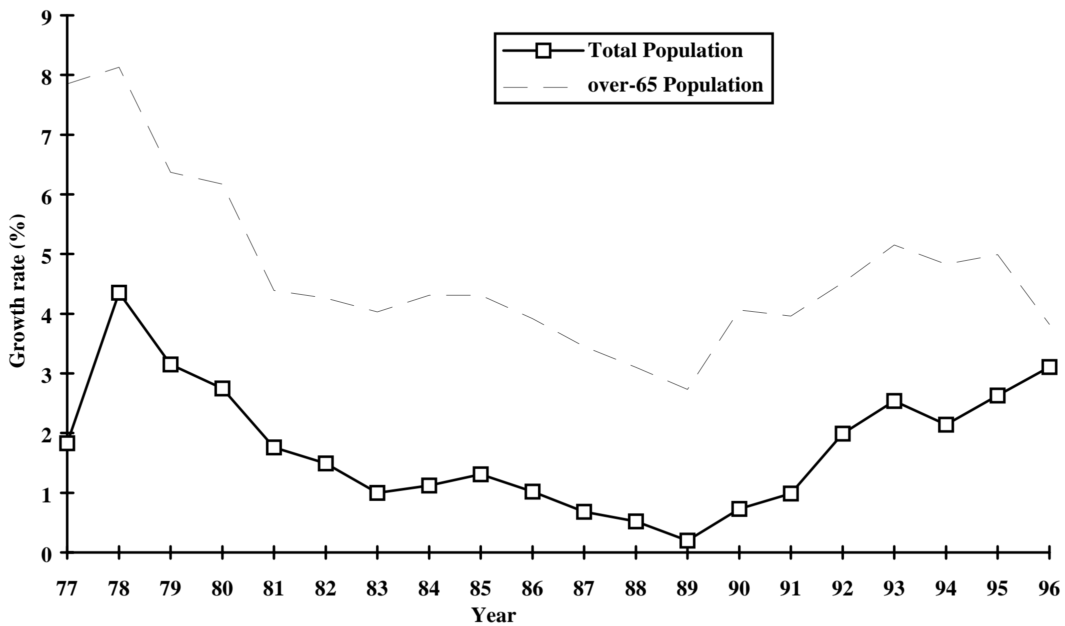
Source: Census and Statistics Department

Fig 1 The Elderly Population, 1977-1996



Source: Census and Statistics Department

Fig 2 Growth Rate of the Elderly Population, 1977-1996



Source: Census and Statistics Department

8.4 Table 2 and Figure 3 show the projected growth of the elderly population in the coming 20 years of 1997-2016. The number of the elderly will almost double in the next 20 years, increasing from 655 400 in 1997 to 1 091 700 in 2016. It will account for 13.3% of the total population in 2016, that is, roughly one in every seven people will be aged 65 years or above in 2016. For the over-75 population, its proportion in the total population is estimated to rise from 3.7% in 1997 to 5.5% in 2016. The projected rate of increase is 50%.

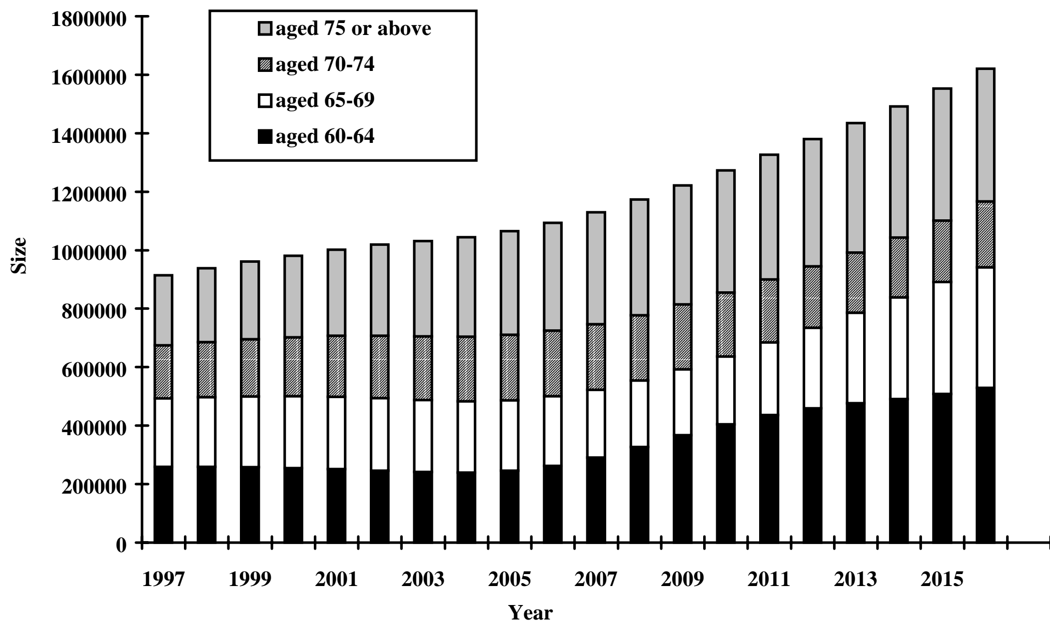
8.5 Figure 4 compares the projected growth rate of the elderly population and the total population in the period 1997-2016. It can be seen that except in 2007 and 2008, the growth of the elderly population is estimated to be faster than that of the total population.

Table 2 - The Elderly Population, 1997-2016 (Projection)

Year	60--64 year	65--69 year	70--74 year	75 or above	Total Population	60+ / total pop.	65+ / total pop.	75+ / total pop.
1997	259 000	234 400	180 900	240 100	6 487 500	14.09%	10.10%	3.70%
1998	258 700	238 800	188 400	252 000	6 659 400	14.08%	10.20%	3.78%
1999	257 700	242 600	195 600	265 000	6 768 900	14.20%	10.39%	3.91%
2000	255 200	245 300	202 100	278 400	6 860 000	14.30%	10.58%	4.06%
2001	251 600	247 400	208 300	294 300	6 951 000	14.41%	10.79%	4.23%
2002	246 300	247 700	214 000	310 900	7 040 200	14.47%	10.97%	4.42%
2003	241 200	246 500	217 700	325 600	7 127 600	14.46%	11.08%	4.57%
2004	239 700	244 700	220 900	340 100	7 213 900	14.49%	11.17%	4.71%
2005	245 600	241 500	223 200	354 400	7 299 200	14.59%	11.22%	4.86%
2006	263 000	237 500	224 300	368 400	7 382 600	14.81%	11.25%	4.99%
2007	291 000	232 200	224 000	382 300	7 465 400	15.13%	11.23%	5.12%
2008	327 500	227 400	223 000	395 100	7 547 900	15.54%	11.20%	5.23%
2009	367 100	226 100	221 400	407 000	7 630 600	16.01%	11.20%	5.33%
2010	404 800	231 800	218 600	417 900	7 713 600	16.50%	11.26%	5.42%
2011	436 100	248 500	214 900	427 400	7 797 100	17.02%	11.42%	5.48%
2012	459 700	275 200	210 000	435 700	7 879 100	17.52%	11.69%	5.53%
2013	476 300	309 900	205 600	442 600	7 961 000	18.02%	12.03%	5.56%
2014	491500	347 400	204 400	448 200	8 042 900	18.54%	12.43%	5.57%
2015	508 300	382 900	209 700	452 000	8 124 600	19.11%	12.86%	5.56%
2016	529 200	412 400	225 100	454 200	8 205 900	19.75%	13.30%	5.54%
% increase in the elderly pop. Over total pop. From 1997 -2016 (19 years)						40.17%	31.68%	49.73%

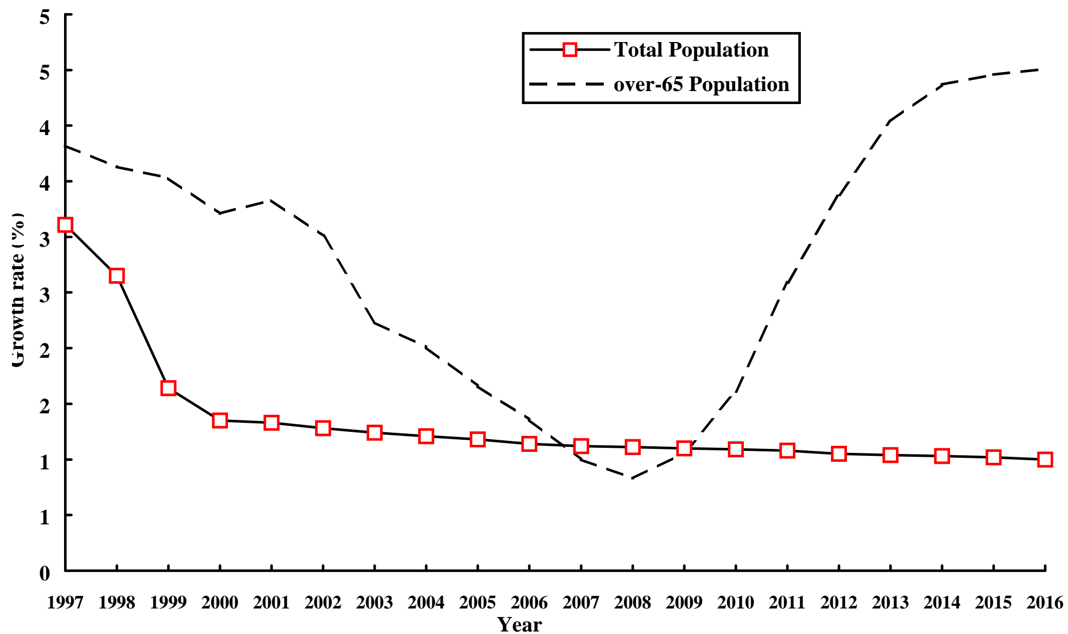
Source: Census and Statistics Department

Fig 3 The Elderly Population, 1997-2016 (Projection)



Source: Census and Statistics Department

Fig 4 Projected Growth Rate of the Elderly Population , 1997-2016



Source: Census and Statistics Department

9. Life Expectancy

9.1 An increase in life expectancy is generally brought about by the application of new and advanced medical and related technology. This would prolong the average number of years that a person is expected to live. Table 3 shows the life expectancy in the period 1977-2016. Life expectancy at different points of age has been increasing steadily in the period 1977-1996 and is projected to remain so in the coming 20 years.

