

**Legislative Council Welfare Panel**

**Meeting on 10 May 1999**

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**Community Rehabilitation Network (CRN)**

**PURPOSE**

This paper informs Members of the outcome of the Consultancy Study on Evaluation of the Community Rehabilitation Network (CRN), and the Administration's response to the Consultants' recommendations.

**BACKGROUND**

2. CRN is a community based rehabilitation service to enhance the quality of life of chronically ill patients and their families. CRN organizes a variety of activities, e.g. group activities that emphasize therapeutic support and experience sharing; community activities that promote self-help groups and mobilize volunteers; empowerment activities that enhance coping and self-care abilities; and networking with other community and professional organisations.

3. With a grant from the former Royal Hong Kong Jockey Club, the Hong Kong Society for Rehabilitation started the operation of a Clearing House (information centre) and two regional centres of CRN in 1994 as a two-year pilot project. The Lotteries Fund supported the funding in 1996. Since April 1997, the Social Welfare Department has been providing recurrent funding for the service. At present, there are three CRN centres with one on Hong Kong Island and two in Kowloon (East and West). In 1999-2000, subvention to the CRN service will total \$19 million.

4. In July 1998, the Government commissioned the Department of Community and Family Medicine of the Chinese University of Hong Kong to conduct a study on the existing CRN and to make recommendations on its future development. The review was completed in January 1999.

5. The Department of Health, the Social Welfare Department, the Hospital Authority and the current CRN operator, the Hong Kong Society for Rehabilitation, were then invited to comment on the Report. The Rehabilitation Advisory Committee was similarly consulted in March 1999.

### **MAJOR RECOMMENDATIONS OF THE CONSULTANCY REPORT**

6. Excerpts of the Report (Executive Summary, Chapter 8 - Conclusion and Chapter 9 - Recommendation) are attached. Copies of the full Report are available upon request to the Health and Welfare Bureau. Major findings of the report are summarized below -

#### ***Future Roles of CRN***

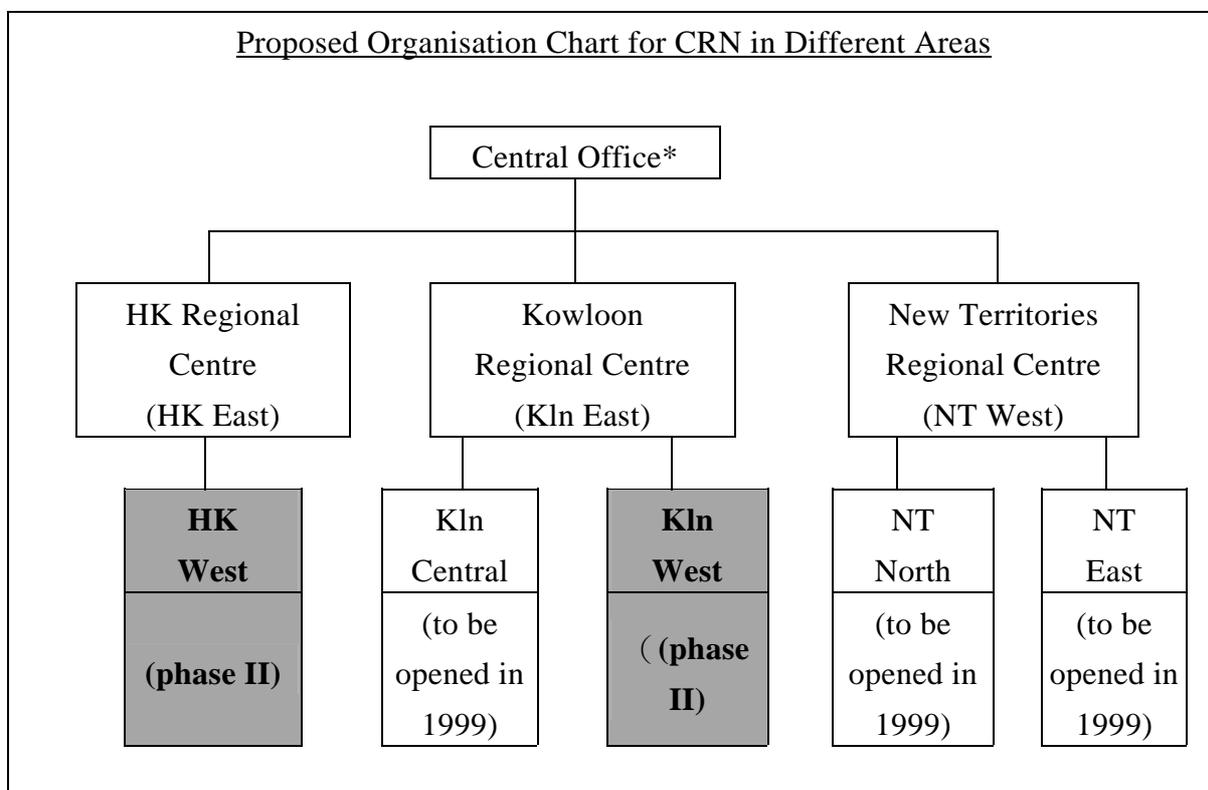
- (a) CRN has been found to be effective in meeting the psycho-social needs of most chronically ill patients;
- (b) the scope of services provided by CRN is too broad. It should concentrate on the psycho-social aspects of rehabilitation and transfer publicity services provided by the Clearing House to other agencies in the community;
- (c) the service delivery should be disease based;

***Interface between CRN and Other Providers***

- (d) duplication of services provided by Hospital Authority and Department of Health is not significant at the macro-level but overlapping does occur at the micro-level;
- (e) CRN has an important role to provide rehabilitation care for patients not treated by the Hospital Authority;

***Organisation and Staffing of CRN***

- (f) there is a need to extend the CRN service to the New Territories;
- (g) an optimal mix of professional social workers and allied health professionals is required to enhance efficiency;
- (h) with a more efficient scheme of staff deployment, a three-tier organisation should be set up as follows:-



\*The Central Office will be located in the Kowloon Regional Centre.

- (i) phase I - convert the Clearing House into a Central Office; relocate a current centre in Kowloon to the New Territories; and set up new stations so as to bring the total to three stations and three centres; and phase II - set up two more stations to bring the total to three centres and five stations. Implementation of second phase, however, will be subject to evaluation of Phase I.

### **THE ADMINISTRATION'S RESPONSE**

7. The Administration recognizes the effectiveness of the CRN service and its pioneering role in community based rehabilitation, and agrees with the general direction of future developments. Within the approved provision for the three existing centres, the Administration is ready to implement the Consultants' recommendations to establish a total of six centres and stations as proposed in Phase I.

8. More specifically, the Administration considers that the CRN service should continue to be disease based rather than centre-based. It should also relinquish its Clearing House operations and concentrate on its strengths such as patient empowerment and mobilization and training of volunteers. CRN should consider extending its service to patients under the care of private doctors and hospitals. As regards interfacing with other services, CRN needs to work more closely with the Patient Resources Centres of the Hospital Authority and the elderly health service of the Department of Health to avoid duplication of service.

## **THE WAY FORWARD**

9. The Government is actively discussing with the current CRN operator on ways to implement the Consultants' recommendations. Subject to the availability of suitable sites and the views of the CRN operator, it is hoped that the relocation of an existing centre from Kowloon to the New Territories can be accomplished in this financial year. Two other stations will be set up as soon as suitable premises are secured. The implementation of Phase II of the Consultants' recommendations will be subject to the outcome of the evaluation of Phase I.

Rehabilitation Division  
Health and Welfare Bureau  
May 1999

**Consultancy Study on  
Evaluation of Community Rehabilitation Network**

**Department of Community and Family Medicine  
The Chinese University of Hong Kong**

## **Executive Summary**

With increasing prevalence of chronic illness, shifting the health care towards community provides one of the greatest potentials for cost-effective health care delivery. Chronically ill patients and their families need a lot of support in the community. Community Rehabilitation Network (CRN) develops an innovative approach in providing community based rehabilitation services by making use of resources for rehabilitation in the community. It aims at enhancing the quality of life of chronically ill patients and their families through provision of psycho-social rehabilitation, promotion of self-help and mutual support, self care and training for the carers, mobilisation of professional and lay volunteers, training of lay volunteers, patient empowerment, and launching of educational as well as community programmes.

Apart from the CRN, the existing Patient Resources Centres (PRC) of the Hospital Authority, Medical Social Workers (MSW) in hospitals and clinics, Department of Health in particular the Elderly Health Services are also providing a variety of support and direct services to patients with chronic illness or visceral disability. In the light of the activities undertaken by various providers in community rehabilitation, the Department of Community and Family Medicine of the Chinese University of Hong Kong was commissioned to conduct a consultancy study to review the existing CRN services and to make recommendation for its future development especially the interfacing strategies with other service providers.