Table 3 - Expectation of Life at Selected Ages for Each Sex, 1977-2016

Year \ Age	Male		Female	
	at birth	at 60	at birth	at 60
1977	70.1	16.4	76.7	21.1
1986	74.1	18.5	79.4	22.6
1996	76.3	20.0	81.8	24.1
2006 *	*77.5*	*20.8*	*82.8*	*24.8*
2016 *	*78.1*	*21.1*	*83.4*	*25.1*

Remark: * Figures in 2006 and 2016 are projected figures only.

Sources:
1. Census and Statistics Department
2. Hong Kong Population Projections, 1997-2016, p. 48

10. Dependency Ratio

10.1 The elderly dependency ratio is another common measure of population aging. It is defined as the number of persons aged 65 years or above per 1 000 persons aged 15-64 years. Table 4 shows the elderly dependency ratio in the period 1977-2016. It can be seen that the elderly dependency ratio has been rising steadily and is projected to remain so in the coming 20 years. It is projected to increase from 141 in 1996 to 153 in 2006 and then to 184 in 2016. This means that in the next twenty years, every 1 000 persons aged between 15 and 64 years have to support 184 elderly people.

Table 4 - Elderly Dependency Ratio, 1997-2016

Year	No. of elderly aged 65 or above (a)	No. of persons aged 15-64 ('000) (b)	Elderly Dependency Ratio (a / b)
1977	261 100	2 993.1	87.2
1986	423 700	3 826.9	110.8
1996	631 300	4 471.8	141.2
2006 *	*830 200*	*5 411.2*	*153.4*
2016 *	*1 091 700*	*5 926.8*	*184.2*

Remark: * Figures in 2006 and 2016 are projected figures only.

Sources:
1. Census and Statistics Department, Hong Kong Annual Digest of Statistics 1987 -1996
2. Census and Statistics Department, Hong Kong Population Projections 1997-2016

10.2 This increase in elderly dependency ratio is not unique to Hong Kong. Most Asian countries are also experiencing rapid increases in the elderly population. It is expected that their elderly population will increase significantly in the next few decades. (Please see Appendix II for details.) Some selected western countries had even higher elderly dependency ratio than that of Hong Kong. (Please see Appendix III for details.) Nonetheless, the elderly dependency ratio of Hong Kong was higher than the average elderly dependency ratio of Asian countries and the rest of the world (Please see Appendix II for details).

10.3 On the one hand, this elderly dependency ratio of Hong Kong shows that there is a continuous improvement in the mortality rate. On the other hand, this implies that there will be a greater demand on our health care services as the health conditions of a person generally deteriorate with age.

11. Health Conditions of the Elderly Population

11.1 Since the government was not able to provide the RLS with the actual figures and information on the current health conditions of the elderly population in Hong Kong, information used in this section was sourced from reports of research institutions or past government papers so as to provide readers with a fairly general picture of the health conditions of the elderly population.

Chronic Illness

11.2 According to the Hospital Authority's (HA) reply to our enquiry, *"about 50% of elderly people suffer chronic illness. About 15% of elderly people suffer from diabetes mellitus, 1/3 from hypertension and 1/4 from osteoporosis. Cancer is also most prevalent in the elderly age group."*

11.3 According to a study on the health status of elderly people in Hong Kong conducted by Edward Leung and Mona Lo[3] , the five most common chronic illnesses found in their sample were rheumatism (34.2%), hypertension (32.2%), fracture (17.1%), peptic ulcer (13.5%) and diabetes mellitus (10.7%). Table 5 shows the details.

Table 5 - Prevalence of Chronic Illness in the Elderly People, 1996

Illness	Number affected	Percentage
Rheumatism	504	34
Hypertension	474	32
Fracture	205	14
Peptic ulcer	198	13
Diabetes mellitus	158	11
Chronic bronchitis	120	8
Coronary heart disease	100	7
Hyperthyroidism	89	6
Urinary incontinence	72	5
Stroke	55	4
Faecal incontinence	43	3
Hyperparathyroidism	21	1

Remark: The above results were based on a survey of 1 480 elderly people with a mean age of 70.6 years.
Source: E. Leung & M. Lo, "Social and Health Status of Elderly People in Hong Kong" in *The Health of the Elderly in Hong Kong* , Hong Kong University Press, 1997.

[3] E. Leung & M. Lo, "Social and Health Status of Elderly People in Hong Kong" in *The Health of the Elderly in Hong Kong,* edited by S.K. Lam, Hong Kong University Press, 1997.

Visual Impairment

11.4 Poor vision is prevalent among old people. Table 6 shows the number of visually impaired persons in 1994. It can be seen that 79% of blind people were aged 60 years or above. Table 7 shows the prevalence rates[4] of totally blind people in 1994. It can be seen that the prevalence rate of totally blind people who were aged 70 years or above per 10 000 people was 128.5[5] which was much higher than the prevalence rate of the other age groups. It is estimated that the elderly aged 60 years or above will account for 28%[6] of the visually impaired population by 1998.

Table 6 - Number of Visually Impaired Persons, 1994

Age	Totally blind[7]		Severe low vision[8]		Mild / moderate low vision[9]	
	No.	%	No.	%	No.	%
0-59	1 591	22%	10 443	87%	15 669	87%
60-69	1 138	16%	912	8%	1 367	8%
70 or above	4 573	63%	712	6%	1 068	6%
Total	7 302	~100%	12 068	~100%	18 102	~100%

Source: Health and Welfare Branch, Hong Kong Review of Rehabilitation Programme Plan (1994/95 - 1998/99), 1996, p. 48.

4 Prevalence rate - the estimated average number of people with a specific type of disability per 10 000 people.

5 Health and Welfare Branch, *Hong Kong Review of Rehabilitation Programme Plan* (1994/95 - 1998/99), Government of Hong Kong 1996 p.47.

6 Health and Welfare Branch, *Hong Kong Review of Rehabilitation Programme* Plan (1994/95 - 1998/99), Government of Hong Kong 1996 p. 258.

7 Total blindness is defined as persons with no visual function, i.e. no light perception.

8 The severe low vision group refers to people with visual acuity of 6/120 or worse or people with constricted visual field in which the widest field diameter subtends an angular subtense of 20 degrees or less, irrespective of the visual acuity.

9 The mild low vision group refers to people with visual acuity from 6/18 to better than 6/60. The moderate low vision group refers to people with visual acuity from 6/60 to better than 6/120.

Table 7 - Prevalence Rates of Totally Blind People, 1994

Age Group	Prevalence Rates (per 10 000 persons)
	Totally Blind
0-2	0.44
3-5	0.73
6-8	1.50
9-11	1.80
12-14	1.89
15-17	2.18
18-19	2.09
20-49	2.46
50-59	11.67
60-69	24.97
70 or above	128.49

Source : Health and Welfare Branch, Hong Kong Review of Rehabilitation Programme Plan (1994/95 - 1998/99) 1996, p.47.

Physical Disability

11.5 Nearly 62% of the physically disabled in 1994 as identified in the Hong Kong Review of Rehabilitation Programme Plan (1994/95-1998/99) were aged 60 years or above. According to the Hospital Authority, about 20% of the elderly population had some forms of disability. Elderly people suffer from visual impairment may easily stumble over and fall. According to the Hospital Authority, the annual incidence of “hip fracture due to fall” for persons aged 70 years or above is 10 in 1 000 and this is also “an important factor contributing to institutionalization”. Table 8 shows the number of physically handicapped persons in 1994.

Table 8 - Number of the Physically Handicapped Persons in 1994

Age group	Physically handicapped persons		Prevalence rates (per 10 000 people)
	Number	%	
0-1	48	0.07	3.32
2-3	239	0.33	17.15
4	215	0.29	31.40
5	296	0.41	40.10
6-11	2 391	3.27	53.19
12-15	1 729	2.37	53.95
16-17	685	0.94	45.75
18-49	16 509	22.59	52.11
50-59	5 978	8.18	126.44
60 +	44 982	61.56	580.33
Total	73 072		

Source: Health and Welfare Branch, Hong Kong Review of Rehabilitation Programme Plan (1994/95 - 1998/99), 1996, p. 63.

Mental Disability

11.6 In 1994, there were 56 630 elderly people aged 65 years or above who had organic psychoses, as identified in the Hong Kong Review of Rehabilitation Programme Plan 1994/95-1998/99. This represented 9% of the elderly population aged 65 years or above. The majority of these had senile dementia and presenile organic brain syndromes. The prevalence rate of organic psychoses of at least moderate severity was estimated at 10% for the elderly population aged 65 years or above. However, the Rehabilitation Programme Plan 1994/95-1998/99 estimated that only around 50% of them would require some form of medical, nursing and other rehabilitation services.

Multiple Diseases or Disabilities

11.7 Furthermore, elderly people usually have more than one disease or disability. In the study conducted by Chi and Boey (1994)[10], about 41% out of a total of 266 elderly people aged 70 years or above had one disease, 21.8% had two diseases and 15.4% had three or more diseases.

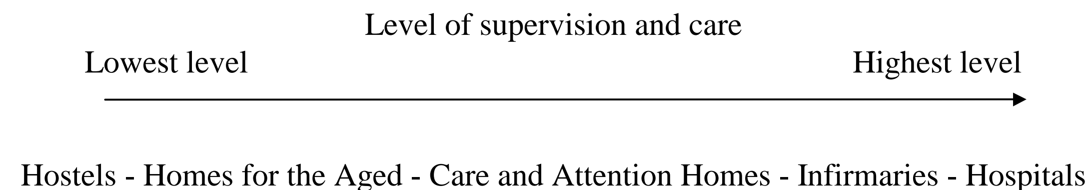
[10] Chi and Boey, *A Mental Health and Social Support Study of the Old-old in Hong Kong,* Department of Social Work and Social Administration, University of Hong Kong, 1994.

11.8 In sum, the general health features of the elderly population can be summarized as follows: a high proportion of them suffer poorer health and functional impairment.

12. Living Arrangement of Elderly People

12.1 When an elderly person's health deteriorates to a certain extent, he will lose the ability to take care of himself independently and will need care services. If his family is not able to provide such care services, the elderly person may need to live in an institution. Different institutions provide different degrees of personal and nursing care to elderly people. For example, while hostels and homes for the aged provide the lowest level of supervision and care, hospitals and infirmaries provide the most intensive medical and nursing care to their patients. Diagram 1 illustrates the continuum of institutional care for elderly people.