The study began in July 1998 with an intensive phase of data collection from a variety of sources both quantitative and qualitative. The data had been collected from service users, service providers, health administrators, professionals, policy makers, academic, office bearers of the organisation, and politicians. Focus groups, cross sectional surveys, casecontrol study, in depth interview and meeting, review of administrative data and literature review, and participant observation study were conducted to ensure a comprehensive assessment within a limited period of time.

The second phase is data analysis. On the whole, the services provided by CRN have been shown to be effective and meeting the needs of most chronically ill patients. However the scope of services provided are too board which would lead to problems of lack of focus and depth. Therefore the CRN should concentrate on its strong areas of services such as counselling and therapeutic aspects of group activities, networking and liaison, and patients empowerment intervention. For services such as publication and production of audio-visual materials and books, organisation of health exhibitions, and administration of health checks; CRN is not as efficient as other organisations so such services should be transferred with advantage to the Health Info World of Hospital Authority, the Department of Health, and other agencies in the community.

The number of chronically ill patients is very large and it would not be appropriate to estimate the size of chronically ill patient by using hospital in patient statistics alone. The assessment of prevalence of chronic diseases requires large scale population study. Without those data, study on the overall supply and demand of community rehabilitation services will require considerable amount of time, planning and research. For example, based on available local

epidemiological data, the prevalence of asthma is about 10%. Even though if only 10% of asthmatic patients require rehabilitative service i.e. 60,000 patients, currently the 4 PRC only have membership of asthmatic patients about 1,000. As the size of the problem is so large, the number of patients with duplication of services from PRC and CRN become insignificant at macro-level.

However at micro-level, there are areas of duplications, but the duplication of services can be minimised by delineation of roles of PRC and CRN with the former provides services to inpatients during the acute stage of the illness and the latter provides continuing services when the patients are discharged back to the community. The MSW provide support services to the patients and families by individual case work approach, and also perform statutory duties. In the community, the CRN should also actively involve the community based doctors as professional volunteers to provide medical back up support in the community with hospital specialists as second line. The community based doctors should be given supporting services in community rehabilitation in order to perform their roles as gate keepers to secondary care, which would lead to further development of the concept of family medical practice. Moreover, the doctors in the private sector including the private hospitals should be made aware of the existence of CRN services. The CRN should also fill the service gaps for patients not being treated by the Hospital Authority.

The Department of Health involvement in the community rehabilitation services covers two main areas, namely health education and information, and the elderly health services. The former service mainly targets on primary prevention. The elderly health services is being developed and operated based on the concepts of family medicine. However the 18 centres are estimated to have membership of around 40,000 so the CRN can still supplement the

elderly health services in the areas of their expertise such as networking and mobilisation of volunteers.

For effective and efficient way of interfacing, the CRN should initiate to set up a committee at local level inviting all parties involved in providing rehabilitative services, local doctors and allied health professionals, and community leaders to join in. This will enable joint planning in order to avoid duplication of services.

The CRN should also prioritise their services based on the size of the health problems in the community, disease groups that would be managed by primary care providers, severity of the problem in terms of relative financial and social costs, potential for tertiary prevention, and qualitative data collected from focus group and in depth interviews. Based on the above criteria, it is suggested that the following disease groups should be given higher priority:- cardiac, diabetes mellitus, stroke, epilepsy, asthma, chronic obstructive pulmonary disease, Parkinson's disease, Alzheimer disease, stabilised spinal cord and brain injury, and arthritic disease groups. However there is NO suggestion that CRN should abandon their services for other disease groups.

To keep down the escalating health care cost and to extend service coverage of CRN territory wide, a more efficient scheme of staff deployment is proposed. The territory will be divided into eight areas: the HK Island East, HK Island West, Kowloon East, Kowloon Central, Kowloon West, NT East, NT North, and NT West based on the population distribution and geography of Hong Kong. The existing three CRN centres will be restructured and redistributed as regional centres, with one in Hong Kong Island, one in Kowloon, and one in New Territories. In addition, five stations will be set up by phases with ultimate goal of

having one regional centre or station in every area. The function of the regional centres and stations are very similar except the centre will operate on a larger scale and also oversee the operation of the region.

As an immediate step, two stations will be set up in New Territories to meet the widespread need in 1999. One station will be set up in Kowloon in 1999 with a second station will be established at a later date. The services in Hong Kong Island will be augmented by addition of a station in due course. There will be a small central office which accommodates a Senior Social Work Officer or equivalent serving as the General Manager of CRN responsible for overall strategic planning. He or she is administratively supported by an executive officer. There will be a manager (Social Work Officer rank or equivalent) in each regional centre responsible for strategic planning of the region, and also provide services to patients especially in areas requiring substantial experience and expertise.

There will be officers who are Assistant Social Work Officer rank or equivalent responsible as disease group co-ordinators, providing the services on out reaching basis. He or she will be supported by the social welfare assistants and clerks in the regional centres and the stations in different districts. The allied health professional will be centralised for more efficient deployment on a territory-wide basis. The allied health professional should concentrate on group approach rather than individual therapies, and mobilise their fellow professionals in the community as volunteers. The general manager together with the managers will decide the optimal staffing mix of each regional centre and station to meet the local need.

Stations are needed in addition to regional centres because it would have the merit of developing a better collaboration network with district organisations, and develop a sense of

belonging of the clients and district organisations in their respective catchment areas. The combination of three regional centres and five stations aims to strike a balance between the pros and cons of wide and narrow span of organisational structure.

The detail proposed organisation structure of CRN is discussed in Chapter 9. The staffing costs implications for the proposed structure will be-:

In phase I, it will be \$ 18,716,682.6 covering the whole territory (the existing establishment costs \$18,140,989 with 3 CRN centres, one in Hong Kong Island and two in Kowloon). In phase II, the cost will be \$ 21,726,054, but the cost will be \$29,261, 673 if 5 CRN centres are established based on existing structure.

Routine data on unit costing and outcome measurements are not readily available so the consultants would only perform the preliminary cost output analysis. The analysis did show that CRN had a lower cost output ratio than PRC. If CRN mainly mobilised community based doctors rather than hospital specialists as professional volunteers, it will no doubt demonstrate a better value for money in providing community based rehabilitation. In future accounting system should be developed to enable calculation of costing by activities and disease programmes.

Outcomes such as health and functional status should be measured rather than output. Disease specific standards and criteria for rehabilitation should be developed. A detail log diary should be kept by the staff for measuring of performance.

Future budget allocation for CRN should be a lump sum budget or one line budget to allow greater flexibility in resource allocation. This will enable the organisation to decide the optimal staff mix to enhance cost effectiveness and efficiency.

## **Chapter 8**

### **Conclusion**

1. It is not only imperative to help the chronically ill patients to live in the community amidst escalating health care cost but psycho-social rehabilitation is also consistent with the modern trend of rehabilitation. The CRN's approach of fostering self care and patient empowerment, supporting the family members and carers, mobilising volunteers (both lay and professionals), training peer counsellors, networking with other rehabilitative service providers and promoting the formation and management of mutual help groups, is designed with the aim of enabling such patients to achieve community-based rehabilitation. Based on data collected from patients, service providers, health care professionals and policy makers, we are inclined to conclude that the concepts of CRN should be endorsed in the face of increasing prevalence of chronic diseases. The CRN services are effective, and that the role of CRN in pioneering community-based rehabilitation should be recognised.
2. There are no large scale studies in assessing on the need of rehabilitation in Hong Kong, but based on existing limited data, there is a high incidence of chronic diseases. With this magnitude of need against limited resources for community-based rehabilitation, the problems of service duplication are mostly apparent although CRN services might sometimes overlap with services provided by other institutions such as PRC of the hospitals.

3. If roles of CRN and PRC are clearly defined, with the former, in principle, providing support to patients in the community after being discharged from hospitals, and the latter providing support to in-patients during the acute diagnostic phase and early treatment stage; the problem of duplication of services will be unlikely. Instead, this interfacing model between PRCs and CRN will render these two institutions complimentary to one another and will ensure a smooth sequential integration of services from treatment phase to rehabilitation phase for the patients.
4. The collaboration between CRN and PRC varies widely among hospitals, subject to the commitment of the individual Hospital Chief Executive to community-based rehabilitation, resources available and other factors. Any initiative short of a central policy from HA cannot bring about much improvement to the interfacing between the two institutions. More joint planning and collaboration between hospitals and NGOs in rehabilitation is urgently needed.
5. The CRN should also put more emphasis in bridging the service gaps of chronically ill patients who are not treated by the Hospital Authority.
6. The Central Health Education Unit in the Department of Health mainly focus on primary prevention. Although the three main components of the Elderly Health Services developed by the Department of Health are health education, counselling and treatment, the 18 centres by the year of 2000 will only have membership of around 40,000 so the degree of duplication with CRN is not significant within next few years. However with the further development of the Elderly Health Services, the services of CRN will need to be re-orientated. The Elderly Health Services should become the major provider for