Diagram 1 Continuum of Institutional Care for the Elderly People



Hostels - Homes for the Aged - Care and Attention Homes - Infirmaries - Hospitals

12.2 Table 9 shows the number of elderly people living in institutions. It can be seen that from 1991 onwards, the number of elderly people living in hostels has been decreasing whereas the number of elderly people living in all other institutions has been increasing. In the period 1989-1997, the number of elderly people living in Care and Attention (C&A) homes has increased considerably (321% for C&A homes). Notwithstanding an increase in the provision of C&A places, the number of applicants on the waiting list for C&A places had not decreased: as at August 1997, there were 19 982 elderly people on the waiting list for C&A places. This reflects that there is an increasing demand for elderly homes which provide a more intensive or regular personal care services[11] .

[11] Please note that residents living in C&A homes are usually in poorer health than those living in hostels and homes for the aged. More details will be given in Part 6 of the paper.

Table 9 - The Elderly Population[1] Living in Elderly Homes and Hospitals

	Elderly Homes Operated by Social Welfare Department and Non-governmental Organizations						
As at end of	**Hostel ***	**Home for the Aged ***	**C & A Homes ***	**Home for the Aged Blind / C & A Provision for Aged Blind ***	**Private Homes for the Elderly ***	**Street Sleepers**	**Hospitals**
3/88	n.a.	n.a.	n.a.	n.a.	n.a.	302	n.a.
3/89	1 483	3 897	1 618	219	6 961	n.a.	n.a.
3/90	1 585	4 045	1 657	213	7 708	297	n.a.
3/91	1 720	4 546	2 077	207	8 870	355	7 459
3/92	1 710	5 371	2 666	259	10 504	316	9 118
3/93	1 259	5 560	3 213	269	11 791	n.a.	9 140
3/94	1 211	5 645	4 200	284	13 563	256	9 555
3/95	1 112	6 031	4 883	295	15 852	n.a.	9 943
3/96	997	6 009	5 765	354	17 715	292	10 968
3/97	889	6 192	6 812	531	19 169	n.a.	10 674

Remarks
1. The elderly population is defined as those aged 60 years or above. However, some of the residents living in the * institutions may be of age below 60 years.
2. C & A stands for Care and Attention
3. n.a. stands for not available

Sources:
1. Census and Statistics Department
2. Social Welfare Department
3. Department of Health
4. Hospital Authority

12.3 Table 10 shows the elderly population by household composition. It can be seen that about 10% of the elderly population live alone and 67% of them live with one family member, giving a rough total of 78% of the elderly population who live either alone or with one family member only (691 690 out of a total of 889 850). Yet, the policy statement of the Report of the Working Group on Care for the Elderly (1994) stated "*the present policy on elderly services is to encourage caring for the elderly by family members within a family context*". In view of the household composition of the elderly population, there might be some difficulties in looking after the elderly person when he falls ill or his health deteriorates. In turn, this might become an increased demand on the public sector health care services.

Table 10 - The Elderly Population by Household Composition, 1981, 1986, 1991, 1996

Household composition	1981	1986	1991	1996
One person	58 810	65 559	80 854	91 967
One unextended nuclear family	164 141	229 107	297 380	398 453
One vertically extended nuclear family	145 328	153 173	162 481	192 794
One horizontally extended nuclear family	7 941	9 310	9 380	8 476
Two or more nuclear families	78 095	93 900	87 712	113 474
Related persons forming no nuclear family	27 633	28 321	32 151	33 112
Unrelated persons	9 792	17 086	14 181	14 694
Collective households	15 278	21 700	32 762	36 880
Total	507 018	618 156	716 901	889 850

Source: Census and Statistics Department

13. Financial Conditions of Elderly People

13.1 Table 11 shows the monthly income of elderly people. It can be seen that in 1996, the majority (594 358 or 67%) of elderly people aged 60 years or above had a monthly income of less than $2,000. Of these, 46% of them (272 918 out of 594 358) had no monthly income. Given the relatively high cost of private sector health care, a large number of elderly people would need to rely on the public sector for its heavily subsidized health care services.

Table 11 - Monthly Income * of the Elderly Population Aged 60 Years or Above

Monthly Income (at 1996 price level)	1981	1986	1991	1996
Nil	205 148	228 582	236 614	272 918
<$2,000	141 772	180 753	253 838	321 440
$2,000 - $3,999	81 066	73 128	56 665	85 621
$4,000 - $5,999	36 501	57 866	66 687	60 693
$6,000 - $9,999	25 227	39 192	47 471	62 475
$10,000 - $19,999	10 447	24 895	33 025	53 884
≥$20,000	6 857	13 740	22 601	32 819
Total	507 018	618 156	716 901	889 850

Remark: * monthly income is defined as the sum of monthly earnings from main employment, monthly earnings from other employment and other cash income. The monthly incomes for 1981, 1986 and 1991 are brought up to the 1996 price level by CPI(A) to facilitate comparison.

Source: Census and Statistics Department

13.2 Recipients of Comprehensive Social Security Assistance (CSSA) receive public medical treatment free of charge. In June 1997, there were 103 945[12] old age cases[13] under the CSSA scheme. For elderly people aged between 60 and 64 years whose income and resources are below the prescribed CSSA level, they are also entitled to receive the CSSA; hence, they are also able to receive public medical treatment free of charge. This ensures that the elderly in Hong Kong are not denied medical treatment due to lack of means.

[12] Source: Census and Statistics Department, *Hong Kong Monthly Digest of Statistics*, August 1997.
[13] Any person aged 65 years or above are eligible to receive old age allowance.

14. Summary of the Characteristics of the Elderly Population

14.1 In sum, the elderly population can be characterized as follows:

(a) increasing in numbers: the elderly population was 10% of total population in 1996 and projected to increase to 13% in 2016;

(b) increasing life expectancy;

(c) a high proportion of the elderly population suffer from poorer health and functional impairment;

(d) increasing demand for elderly homes which provide a more intensive or regular personal care services as 78% of the elderly population live either alone or with one family member only; and

(e) increasing number of elderly people who had no or limited monthly income (67% of the elderly aged 60 years or above).

PART 4 - PRIMARY HEALTH CARE FOR ELDERLY PEOPLE

15. Primary Health Care

15.1 Primary health care is the first point of contact which individuals and the family have with a continuing health care process. It constitutes the first level of a health care system[14], which includes the provision of promotive, preventive, curative and rehabilitative services.

Preventive and Promotive Services

15.2 If the provider of primary health care services performs the function of a "gatekeeper", there will be a lower demand for secondary and tertiary health care services. For example, aging is associated with a marked increase in the prevalence of chronic illness such as diabetes mellitus. To best forestall diabetes mellitus in the aged, individuals who are "vulnerable" to diabetes mellitus (for example, individuals who have familial inherence of such disease) should be monitored long before symptoms appear. To do this, urine glucose, blood glucose concentration and blood insulin level should be regularly monitored.

15.3 This point is also echoed by Dr. Knight Steel, a known authority in the field: "*it is becoming increasingly obvious that preventive measures undertaken decades earlier are of critical importance in the reduction of morbidity in old age*"[15]. Health education also plays an important part here. For example, many chronic diseases such as cardiovascular diseases are related to unhealthy lifestyles. Through health education, individuals may learn to adopt healthy lifestyles to prevent such diseases, and to seek early treatment before developing disabling chronic conditions.

15.4 In Hong Kong, primary health care services for elderly people are mainly provided by the Department of Health through Elderly Health Centres. The Central Health Education Unit and the General Out-patient Clinics also undertake the promotion of health of the elderly people through a range of health education activities.

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[14] Report of the Working Party on Primary Health Care, *Health For All The Way Ahead,* Hong Kong Government, 1990.

[15] Somers, "Preventive Health Services for the Elderly: The Growing Consensus" in *Health Promotion and Disease Prevention in the Elderly,* edited by Chernoff and Lipschitz, Raven Press, 1988.

15.5 Some private health care service providers and some Non-government Organizations (NGOs) also provide preventive health care services for the elderly. It is reported[16] that most elderly people who go to these private health care service providers or NGOs are relatively well-off. This is because the health care centres run by private health care service providers or NGOs are running on a self-financing basis. These organizations also provide a number of health care services, including health screening, health promotion talks, dietetic counselling and psycho-social counselling services. However, there are no official statistics on the number of elderly attendees of these non-government-run health care services.

Utilization of Elderly Health Centres

15.6 Elderly Health Centres aims to promote the health and well-being of elderly people in the community through enhancement of the individual's knowledge of healthy lifestyle and self care, screening for common health risks and diseases, and promotion of community participation in health maintenance. They were established in 1994 and designated for people aged 65 years or above.

15.7 A 51-membered team of doctors, nurses, relevant medical personnel and non-medical staff is deployed to man Elderly Health Centres. At present, there are seven Elderly Health Centres[17] : two on Hong Kong island, two in Kowloon and the remaining three in the New Territories. The "1997 Policy Address" states that the government will set up an additional five Elderly Health Centres in 1998-99 and another six in 1999-2000 to make Elderly Health Centres more accessible to the elderly people. Between 1994 and mid-1997, there was an increase in service utilization of Elderly Health Centres from 48% to 59%. According to the Department of Health, clients are usually seen within 10 working days of making an appointment. Service utilization is detailed in Table 12.

Table 12 - Service Utilization of Elderly Health Centres

Year	Capacity	New Cases	Utilization Rate
1994	1 500	718	48%
1995	4 000	2 031	51%
1996	8 050	4 068	51%
1997 (up to July)	7 100	4 165	59%

Source: Department of Health

16 Interview with Ms Cheung, supervisor of St. James Settlement.
17 The seven Elderly Health Centres are located in Nam Shan, Kwun Tong, Shaukeiwan, Shek Wu Hui, Kennedy Town, Tsuen Wan and Yuen Chau Kok

15.8 It is noted from Table 12 that although there is a steady increase in the service utilization of Elderly Health Centres, there exists a large spare capacity. If we compare the total elderly population aged 65 years or above as at 1996 with the utilization rate in the same year, less than 1% (0.65%) of the over-65 population had used the services provided by Elderly Health Centres.

15.9 According to a survey conducted by the Elderly Rights League (H. K.) in January 1996, the low utilization rate of Elderly Health Centres was due to "the poor publicity, poor accessibility and high annual fees[18] of Elderly Health Centres". As the accessibility of these Centres is going to be improved by 1998-99, the publicity and fees of Elderly Health Centres might need to be reconsidered.

15.10 It is noted in section 11 that the health conditions of some elderly people started to deteriorate at the age of 60 years or above. For example, the prevalence rates of totally blind people aged between 20 and 49 years, 50 and 59 years, 60 and 69 years in 1994 were 2.46, 11.67 and 24.97 respectively. This illustrates that the health conditions of the population would start to deteriorate after 60 years, not necessarily 65 years. Yet, services provided at Elderly Health Centres (which aim to forestall illness) cater for people aged 65 years or above. As there is spare capacity in these Centres, considerations can be given to allow access to elderly people under 65 years of age.

Oral Health Care

15.11 The oral health need of the community is monitored by a Dental Sub-Committee under the Health and Medical Development Advisory Committee appointed by the government. At present, only limited oral health care services are provided by the government. Emphasis of the public oral health services is placed on the provision of preventive and promotive services[19] .

15.12 According to the reply from Health and Welfare Bureau to our enquiry, only promotive oral health care services on oral hygiene measures, oral health awareness and proper use of oral care services are provided to the elderly by the government. Comprehensive dental care such as regular oral examination, fillings, root treatment, extractions and specialist services, etc. is provided to civil service pensioners only, which is in fulfilment of government's contractual obligation towards its employees. Oral health education for elderly people is provided by Elderly Health Centres. CSSA elderly recipients can seek treatment at non-profit-making dental clinics designated by the Social Welfare Department and their fees are reimbursed through the CSSA scheme.

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[18] The annual fee of Elderly Health Centre is $220 per person.

[19] Health and Welfare Branch, *Information Paper on Medical Services for the Elderly,* prepared for the meeting of LegCo Panel on Health Services on 6 May 1996.

15.13 Table 13 shows a comparison between the oral health goals for the elderly recommended by World Health Organization (WHO) for the year 2010 with the oral health condition of the elderly aged 60 years or above in Hong Kong in 1991. It can be seen that if the government of Hong Kong wishes to meet the global oral health goals set by WHO, measures must be taken to improve the oral health conditions of the elderly.

Table 13 - Comparison of Oral Health Goals for the Elderly Recommended by WHO and Actual Elderly Oral Health Situation in Hong Kong

WHO global oral health goals for the year 2010	Oral health situation for the elderly aged 60 years or above in 1991
No more than 5% edentulous	About 10% edentulous
75% with a minimum of 20 functional teeth	40% with a minimum of 20 functional teeth
No more than 0.5 sextants with deep pockets	0.2 sextants with deep pockets

Source: Department of Health, *Public Health Report No. 2 : Oral Health, 1995*, p.21

15.14 Public oral health care services in Hong Kong are confined to preventive and promotive services only and are provided to the elderly through Elderly Health Centres where utilization is low. The poor oral health of the elderly in Hong Kong may be attributed to their low awareness of regular dental care. Moreover, unlike other age groups for which the Dental Subcommittee has set up oral health goals, there is no oral health goal set for the elderly group. This reflects the low priority of oral health care services provided to the elderly by the government.

Leading Causes of Death

15.15 Table 14 shows the leading causes of death of the elderly population in the period 1961 to 1995. The five leading causes of death could be considered as chronic illnesses since normally they would not cause immediate death of the patients. If the patients adopted healthy lifestyles such as a balanced diet which included less consumption of high cholesterol and salty food, taking more exercise to strengthen their immunity system, avoidance of inverse effect of their living environment on their health (such as exposure to air pollution) etc., these patients might have been able to reduce the risk of having these diseases or aggravation of their health status. All the above measures belong to the area of primary health care.

Table 14 - Leading Causes of Death 1961-1995

Causes of death	**Number of Deaths**					
65 years or above	**1961**	**1971**	**1981**	**1991**	**1994**	**1995**
Malignant neoplasms	503	1 349	2 933	5 026	5 758	5 938
Heart diseases, including hypertensive heart disease	817	1 652	2 637	3 782	3 931	4 003
Pneumonia, all forms	435	1 140	1 542	1 475	1 682	2 892
Cerebrovascular disease	747	1 137	2 222	2 350	2 590	2 706
Nephritis, nephrotic syndrome and nephrosis	88	95	442	810	686	699
All other causes	1 934	3 315	4 114	5 695	6 424	5 777
All causes (total)	**4 524**	**8 688**	**13 890**	**19 138**	**21 071**	**22 015**

Source: Department of Health, *Annual Report 1995/96* p. 72.

Curative Services

General Out-Patient Clinics

15.16 The general out-patient service forms a vital part of the primary health care system. At present, there are 68 General Out-Patient Clinics (GOPCs) (including nine non-public clinics) run by the Department of Health and Hospital Authority. In 1995, the elderly patients aged 65 years or above accounted for about a third (34%)[20] of the total attendance at GOPCs, which was a proportion higher than that of the general population (10%). These patients were also found to be poorer, less well educated and hence more in need of health education and preventive health services[21] .

[20] Health and Welfare Branch, *Information Paper on Medical Services for the Elderly,* prepared for the meeting of LegCo Panel on Health Services on 6 May 1996.

[21] Report of the Working Party on Primary Health Care, Health for All: The Way Forward, 1990 p. 89.

Patient's Waiting Time

15.17 Some elderly patients claimed that they had to wait for an average of four hours before they were seen by the doctor[22] . According to the Department of Health, about 1 500 priority discs of GOPCs (which were about 10% of the daily consultation capacity) were set aside for elderly patients. An advance appointment system for those with chronic disease is also available to reduce the waiting time. The patients need to book in person. The Department of Health also pledged that these chronic patients who had made advance appointment would be seen by the doctor within 30 minutes of the appointment time.

15.18 However, only one-third[23] of the elderly patients with chronic diseases make use of this advance appointment system. More than 50%[24] of the patients (including patients below the age of 65 years) prefer to attend GOPCs in the early hours of the morning to suit their own personal convenience. Possible reasons for this behaviour were that appointment could not be made by telephone and most elderly people would prefer to come early in the day to be certain that they obtain the discs.

Coordination with Hospitals

15.19 At present, the medical records of patients cannot be shared among the Hospital Authority, the GOPCs and Elderly Health Centres. Since elderly patients consume heavily services provided by the above organizations, the absence of shared medical records may form a barrier to the continuity of care for the patients. Moreover, if the patient is referred by the GOPCs to the hospital for further treatment, the patient may be asked to undergo the same medical checkup and initial treatment procedures. This might give rise to duplication of resources expenditure and delay in the proper treatment of the patient.

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22 Elderly Right League (H.K.), submission paper to the meeting of LegCo Panel on Health Services on 6 May 1996.

23 Hansard, 3 April 1996.

24 lbid.

15.20 The Report of the Working Party on Primary Health Care (1990) also highlighted the following deficiencies in the GOPCs[25] :

(a) no clear objectives;
(b) little continuity of care;
(c) very basic and mostly episodic treatment of minor ailments;
(d) inadequate investigation;
(e) inadequate patient education and health counselling;
(f) heavy patient load and very short consultation time;
(g) lack of health information;
(h) low morale among doctors;
(i) inappropriate utilization of nursing resources;
(j) absence of a team approach;
(k) inadequate coordination with specialist clinics and hospitals; and
(l) little intersectoral communication and community participation.

15.21 The Working Party on Primary Health Care then went on to make a number of recommendations to improve the GOPCs services and the development of primary health care. We requested information on the progress of the implementation of the recommendations and the development of primary health care, in particular, with respect to health care for the elderly patients. To date, no reply has been received from the government.

[25] Report of the Working Party on Primary Health Care, *Health For All: The Way Ahead*, 1990 p. 139.

Rehabilitative Care

15.22 In general, elderly patients suffer from either physical or visceral impairment or both. They require rehabilitative services such as occupational therapy and physical therapy, and systems of psycho-social support such as psychological assessment and community psychiatric nursing so as to raise their self-help abilities. For example, knowledge about disabilities and the avoidance of preventable complications such as pressure sore, infections and contracture can reduce the frequency of re-admissions to hospitals, length of hospital stay and unnecessary attendance at outpatient clinics and accident and emergency departments.

15.23 The government policy objectives of rehabilitation are to promote and provide measures to prevent disability and to develop the physical, mental and social capabilities of people with a disability[26] . Provision of rehabilitative services involves a wide range of medical and professional personnel such as doctors, audiologists, chiropodists, psychologists, occupational therapists and nurses, etc. Patients may go to hospitals, clinics or rehabilitation centres run by the HA, government or NGOs to receive treatment.

15.24 We try to estimate the demand for rehabilitative services from the elderly population. First, the physically disabled. Nearly 62% of the physically disabled persons were aged 60 years or above (44 982) and about 20% of the elderly population has some forms of disability (126 260).

15.25 Secondly, the viscerally impaired. The actual number of elderly people with visceral disability is not available from government statistics. Since visceral impairment is usually related to chronic illness, we can use the number of the elderly with chronic illness as proxy (which is about 50% of the elderly population aged 65 years or above). We deduce that quite a significant number of elderly people would need rehabilitative services.

15.26 Table 9 shows that there were 10 674 elderly people staying in hospital at the end of March this year. If we compare the total number of elderly patients with physical and visceral disability, it can be inferred that a majority of these patients are living in the community outside a hospital setting. In this regard, community-based rehabilitation services or outreach services are needed to allow these elderly people to live as independently and normally as possible.

[26] Report of the Working Party on Primary Health Care, *Health For All: The Way Ahead,* 1990 p. 1.

Outreach Medical Service

Community Nursing Service (CNS)

15.27 CNS is provided to patients who no longer require hospital care but have difficulty in attending clinics for follow-up. They need skilled nursing care which aims to prevent them from relapse. A community nursing centre is mainly staffed by nursing staff. Staff composition depends on the patient load of each centre.

15.28 According to the Hospital Authority, CNS helps to reduce pressure on hospital beds and alleviate overcrowding in public hospitals by providing to qualified discharged patients domiciliary nursing care such as health assessment, injections, counselling, etc.

15.29 At present, CNS serve patients who are referred by doctors only. It is noted from Table 15 that since 1992/93, utilization of CNS by patients has been increasing, in particular, CNS offered at geriatric day centres.

Table 15 - Utilization of CNS, 1992/93-1999/2000

CNS	92/93	93/94	94/95	95/96	96/97	97/98*	98/99*	99/2000*
No. of home visits by community nurse	270 685	281 972	298 224	335 299	383 401	*443 700*	*443 700*	*443 700*
% change over previous year	--	+4.2%	+5.8%	+12.4%	+14.3%	*+15.7%*	*0%*	*0%*
Attendance at psychiatric day centres	102 682	98 291	100 869	107 713	109 406	*109 400*	*109 400*	*109 400*
% change over previous year	--	-4.3%	+2.6%	+6.8%	+1.8%	*0%*	*0%*	*0%*
Attendance at geriatric day centres	39 078	44 540	62 653	76 312	91 739	*94 800*	*94 800*	*94 800*
% change over previous year	--	+14.0%	+40.7%	+21.8%	+20.2%	*+3.3%*	*0%*	*0%*

Remark: * estimated figure

Source: Health and Welfare Bureau

15.30 The two major groups of CNS clients were postnatal mothers and the elderly with chronic diseases or physical disability. In 1996, around 55% of the CNS patients were aged 65 years or above and most of them required frequent visits such as daily wash of wounds or regular injections. It is reported[27] that CNS was welcomed by patients and operators of private homes.