medical and health services including education and counselling. The CRN should play their roles in networking, providing psycho-social support to patients, promote self help, and mobilisation and training of volunteers. The CRN might need to re-orientate their services towards younger age groups.

7. The family physicians/general practitioners should be more actively involved by the CRN in community rehabilitation as they can act as good gatekeepers to the hospitals with the supporting services provided by NGOs, and the concept of family medical practice can be further developed. Also they can provide front line medical back up to CRN in the community where the services are delivered with the specialists providing second line back up.
8. The objectives of CRN are too wide and broad, and so the staff tended to perform a large variety of roles. This would lead to problems of lack of focus in regard to activities and proliferation of programmes of a peripheral nature, thus frittering away staff energy and resources.
9. As the strong areas of CRN are networking and co-ordination of services, mobilisation of volunteers, promotion of self help and patient empowerment, support of mutual help groups, training of volunteers and liaison with different types of personnel; the preponderance of social workers in the staff establishment are suitable. However a more structured supporting system is needed to minimise the professional social workers from being engaged in less professional types of work.

10. Health professionals in CRN such as nurses, occupational therapists and physiotherapists are not optimally deployed. They should concentrate on group approach, and mobilise their fellow professionals in the community as professional volunteers. Perhaps a different way of utilising their professional expertise may be considered. To centralise them for deployment to meet CRN's territory-wide service need is one option.
11. The empowerment strategy is a unique contribution of CRN. Hence, CRN should optimise the effort of its staff on group activities and activities supporting the family members, training and mobilisation of volunteers, and promotion of self care and self esteem rather than on organising exhibitions, health talks and health checks.
12. The services of CRN should be prioritised in alignment with the need of primary health care providers and epidemiology, i.e., diseases with complications that are highly preventable with structured rehabilitation programmes. Therefore CRN should put stronger emphasis on disease groups such as cardiac, diabetes mellitus, stroke, epilepsy, asthma, COPD, Parkinson's disease, Alzheimer disease, stabilised spinal cord and brain injury, arthritic disease group. The CRN should try relinquishing patients to other organisations which are in a better position to provide the services, e.g., Cancer Link. Therefore CRN can take on new diseases groups which are also in urgent need of community rehabilitation with reference to the criteria recommended earlier on. This will enable CRN to establish the role of pioneer in community based rehabilitation.

13. The function of the clearing house needs to be re-examined with establishment of HA Health Info-World, dropping of utilisation statistics and members' low level of awareness of the services provided by clearing house.
14. To promote an easy and unrestrained access to community-based rehabilitation services by patients in the New Territories is not only of clinical necessity but also in line with the emphasis of WHO of providing equity of access for patients to services. If resources are limited, the expanded services can be first restricted to some of those disease groups described in the preceding paragraph 12 with greatest need in the region.
15. The CRN should continue to operate on the existing model based on disease groups rather than as centre-based. This model should also apply when the services are expanded to New Territories. CRN must outreach to its clientele. This outreaching style of operation makes possible a more flexible and efficient deployment of staff to respond to needs far away from the centre and an economy on capital and overhead spending.
16. As CRN is an innovative service and is the first organisation set up in providing community-based rehabilitation services in Hong Kong, the results of this study on unit costing can only serve a benchmark providing a baseline for future monitoring and comparison.
17. The performance indicators are mainly outputs orientated rather than outcomes orientated. The outcome indicators should include health and function status, and quality of life.

18. The dividing line between health and social care for rehabilitation is not clear-cut and advisable; they are so intertwining that the cause-effect relationship between them becomes inseparable. Thus, it serves no useful purpose to force an artificial definition as to whether CRN should be social or health care services. Rather, it is in the interest of all the general public and the chronically ill, if effort and attention in this study is directed to raise the efficiency and cost-effectiveness of the community-based rehabilitation services, to weed out conditions creating overlapping and proliferation of services and to improve interfacing and networking among agencies dedicated to the same goal of community rehabilitation. It is befitting to accept in this context that rehabilitation and health contains physical and psycho-social elements.