Community Geriatric Assessment Teams (CGATs) and Psychogeriatric Teams (PTs)

15.31 There are a total of nine CGATs and eight PTs which provide outreach medical services to the elderly people in residential care institutions. Each CGAT comprises one Senior Medical Officer, one Registered Nurse and one Assistant Social Work Officer, one Physiotherapist, one Occupational Therapist and one Clerk. Each PT comprises three Senior Medical Officers, four Medical Officers, six Registered Nurses, one Clinical Psychologist and one Assistant Social Work Officer. Each CGAT serves about 1 625 patients per annum whereas the PT serves about 4 600 patients per annum. Table 16 and 17 show the number of patients served by CGAT and PT respectively.

Table 16 - No. of Patients Served by CGAT (Service start in 1994/95)

	94/95	95/96	96/97	*97/98 **	*98/99 **	*99/2000 **
No. of teams	5	8	8	*9*	*10*	*10*
No. of patients served	6 500	13 000	13 000	*13 812*	*16 250*	*16 250*

Remark: * estimated figure

Source: Health and Welfare Bureau

Table 17 - No. of Patients Served by PT (Service start in 1993/94)

	93/94	94/95	95/96	96/97	*97/98 **	*98/99 **	*99/2000 **
No. of teams	3	4	6	8	*8*	*9*	*9*
No. of patients served	13 800	18 400	27 600	36 800	*36 800*	*41 400*	*41 400*

Remark: * estimated figure

Source: Health and Welfare Bureau

[27] Interviews with health care services providers.

Effectiveness of Outreach Medical Teams

15.32 According to the Hospital Authority, there was a 10% reduction in unplanned hospital re-admission, accident and emergency attendance and geriatric out-patient attendance in 1995-96 among the elderly people served by the outreach medical teams.

15.33 CNS is provided to patients referred by medical personnel only. CGATs and PTs pay visits to the elderly people living in residential care institutions such as C&A homes or private homes for the elderly. The proportion of the elderly population visited by these teams accounts for less than 10% of the total elderly population. As 78% of the elderly population are elderly singleton or live with only one family member, they might need such outreach medical services once their health deteriorates.

Discussion

15.34 Although the government has set up seven Elderly Health Centres since 1994 to promote primary health care, their utilization has been low, viz. 59% of capacity (mid-1997); at present, 0.65% of the elderly population benefited from this service. The publicity, the annual fee of these centres, the age barrier and the link to the secondary and tertiary services provider (sharing of patient records) might need to be reviewed.

15.35 Only one-third of the elderly patients with chronic diseases make use of the advance appointment system. Improvement to this appointment system may require further consideration in order to increase its utilization by chronic elderly patients and reduce their waiting time.

15.36 The absence of shared medical records between the GOPCs and the Hospital Authority does not affect solely the elderly patients. If the elderly patients are referred by the GOPCs to the hospitals for further treatment, they may have to repeat the same medical check-up and initial treatment procedures. This may affect the elderly patient more seriously and may lead to delay in the proper treatment of patients. Sharing of medical records between HA and DH in the primary, secondary and tertiary care would seem to merit priority consideration.

15.37 The elderly people who stay in residential care institutions (10% of the total elderly population) or patients referred by medical personnel benefit from the outreach medical services provided by CNS, CGATs and PTs. There is a latent demand for these services from the majority of the elderly people who live on their own or with only one family member (78% of the total elderly population).

15.38 The Working Party on Primary Health Care admitted that the development of quality primary medical care has been seriously neglected in the public sector: "*Despite the well acknowledged health needs of the elderly, their heavy demand on the existing hospital and clinic services and the aging of Hong Kong's population, there is no comprehensive preventive health care programme for the elderly*"[28] .

[28] Report of the Working Party on Primary Health Care, *Health For All: The Way Ahead,* 1990 p. 88.

PART 5 - SECONDARY AND TERTIARY HEALTH CARE FOR ELDERLY PEOPLE

16. Introduction

16.1 Secondary health care refers to medical care which is more specialized and complex. Secondary health care patients are normally referred by primary care practitioners. Tertiary health care caters for a small fraction of patients requiring highly complex and specialized care. Both secondary and tertiary health care services are provided in a hospital setting.

16.2 The Hospital Authority provides about 90% of secondary and tertiary care services in Hong Kong. The private sector provides the other 10% of secondary and tertiary care. Extended and long-term care which involves medical rehabilitation is provided almost exclusively by the Hospital Authority.

16.3 Elderly people who seek secondary and tertiary health care services usually go to the hospitals run by the Hospital Authority. In general, medical treatment services in all specialties are accessible to elderly patients depending on their clinical needs. Geriatricians play a key role in co-ordinating the multidisciplinary services for elderly patients, who often suffer from a number of medical conditions requiring curative and rehabilitative treatment.

17. Geriatric Beds of Hospitals

17.1 Table 18 shows the number of geriatric beds in the period 1992/93 - 1997/98. It can be seen that from 1993-94 onwards, there was no change in the provision of psychogeriatric beds whereas there was an increase of 77% in the number of acute geriatric beds provided in the period 1993/94-97/98.

17.2 In the period 1993/94-97/98, the elderly population experienced a growth of 20% (viz. Tables 1 and 2). However, only the provision of the acute geriatric beds has been adjusted to meet the increased demand. According to the Hospital Authority, *"hospitalisation / institutionalisation of psychogeriatric patients should be avoided as far as possible. The major initiative in supporting their care and integration in the comunity is the establishment of psychogeriatric teams*".

Table 18 - No. of Geriatric Beds in Hospital

	1992-93	**1993-94**	**1994-95**	**1995-96**	**1996-97**	**1997-98 (Estimate)**
Psycho geriatric beds	573	598	598	598	598	598
Acute geriatric beds	967	999	1 124	1 310	1 518	1 768

Source: Hospital Authority

18. In-patient Services of Hospitals

18.1 In Hong Kong, elderly patients account for 33% to 43% of the in-patients of hospitals in the years 1991-97. (Please see Table 19 for details.) As the over-65 age group accounted for only 14% of the total population in the years 1991-97, their utilization of in-patient services has been disproportionately higher than the rest of the population. One possible reason is a general deterioration in the health of the elderly population. Another possible reason is the inadequacy of the existing primary health care provider in meeting the demand for preventive care.

Table 19 - Number of In-patients Staying in Hospitals of the HA at Midnight by Age Group Mar 91-Mar 97

Time point	0-64		65+		Unknown age		Total	
	No.	%	No.	%	No.	%	No.	%
27.3.91 *	11 553	65.4	6 120	34.6	-	-	17 673	100
30.9.91 *	12 155	67.1	5 963	32.9	-	-	18 118	100
31.3.92	11 614	63.0	6 834	37.0	-	-	18 448	100
30.9.92	11 876	66.0	6 119	34.0	-	-	17 995	100
31.3.93	11 626	62.5	6 962	37.5	-	-	18 588	100
30.9.93	10 908	64.2	6 035	35.5	55	0.3	16 998	100
30.3.94	11 691	60.8	7 478	38.9	54	0.3	19 223	100
29.9.94	12 113	63.0	7 063	36.8	43	0.2	19 219	100
30.3.95	11 688	59.5	7 923	40.3	48	0.2	19 659	100
28.9.95	12 162	61.5	7 561	38.3	43	0.2	19 766	100
28.3.96	11 741	56.8	8 883	43.0	33	0.2	20 657	100
30.9.96	11 750	59.4	8 006	40.4	37	0.2	19 793	100
26.3.97	11 770	57.3	8 743	42.6	30	0.1	20 543	100

Remark: * total for government and government-assisted hospitals
Source: Hospital Authority

19. Specialist Out-patient Services

19.1 Elderly patients represent about 32% of attendance at specialist out-patient clinics. The waiting time for first appointment varies between clinics and between different specialties. HA has pledged to reduce the average waiting time for first appointment at 90% of specialist clinics to less than three months and that for cataract surgery to less than nine months. Priority appointment will be given to patients with urgent needs as identified by their referring doctors. However, the RLS did not receive data on the actual waiting time for these services.

20. Geriatric Specialist Out-Patient (SOP) and Geriatric Day Hospital Attendance

20.1 Table 20 shows the number of geriatric SOP and geriatric day hospital attendance from 1992/93 to 1996/97. It shows that geriatric SOP attendance had increased by 103% and geriatric day hospital attendance had increased by 135% in these five years. In roughly the same period (1992-1996), the elderly population had increased by 21%. This reflects that there was a large demand for the services and the general health conditions of the elderly had deteriorated.

20.2 If we compare the total capacity with the number of attendance, it is found that each geriatric SOP clinic/ hospital has to serve an increasing number of patients each year. For example, if we use 1992/93 data as a baseline, each geriatric SOP clinic serves 8 688 patients per year. However, in 1997/98, it is expected that each SOP clinic can serve 12 609 patients per year. For geriatric day hospital, each place served about 206 patients in 1992/93. However, in 1997/98, each place is expected to serve 225 patients. This would mean a shorter consultation time per doctor per patient, which could affect the quality of care that the patient receives.

Table 20 - Geriatric SOP Attendance and Geriatric Day Hospital Attendance

Year	Geriatric SOP Attendance		Geriatric Day Hospital Attendance	
	No. of total attendance	Total capacity (No. of clinic / hospital with geriatric SOP attendance)	No. of total attendance	Total capacity (No. of places)
1992/93	60 817	7	39 078	190
1993/94	82 162	7	44 540	240
1994/95	98 480	9	62 653	325
1995/96	111 220	10	76 312	415
1996/97	123 282	11	91 739	415
1997/98 [1]	138 700 [2]	11 [3]	93 400 [2]	415

Remarks:
1. Figures are projected based on April - August 1997 data.
2. Figures are rounded to hundreds.
3. As at August 1997

Source: Hospital Authority

21. Length of Hospital Stay

21.1 According to the Hospital Authority, the average length of hospital stay of patients aged 65 years or above is 21.9 days, which is more than 50% higher than that of general patients.

21.2 There are several possible reasons for the long hospital stay of the elderly patients. First, elderly patients may recover more slowly than younger patients. Secondly, some elderly patients may require assistance from medical social workers, such as arrangement for residential placement, before they are discharged. If the medical social worker is not informed by the doctors of the date when the elderly patient is discharged, there might not be enough time for the social worker to prepare for the proper discharge of the patient. Therefore, some of these elderly patients may remain in hospital longer than expected. Thirdly, some acute beds may be occupied by elderly chronic patients. In normal circumstances, chronic patients should not occupy acute beds except when there is an unexpected deterioration of their health. If these elderly patients had received regular and routine monitoring of their health status through primary health care, the probability of unexpected health deterioration could have been reduced.

22. Pre-Discharge Plan

22.1 The aim of a pre-discharge plan is to identify at an early stage the needs of each patient including placement, social support and rehabilitation services. A lack of proper pre-discharge plan will result in unnecessary hospital re-admissions and affect the quality of life for elderly patients.

22.2 At present, the quality of pre-discharge planning for elderly patients tends to vary with different clinical specialties. The reasons identified in the Report of the Working Group on Care for the Elderly (1994) are as follows: [29]

(a) Only geriatric units are supported by geriatricians who have better knowledge and experience in the needs of elderly patients. However, at present, not all hospitals have geriatric units.

(b) The existing provision of service on a referral basis has resulted in some post-discharge social problems being handled by carers who are not medical social workers and who may not be familiar with the continuity of patient care.

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[29] *Report of the Working Group on Care for the Elderly,* 1994, p. 140.

22.3 According to the Annual Report of the Hospital Authority 1995-1996, only five hospitals had introduced pre-discharge planning for the elderly persons to enhance continuity of care and to co-ordinate post-discharge care by other service providers and carers.

23. Discussion

23.1 The major users of the public secondary and tertiary health care services are elderly people (over 40%). They, as a group, represent a large proportion of attendance at specialist out-patient clinics and in-patients services. The average length of hospital stay of the elderly patients is also longer than that of general patients.

23.2 Since RLS was not able to find adequate information on the utilization of different types of hospital services by elderly patients, it is difficult to analyse whether or not the present secondary and tertiary health care services are able to meet their demand. Nonetheless, the foreseeable increasing demand for geriatric SOP and day hospital service with the relatively slow expansion of service capacity might further prolong the waiting time of elderly patients for the services. Moreover, the lack of pre-discharge plan in some hospitals for elderly patients may affect the quality of health care services delivered to them.

PART 6 - INSTITUTIONAL CARE

24. Introduction

24.1 The increase in the proportion of old-olds (that is, elderly aged 75 years or above) has exacerbated the problems relating to the care of the elderly people. A recent study in the UK shows that 38.8% of those over the age of 80 years required much intensive care. Similarly, it has been estimated that in European countries, the need for nursing care would increase sharply with age; and in the age group of 80 years or above, one in three persons would need daily care[30] . This implies a substantial demand for institutional services for the frail elderly as life expectancy increases.

25. Types of Institutional Care

25.1 This paper discusses the four main types of institutions which provide varying degree of medical and nursing care to the elderly people. They are, namely, infirmaries, nursing homes, care and attention (C&A) homes and private homes for the elderly.

Infirmaries

25.2 Infirmaries are managed by the Hospital Authority. They are provided for patients who no longer require intensive medical treatment, but who are still in need of long-term hospitalization. They enable elderly patients with unstable physical or mental conditions to be cared for in an institutional setting outside an acute hospital environment. As an institution, infirmaries provide the most care.

Nursing Homes

25.3 Nursing homes are set up under the management of Department of Health. They are set up with an aim to provide an intermediary type of service between infirmaries and C&A homes. They are planned to provide a non-hospital-based residential care service for elderly people who can no longer be taken care of at home and who require a certain amount of medical/nursing care.

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[30] Leung, Chan, Lee and Cheng, “Residential Care Policy for Elderly People in Hong Kong” in the Asian Journal of Public Administration, Vol. 15 No. 1 June 1993, p.10.

Care and Attention (C&A) Homes

25.4 C&A homes provide accommodation with general personal care and some nursing care to elderly people who suffer from poor health or physical/mental disabilities. They can be run by NGOs subvented by the Social Welfare Department or they can be privately-run under the Bought Place Scheme[31] . Since the health of residents might deteriorate and might then require infirmary care, some C&A homes establish infirmary units as an interim measure to care for those frail elderly while waiting for medical infirmary beds.

Private Homes for the Elderly

25.5 Different private homes for the elderly provide different degrees of nursing and personal care to their residents. The Residential Care Homes (Elderly Persons) Ordinance mainly governs the physical design, space, operators duties and safety precautions of private homes. The Social Welfare Department is responsible for overseeing the compliance of the Ordinance by private homes. The health status of the residents in the private homes ranges from capable of self-care to bedridden.

Coordination of Different Institutions

25.6 As the health conditions of elderly people may deteriorate with age, elderly people at different points of old age may require different kinds of institutional care. An efficient system of referrals and coordination among different institutional care providers is thus required to ensure that elderly people are able to enjoy a continnum of care.

25.7 It can be seen that different institutions are managed by different agencies such as the Hospital Authority, the Department of Health, the Social Welfare Department, the NGOs and the private sector. At present, there is no effective authority which can act as an overall coordinator of these services providers and command resources to cater for the needs of the elderly. This fragmentation of institutional care services may further increase the burden on the secondary and tertiary care services: the subvented C&A home may be reluctant to take its elderly resident back when he is discharged from hospital because of the deterioration in his health conditions. This elderly may then be forced to remain in hospital longer than is necessary while waiting for transfer to infirmary.

[31] The Bought Place Scheme was implemented in 1989. It aims to provide financial incentives to help private homes for the elderly to raise their service standard and to expand the supply of C&A places.

26. Infirmary Care

26.1 Infirmary service is provided for patients who are in need of long stay and active rehabilitation to maximize their residual abilities, or to patients with terminal illness requiring continuous medical or nursing care. It enables elderly patients with unstable physical or mental conditions to be cared for in an institutional setting outside an acute hospital environment. As at 31 March 1997, there were 1 927 infirmary beds.

26.2 It normally takes at least ten years or more to establish one infirmary. Table 21 shows the number of infirmaries in the period 1991 to 1997. Except in 1995 and 1996 when there were increases of over 20% in the provision of infirmary beds, the growth of infirmary beds in the rest of the period ranged from 7% to 10%.

Table 21 - Number of Infirmaries

Year	No. of infirmary beds	% increase over previous year
1991*	1 065	--
1992	1 166	9.5%
1993	1 128	- 3.3%
1994	1 203	6.7 %
1995	1 472	22.4%
1996	1 772	20.4%
1997	1 927	8.8%

Remark: * data in 1991 was calculated as at the end of December whereas data from 1992 to 1997 were calculated at the end of March of that year.
Source: Hospital Authority

26.3 In 1988, the Medical and Health Department set up a central waiting list for elderly patients who need infirmary care. The list includes referrals from both medical and social welfare sectors. Each elderly patient who would wish to apply for an infirmary bed has to undergo a pre-admission assessment by doctors to ensure proper placement. If the required level of care satisfied the admission criteria of the institutions, the elderly patient would then be placed on the central waiting list.

26.4 Since 1988, the waiting list has increased rapidly from 800 in 1988 to 3 107 in 1992 and then to 6 248 in 1997. Table 22 shows the details.

Table 22 - No. of Applicants on the Infirmary Waiting List, 1998-1992

Year	Applicants	
	Number	% change over previous year
1988	800	--
1989	1 320	+65%
1990	3 000	+127%
1991	n.a.	--
1992	3 017	--
1993	n.a.	--
1994*	6 137	--
1995*	4 199	- 32%
1996*	4 499	+72%
1997*	6 248	+39%

Remarks:
1. n.a. stands for not available
2. * data were from Hospital Authority which were calculated as at the end of March of that year.

Sources:
1. Leung, Chan, Lee and Cheng, "Residential Care Policy for Elderly People in Hong Kong" in the *Asian Journal of Public Administration*, Vol. 15 No.1 June 1993.
2. Hospital Authority

26.5 With the waiting list growing at more than 30% per year, the provision of infirmary beds is inadequate to meet the demand. In 1997, the shortfall is 4 321 infirmary beds (6 248 applicants on the Infirmary Waiting List less 1 927 infirmary beds), implying an almost 70% shortfall in meeting the known demand for infirmary care.

26.6 Due to the shortage of infirmary beds, some elderly patients cannot be referred to receive the necessary infirmary care even after they have been assessed by doctors. Instead, they have to wait for a period of time [32]. Unlike those applicants on the waiting list of public housing who are sometimes arranged to settle in temporary housing, elderly patients waiting for infirmary placement are not given any assistance. They have to wait either at home, in hospitals or at the private homes for the elderly in the interim period. If the health of these patients who stay at home or at private homes for the elderly deteriorates due to lack of infirmary care, very often they would need to go to the hospital for health care service, leading to consumption of the more expensive secondary and tertiary health care services.

26.7 Mr. M B Wong, the Chairman of the H.K. Association of The Private Homes for the Elderly, informed us that about 40% of the private homes residents require infirmary care and a large proportion of them are unable to receive such level of care in the private homes. According to the reply from the Hospital Authority, the number of applicants on the infirmary waiting list who were residing in the private homes for the elderly as at 27 September 1997 was 3 699, which was approximately 20% (3 699 out of a total of 19 169 as in Table 4) of the total number of residents living in the private homes. This implies that when the frail elderly who live in private homes did not receive the required level of infirmary care, they would be sent to hospitals once their health deteriorated, leading to a heavier consumption of the secondary and tertiary health care services.

26.8 It is necessary to meet the need of these frail elderly people urgently. According to the study conducted by Leung and al. (1993), many old people on the waiting list for infirmaries could not wait: "*a high percentage of them was already dead before they could be admitted to institutional care facilities*" [33].

27. Nursing Homes

27.1 The Governor pledged in his "1993 Policy Address" to provide a new nursing home service for the frail elderly. It aims to provide medical and nursing care to the frail elderly who have lost the ability to care for themselves and who need non-hospital-based residential care at an intermediate level between infirmary care and general nursing care. These homes would meet the needs of these elderly people outside a hospital setting. It also aims to relieve the pressure on the infirmaries and to take care of the frail elderly whose health condition has deteriorated to such an extent that C&A homes can no longer provide adequate care.