## **Chapter 9**

### **Recommendations**

#### **Proposed Organisation and Functions of CRN**

##### **Future Roles of CRN**

###### *Scope of services:*

Data collected from variety of services demonstrate that there is a strong need for community based rehabilitation to maintain patients living in their natural environment, hence saving the costs of hospital beds. The role of CRN in pioneering community-based rehabilitation should be recognised. The CRN should strengthen their roles in providing psycho-social support, networking, patient empowerment, mobilisation and training of volunteers, and facilitate the formation of self help groups. However CRN should relinquish services provided by the clearing house, and also the health check up services and organisation of health exhibitions. Otherwise the wide scope of services provided by CRN will lead to problem of lacking focus and depth.

###### *Prioritisation of services:*

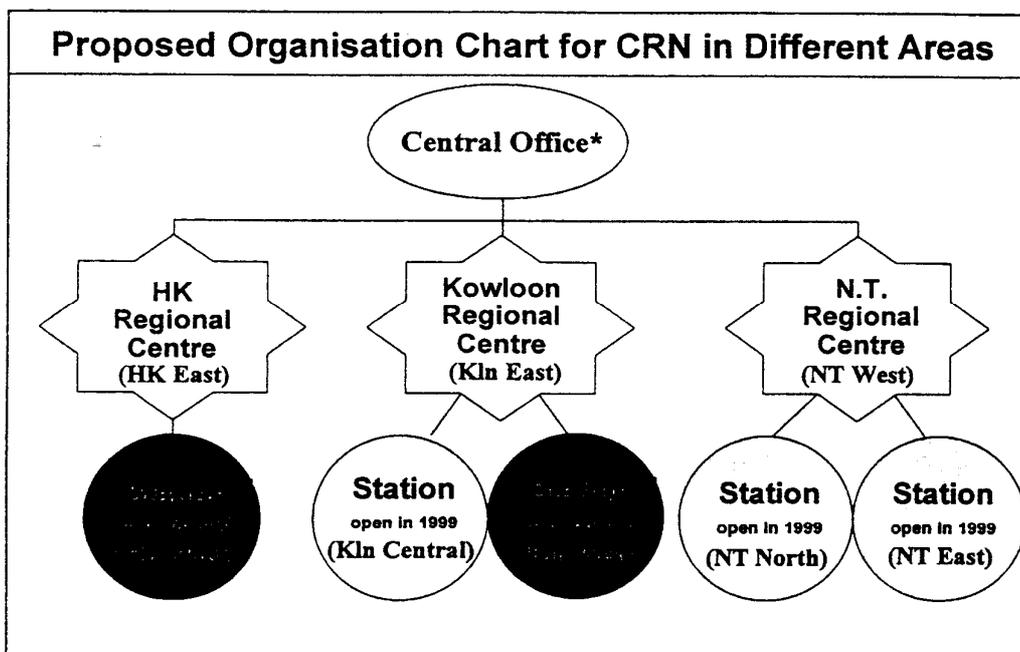
The services of CRN should be prioritised for efficient utilisation of resources as discussed in Chapter 5. If any other organisations or self help groups become mature enough to provide the services for particular disease groups, CRN should facilitate their development to become independent bodies in serving those patients. This will allow CRN more room for future development in coping with increasing need. There is every advantage for those independently operated self help groups to continue their independent operations.

## Organisation Structure and Staffing Level

### *Organisation:*

To keep down the escalating health care cost and to extend services coverage territory-wide, a more efficient scheme of staff development is proposed.