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[32] The RLS did not receive data on the average waiting time for the admission to infirmaries.

[33] Leung, Chan, Lee and Cheng, "Residential Care Policy for Elderly People in Hong Kong " in the Asian Journal of Public Administration, Vol. 15 No. 1 June 1993.

27.2 The Department of Health is responsible for co-ordinating matters related to the nursing home projects. A Steering Committee on Nursing Homes chaired by the Secretary for Health and Welfare, with representatives from the Finance Branch, Architectural Services Department, Social Welfare Department and Department of Health meet regularly to monitor progress in order to ensure timely achievement of targets.

27.3 According to the 1994/95 Annual Report of the Department of Health, the target was six nursing homes for the elderly with 1 400 beds by 1997. Yet, in the paper presented by the Secretary for Health and Welfare to the meeting of LegCo Panel on Welfare Services on 21 April, 1995, the target was changed to four (two less) nursing homes completed and providing 900 beds (500 beds less) by 1997. To date, none of these six nursing homes are in operation. According to the "1997 Progress Report", the construction works of only one nursing home project was completed. It is understood that there have been difficulties in identifying suitable sites and recruiting qualified staff.

28. Care and Attention (C&A) Homes

28.1 A C&A home is a special kind of residential facility. It provides personal and limited nursing care for the frail elderly. At present, C&A homes offer 7 637 places for the frail elderly

28.2 Although the planning ratio of C&A home has been revised upwards in recent years, there has been a serious shortfall in the provision of C&A homes. The revision of planning ratios is detailed in Table 23.

Table 23 - Planning Ratio of C&A home

Year	Planning Ratio (no. of places per 1 000 elderly population)
1977	4
1985	5
1988	8
1990	11
1994	17

Sources:
1. Leung, Chan, Lee and Cheng, "Residential Care Policy for Elderly People in Hong Kong" in the *Asian Journal of Public Administration*, Vol. 15 No.1 June 1993, pp. 10.
2. Health and Welfare Branch, Information Note for LegCo Panel on Welfare Services Meeting on 21 April, 1995.

Table 24 - Provision of C&A Places 1991/92 - 1997/98

	Provision						
	91/92	**92/93**	**93/94**	**94/95**	**95/96**	**96/97**	**97/98**
Demand based on planning ratio	8 462	8 867	9 243	9 619	9 998	10 365	11 142
Provision							
- subvented NGO	3 149	3 789	5 039	6 045	7 334	7 629	8 011
- Bought places	0	0	500	700	835	1 200	1 200
- Self financing	600	600	600	727	681	787	881
Total	3 749	4 389	6 139	7 472	8 850	9 616	10 092
Shortfall (-) / Surplus (+)	-4 713	-4 478	-3 104	-2 147	-1 148	- 749	-1 050

Remarks:
1. Demand for 92/93, 93/94, 94/95, 95/96, 96/97 is calculated on the basis of population projection 1992-2011.
2. Demand for 97/98 is calculated on the basis of population projection 1998-2016.

Source: Health and Welfare Bureau

28.3 Table 24 shows that there has been a shortfall in the provision of C&A places throughout the 1990's despite the consequent steady increase in the provision of C&A places. In 1997/98, there is a shortfall of 1 050 in the planned supply of C&A places.

28.4 Table 25 shows a significant increase in the number of applicants on the waiting list for C&A homes in the period 1981-1997. This increase is higher than the demand provided for by the increased planning ratio. In 1994/95, the demand based on the planning ratio for C&A places was 9 619 whereas the number of applicants on the waiting list for C&A places in the same year was 12 299, indicating a planning shortfall of 2 680 places, or 22%. In 1997/98, the shortfall has grown to 8 840 C&A places, or an under-provision of 44%.

Table 25 - Waiting List of Applicants for C&A Homes, 1981-1997

Year	No. of Homes	Places Offered	No. of Applicants on the Waiting List
81/82	5	375	704
82/83	6	500	3 575
83/84	8	880	2 414
84/85	9	1 020	3 046
85/86	11	1 099	4 312
86/87	12	1 313	5 386
87/88	13	1 414	7 038
88/89	15	1 618	7 669
89/90	15	1 994	8 769
90/91	26	2 703	8 982
91/92	34	3 749	8 928
92/93 *	n.a.	3 789	--
93/94 *	n.a.	5 039	--
94/95 *	62	6 045	12 299
95/96 *	71	7 334	14 425
96/97 *	72	7 629	17 834
as at Aug. 97 *	72	7 637	19 982

Remark: * data were from Health and Welfare Bureau

Sources:
1. Leung, Chan, Lee and Cheng, "Residential Care Policy for Elderly People in Hong Kong" in the *Asian Journal of Public Administration*, Vol. 15 No.1 June 1993, pp. 11
2. Health and Welfare Bureau

28.5 Table 26 shows the average waiting time of elderly people to be admitted to C&A homes. The elderly people have to wait for an average of two and a half years before they can be admitted to C&A homes. This is assuming that the health status of the elderly remains quite stable; otherwise, the elderly people will need to be transferred and wait for infirmary places.

Table 26 - Average Waiting Time for the Elderly to be Admitted to the C&A Homes

Year	Average waiting time (months)
Mar 95	32.9
Mar 96	33.4
Mar 97	33.2
June 97	30.7

Source: Health and Welfare Bureau

28.6 One factor contributing to a large shortfall and a long waiting list for C&A homes is the time required to set up a new home. C&A homes are supposed to be located in purpose-built buildings and the process of establishing these homes usually takes at least two to three years. It is understood that difficulties were involved in finding suitable sites for the construction. There is therefore always a long list of applicants waiting for admission into the C&A homes.

29. Private Homes for the Elderly

29.1 There were 3 699 elderly people on the infirmary waiting list as at September 1997 and 19 982 elderly people on the C&A homes waiting list at August 1997. This illustrated that the supply of these public sector institutions was not capable of meeting the demand. This high level of unsatisfied demand brings about the mushrooming of privately-run elderly homes.

29.2 Private homes for the elderly are business-oriented. These homes provide residential accommodation for elderly people in private, commercial buildings which are not built for such a purpose. Private homes admit old people with varying degrees of self-care abilities, ranging from ambulant to infirm. However, about 80% of the residents of private homes are reported to be in need of infirmary and C&A homes services[34] .

[34] Interview with Mr. M B Wong, the Chairman of the H.K. Association of the Private Homes for the Elderly.

29.3 It is reported that private homes would send their residents to hospitals whenever they are found to be sick. This is because these private homes do not have the appropriate medical personnel to provide the necessary health treatment to the residents [35]. If the private homes for the elderly are incapable of providing the required health care for their elderly residents, this would mean an unnecessary deterioration in the health of their residents and an increase in the demand for public sector secondary and tertiary health services.

30. Discussion

30.1 Overseas research studies show that the demand for institutional care services for the frail elderly increases as life expectancy increases. In Hong Kong, the supply of these public institutions (infirmaries and C&A homes) cannot meet the demand for them: as at March this year, there were 6 248 elderly waiting for the admission to infirmaries; at Aug. this year, there were 19 982 elderly people waiting for C&A places.

30.2 At present, there is no interim institutional care assistance given to the elderly people who are waiting for admission to infirmaries even though they have been assessed by doctors that they have a genuine need of these care services. The shortfall amounts to 70% of the known demand.

30.3 Nursing homes are set up to relieve the pressure on infirmaries and C&A homes. It was originally planned in 1994/95 to establish six nursing homes with 1 400 beds by 1997. It was later revised in 1995 to supply four nursing homes with 900 beds by 1997. Yet, none of the six homes are in operation to date.

30.4 Elderly patients who require nursing care provided by infirmaries, nursing homes or C&A homes but are not able to receive it at the moment may stay either at private homes for the elderly or in hospitals. Since most private homes are incapable of taking care of infirm elderly, this would increase further the pressure on the secondary and tertiary care services.

[35] Ibid.

PART 7 - OVERALL DISCUSSION

31.1 People in Hong Kong are expected to live longer as medical technology advances. However, health conditions generally deteriorate with age: 50% of the over-65 population suffer from chronic illnesses, 79% of totally blind persons were aged 60 years or above, 62% of physically disabled persons were aged 60 years or above, 9% of the elderly population suffer from mental disabilities. These all constitute demand for health care services. Therefore, the issue of population aging which brings pressure to our health care system needs to be resolved.

31.2 In developing the public health services for the community, the government has put emphasis on the expansion of hospitals and development of acute care services. This has led to an emphasis on the curative rather than the preventive aspect of health care. An inadvertent consequence is the relative under-provision of primary health care.

31.3 This inadequate provision of primary care services leads to a heavy consumption of the secondary and tertiary health care services. The reasons are as follows: primary health care involves preventive, promotive, curative and rehabilitative care. If the elderly can learn through primary health care services of healthy lifestyles and health preventive measures, which will help to maintain their health conditions, the pressure on the secondary and tertiary health care services can thus be relieved.

31.4 Since the expenditure on the provision of secondary and tertiary health care services is much higher than that of the primary care services, the financial burden placed on the community will grow larger in the long run. Details of the analysis will be given in the third in this series of research on the health care system, the Health Care Financing.

31.5 There exists a fairly large spare capacity in the seven Elderly Health Centres (around 41%). With the commitment of setting up an additional five Elderly Health Centres by 1999 to improve the accessibility of the Centres, it might be beneficial to re-consider the publicity, annual fees and age barrier of admission to the Centres.

31.6 There is limited provision of oral health services for the elderly services: services are confined to preventive oral education only. Public oral health services for the elderly seems to be neglected as there are no oral health goals set for the elderly by the Hong Kong government. The government of Hong Kong needs to take measures if it wishes to meet the global oral health standards set by WHO.

31.7 The absence of shared medical records between the HA and DH may affect the effectiveness of integrated health care. It might also give rise to wasting of resources and delay in the proper treatment of patients as the patients may be required to undergo the same medical check-up and initial treatment after they are referred to the hospitals by the GOPCs.

31.8 Outreach medical teams have proved to be effective. There was a reduction in unplanned hospital re-admission, accident and emergency attendance and geriatric out-patient attendance in 1995-96 among the elderly patients served by the outreach medical teams. Since the clientele of these teams only include elderly people living in residential institutions or patients referred by doctors, the majority of the elderly population outside these institutions might also require such outreach medical services once their health deteriorates.