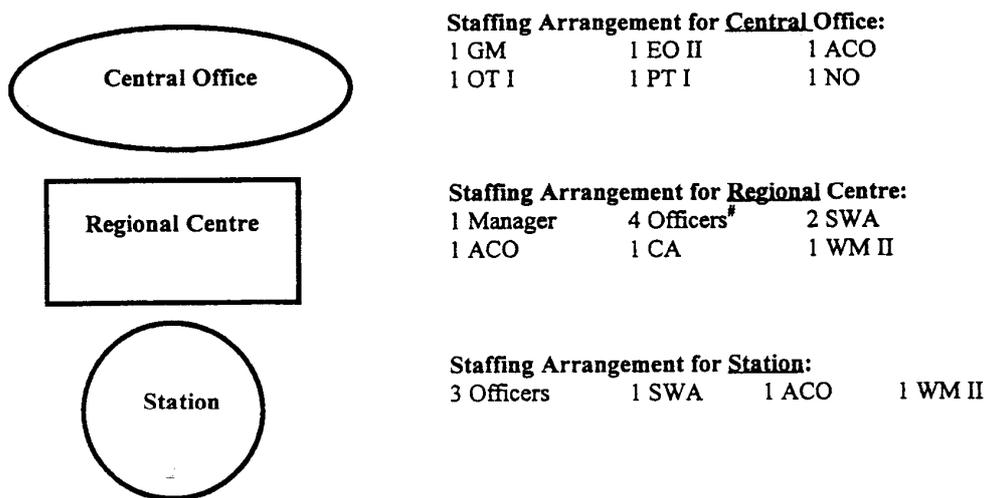
Figure 9.1 shows the new organisation structure. On the top level of the organisation, a small central office will be set up for territory wide strategic planning and co-ordination. It will accommodate a General Manager who can be a Senior Social Work Officer (SSWO) or equivalent in rank, and administratively supported by an Executive Officer.



**Figure 9.1. Proposed Organisation Chart for CRN**

\* The Central Office will be located in the Kowloon Regional Centre.

The staff are required to do more out-reaching with the aim of bringing cost-effective services to a wider area. The number of different types of staff in each regional centre and station are shown in Figure 9.2. The decision of deploying which types of professional officers in co-ordination of different disease groups will be determined by the general manager and the managers.



GM = General Manager    RM = Regional Manager    EO II = Executive Officer II  
 PT I = Physiotherapist I    OT I = Occupational Therapist I    NO = Nursing Officer  
 ACO = Assistant Clerical Officer    CA = Clerical Assistant    WM = Workman II

<sup>#</sup> In phase II, 3 officers will be needed instead of 4 for each regional centres as more stations are being set up.

**Figure 9.2. Proposed Staff Provision in Phase I**

The allied health professionals will be deployed to serve the whole territory by out-reaching as they should focus on group approach and mobilise their fellow professionals as volunteers. A team of allied health professionals will be centralised and the assignment of their duties will be determined by the general manager. Allied health professionals would also be deployed to serve as managers or officers.

For the district organisation, it is proposed to divide the whole territory into eight areas namely the Hong Kong Island East, Hong Kong Island West, Kowloon East, Kowloon Central, Kowloon West, New Territory West, New Territories North, New Territory East based on the population distribution and geography of Hong Kong (Table 9.1). The existing three CRN centres are going to be restructured and re-distributed as regional centres, with one in Hong Kong Island (HK East), one in Kowloon (Kln East), and one in New Territories (NT West). The five stations will be set up by phases. The ultimate goal is to have either a regional centre or station in every area. The function of regional centre and station is very similar in terms of service provision except the regional centre operates on a larger scale, and also oversee the operation of the region.

***Staffing:***

Each Regional centre will be headed by a Manager of Social Work Officer (SWO) rank or equivalent responsible for strategic planning and co-ordination of services in the region, and supervision and training of the staff in the region. The manager will also help out in service provision for certain disease groups although the disease group co-ordinators will be the officers of Assistant Social Work Officer (ASWO) rank or equivalent professionals, responsible for co-ordination of his or her disease group by outreaching on territory wide basis. For disease groups of large number of patients with widespread need, the manager will also help especially in areas requiring substantial experience and expertise. The officers will be supported by Social Work Assistants and clerks in the regional centres/stations in different areas. The optimal mix of professional social workers or allied health professionals, social work assistants and clerks will need to be designed in order to bring cost down but without prejudice against quality of services.