31.9 There are long waiting lists for placement into public infirmaries and C&A homes. Yet, the progress of providing public infirmaries and C&A homes has been slow. The rapid increase in the number of private homes has clearly illustrated the gross under-provision of publicly funded residential nursing care facilities. The inadequate provision of health service in these private homes place a large burden on the public hospitals which provide secondary and tertiary care.

31.10 Health care for the elderly in Hong Kong is a “revolving door phenomenon”. Inadequate primary health care leads to a higher pressure on the secondary and tertiary health care services. People with low awareness of the need to prevent disease or promote health are likely to have their health deteriorated. If the primary health care providers fail to perform the function of “gate-keepers”, this might open the “flood-gates” of hospitals. It imposes further pressure on the secondary and tertiary health care services. After the patients are treated and discharged by hospitals, insufficient rehabilitation services and inadequate institutional care placements will induce unnecessary or more frequent re-admissions to hospitals. In other words, patients are frequently going in and out of the hospitals. The final result is an increase in the demand for our public health care resources.

Appendix I

List of Relevant Government Papers on Health Issues for the Community

Year	Policy Papers
1964	White Paper on Development of Medical Services in Hong Kong
1974	White Paper on the Further Development of Medical and Health Services in Hong Kong
1977 *	Green Paper on Services for the Elderly 1977
1985 *	White Paper on Social Welfare into the 1980s
1985	Consultancy Report on the Delivery of Medical Services in Hospitals
1988 *	Report by the Central Committee on Services for the Elderly
1990	Health for All the Way Ahead - Report of the Working Party on Primary Health Care
1991	Hong Kong 1990 Review of Rehabilitation Programme Plan
1993	Consultation Document on Towards Better Health
1994 *	Report by the Working Groups on Care for the Elderly
1995	White Paper on Rehabilitation "Equal Opportunities and Full Participation - A Better Tomorrow for All"
1996	Hong Kong Review of Rehabilitation Programme Plan (1994/95-1998/99)
1996	Review of the Health Care System

* refers to those government papers which discuss the provision of health care services for the elderly

Appendix II

Elderly Dependency Ratio of Selected Asian Countries, 1985 and 2025

Territory	1985	2025	% change
Japan	151	387	156.3%
Hong Kong	109	332	204.6%
China	81	189	133.3%
Vietnam	81	94	16.1%
Sri Lanka	77	183	1.4%
Singapore	74	297	301.4%
India	73	120	64.4%
Myanmar	67	100	49.3%
Malaysia	65	138	112.3%
Korea	64	168	162.5%
Indonesia	62	133	114.5%
Thailand	61	147	141.0%
Philippines	61	101	65.6%
Iran (Islamic of)	61	90	47.5%
Bangladesh	60	68	13.3%
Mongolia	59	76	28.8%
Bhutan	58	73	25.9%
Nepal	55	80	45.5%
Pakistan	53	76	43.4%
Lao PDR	53	74	39.6%
Afghanistan	48	66	37.5%
East Timor	42	91	116.7%
Cambodia	41	105	156.1%
Asia	**77**	**141**	**83.1%**
World	**99**	**148**	**49.5%**

Remark: Elderly dependency ratio is defined as persons aged 65 years or above per 1 000 persons aged 15-64 years.

Source: United Nations, "World Population Prospects, 1988 (United Nations publications, Sales No. E. 88.XIII.7) and Global Estimates and Projections of Population by Sex and Age: The 1988 Revision (ST/ESA/SER.R/93)" in *The Ageing of Asian Populations*, 1994, p. 16.

Appendix III

A Comparison of Elderly Dependency Ratio between Hong Kong and Selected Territories, 1995

Territories	No. of persons aged 15-64 (‘000) (a)	No. of persons aged 65 years or above (b)	Elderly Dependency Ratio (b / a)
Hong Kong	**4 359.2**	**601 300**	**137.9**
Sweden	5 592.9	1 518 940	271.6
United Kingdom	37 867.7	9 029 990	238.5
France	37 977.6	8 639 169	227.5
Germany	56 053.0	12 401 832	221.3
Finland	3 411.5	720 087	211.1
Switzerland	4 904.6	1 022 684	208.5
United States	171 902.3	33 169 500	193.0
Canada	19 828.6	3 476 634	175.3

Remark: Population figures of the above selected territories (except that of Hong Kong which are actual figures) are estimated figures only.

Sources:
1. Census and Statistics Department, Hong Kong Monthly Digest of Statistics, August 1997.
2. World Health Organization, 1995 World Health Statistics Annual.

References

1. Andreoli, Musser, Reiser (eds), Health Care for the Elderly: Regional Responses to National Policy Issues, The Haworth Press, 1986.

2. *Asia Healthcare Focus*, June 1996.

3. Bender, Lloyd and Cooper, *The Quality of Dying*, Winslow Press, 1990

4. Census and Statistics Department, *1996 Population By-census*.

5. Census and Statistics Department, *Special Topics Report No. VI, No. VII, No. X, No,13*.

6. Chernoff and Lipschitz (eds), *Health Promotion and Disease Prevention in the Elderly*, Raven Press, 1988.

7. Chi and Leung, *An Evaluation Study of the Health Promotion Program for the Elderly in Hong Kong*, Department of Social Work and Social Administration, University of Hong Kong, 1992.

8. Chi, Yip and Yu, *Elderly Suicides in Hong Kong*, Befrienders International, 1997.

9. Chin and Boey*, A Mental Health and Social Support Study of the Old-old in Hong Kong*, Department of Social Work & Social Administration, University of Hong Kong, 1994.

10. Department of Health, *Annual Report 1994/95, 1995/96*.

11. Department of Health, *Information Paper on District Health System Submitted to the LegCo Panel on Health Services*, 1996.

12. Department of Health, *Public Health Report No. 2: Oral Health*, 1995.

13. Department of Social Work & Social Administration of the University of Hong Kong and Community Rehabilitation Network of the Hong Kong Society for Rehabilitation, *Evaluation Report and Study of Quality of Life of Persons with Chronic Illness of Community Rehabilitation Network*, 1996.

14. Graycar (ed), “Age Care - Whose Responsibility” in *SWRC Reports and Proceedings*, 1982.

15. Health and Welfare Branch, *Information Note for LegCo Panel on Welfare Services Meeting on 21 April 1995*.

16. Hong Kong Government, *Report of the Working Group on Care for the Elderly, 1994*.

17. Hong Kong Government, *Services for the Elderly*, 1977.

18. Hong Kong Government, *The Further Development of Medical and Health Services in Hong Kong*. 1974.

19. Hong Kong Legislative Council, *Hansard of 1994-1997.*

20. Hong Kong Legislative Council, *Minutes and Information paper submitted to the Meeting of LegCo Panel on Health Services of 6 May 1996.*

21. Hong Kong Legislative Council, *Minutes and Information papers submitted to the Meeting of LegCo Panel on Health Services of 10 June 1996, 8 July 1996, 7 and 14 October 1996, 13 Jan. 1997.*

22. Hong Kong Legislative Council, *Minutes and Information papers submitted to the Meeting of LegCo Panel on Welfare Services of 26 October 1994, 11 November 1994, 20 Jan. 1995, 19 May 1995, 17 and 24 Feb. 1996, 8 March 1996, 30 October 1996.*

23. Hospital Authority, *Annual Plan 1996-1997, 1997-1998.*

24. Hospital Authority, *Annual Report 1995-1996.*

25. Joint HKCSS/SWD Working Group on Social Service Needs of the Elderly, *Report of the Study on the Social Service Needs of the Elderly in Hong Kong*, 1977.

26. Kwok, *Survey on the Prsent Situations, Attitutes and Problems of Elderly Residents in the Central and Western District*, Working Group on theWelfare of the Elderlies in the District Central and Western District Board, 1990.

27. Lam (ed), *The Health of the Elderly in Hong Kong*, Hong Kong University Press, 1997.

28. Leung, “Medical and Health” in *The Other Hong Kong Report 1993.*

29. Leung, Chan, Lee and Cheng, “Residential Care Policy for Elderly People in Hong Kong”, in the *Asian Journal of Public Administration*, June 1993.

30. Manton, Singer and Suzman (eds), *Forecasting the Health of Elderly Populations,* Springer-Verlag, 1993.

31. Means and Smith, *Community Care: Policy and Practice*, MacMillan Press, 1994.

32. Monk (ed), *Health Care of the Aged: Needs, Policies, and Services*, The Haworth Press, 1990.

33. Musgrove, *Public and Private Roles in Health: Theory and Financing Patterns,* The World Bank, 1996.

34. Ngan, *City Polytechnic of Hong Kong*, 1993.

35. OECD, Health Care Reform: *The Will to Change*, 1996.

36. Ory and Bond (eds), *Aging and Health Care: Social Science and Policy Perspectives*, Routledge, 1989.

37. Provisional Legislative Council of HKSAR, *Minutes and Information papers submitted to the Meeting of LegCo Panel on Welfare Services of 12 Sep. 1997.*

38. Rehabilitation Division of Health and Welfare Branch, *Hong Kong 1990 Review of Rehabilitation Programme Plan*, Hong Kong Government, 1991.

39. Rehabilitation Division of Health and Welfare Branch, *Hong Kong Review of Rehabilitation Programme Plan 1994/95-1998/99*, Hong Kong Government, 1996.

40. Report of the Working Party on Primary Health Care, *Health For All, The Way Ahead*, 1990

41. United Nations, *Economic and Social Implications of Population Aging*, 1988.

42. United Nations, *The Ageing of Asian Populations*, 1992

43. United Nations, *Demographic Yearbook, Special Issues: Population Ageing and the Situation of Elderly Persons,* 1993

44. Wells and Freer (eds), *The Ageing Population: Burden or Challenge?* MacMillan Press, 1988.

45. World Health Organization*, World Health Statistics Annual 1995*

46. 分項收費與醫療融資，香港市民對政府推行「分項收費」意見的研究報告，香港政策透視，一九九五年六月。

47. 老人服務人央委員會報告書，一九八八年九月。

48. 促進健康，諮詢文件，香港政府一九九三。

49. 香港康復計劃方案檢討，(一九九四/九五至一九九八/九九年度)，布政司署衛生福利科康復組，一九九六年六月。

50. 耆英關顧大行動，中環社區老人調查報告書，一九九二年八月。

51. 許早洱，香港醫療服務的經濟分析，香港經濟研究中心。

52. 黃大仙區獨居老人生活調查報告，聖公會教區福利協會。

53. 獨居老人關顧大行動，中環獨居老人生活及政策透視。

54. 舊公共屋村老人醫療服務的選擇向性《 1992年問卷調查 》。