**Table 9.1. Distribution of Public Hospitals and Institutions in Hong Kong with the corresponding discharges per year.**

	Population	Areas	No. of Hosps	Name of Hospitals	No. of Hosp Beds	Discharge per year
HK Island	1312637	HKW	8	Queen Mary Hospital, Tsan Yuk Hospital, Tung Wah Hospital, Fung Yiu King Hospital, Duchess of Kent Children's Hospital, MacLehose Medical Rehabilitation Centre, Grantham Hospital, Nam Long Hospital	3658	133438
		HKE	7	Pamela Youde Nethersole Eastern Hospital, Ruttonjee Hospital, Tang Shiu Kin Hospital, Tung Wah Eastern Hospital, St. John Hospital, Cheshire Home (Chung Hom Kok), Wong Chuk Hang Hospital	3033	104817
<b>Total in HK Island:</b>		<b>2</b>	<b>15</b>		<b>6691</b>	<b>238255</b>
Kowloon	1987996	KlnC	3	Queen Elizabeth Hospital, Hong Kong Buddhist Hospital, Kowloon Hospital	3078	141697
		KlnW	3	Kwong Wah Hospital, Our Lady of Maryknoll Hospital, Wong Tai Sin Hospital	2542	83241
		KlnE	4	United Christian Hospital, Haven of Hope Hospital, Margaret Trench Medical Rehabilitation Centre, Hong Kong Eye Hospital	1394	70368
<b>Total in Kowloon:</b>		<b>3</b>	<b>10</b>		<b>7014</b>	<b>295306</b>
New Territories	2906733	NTW	5	Princess Margaret Hospital, Kwai Chung Hospital, Caritas Medical Centre, Lai Chi Kok Hospital, Yan Chai Hospital	5177	192407
		NTE	6	Prince of Wales Hospital, Shatin Hospital, Cheshire Home (Shatin), Bradbury Hospice, Alice Ho Miu Ling Nethersole Hospital, Tai Po Hospital	3497	115531
		NTN	6	Tuen Mun Hospital, Pok Oi Hospital, Fanling Hospital, Castle Peak Hospital, Siu Lam Hospital, North District Hospital	4621	108665
<b>Total in New Territories:</b>		<b>3</b>	<b>17</b>		<b>13295</b>	<b>416603</b>

Social work assistants are suitable types of social workers to assist the officers in performing more routine types of work. As the proposed thrust of work of the CRN will emphasise on the therapeutic aspects of counselling, networking and liaison with other NGOs and family physicians, expanding territory wide service, and other activities requiring initiative and creativity, a lower grade of social workers such as welfare workers are not competent enough to handle the tasks, and will affect the quality of the service. Such work demands more training and skills.

The staffing provision of present setting, phase I and phase II is shown in Table 9.2.

**Table 9.2. Staffing Provision in Present Setting, Phase I and Phase II**

<b>Existing establishment (3 CRN Centres)</b>	<b>Phase I (3 regional centres and 3 stations)</b>	<b>Phase II (3 regional centres and 5 stations)</b>
0.6 SSWO	0.6GM <sup>1</sup>	1 GM <sup>1</sup>
0.6 EO II	0.6 EO II	1 EO II
3 SWO	3 Managers <sup>2</sup>	3 Managers <sup>2</sup>
19 ASWO	21 Officers <sup>3</sup>	24 Officers <sup>3</sup>
0 SWA	9SWA	11 SWA
3 PTI	1 PTI	1 PTI
3 OTI	1 OTI	1 OTI
4 RN	1 NO	1 NO
1 CLO II	0 CLO II	0 CLO II
4 CO II	7 ACO <sup>4</sup>	9 ACO <sup>4</sup>
4 CA	3 CA	3 CA
3 TP	0 TP	0 TP
3 WM II	6 WM II	8 WM II
<b>Total: 48.2</b>	<b>53.2</b>	<b>63.0</b>

<sup>1</sup> 1 GM=1 SSWO or equivalent

<sup>2</sup> 1 Manager=1 SWO or equivalent

<sup>3</sup> 1 Officer=1 ASWO or PT or OT or RN or equivalent allied health professional

<sup>4</sup> 1 ACO=1 CO II or equivalent

### ***Schedule of accommodation:***

Although the officers as disease group co-ordinators with the support of social work assistants and clerks will provide services on out-reaching basis, they still need office space for administrative work, planning and co-ordinating. The general manager and managers will work out how they should be stationed. Apart from regional centres, there is a need for stations to cover a widespread need. A station is needed to organise and co-ordinate activities to the catchment area, although many activities can be held in the regional centres and other community facilities by borrowing or renting from community halls, schools or hospitals (including private hospitals which are not receiving any support service).

With establishment of stations, patients can easily identify the services in their own catchment area similar to the Community Nursing Services having an office in the district. This would help to develop a sense of belongings of the clients and district organisations in the respective catchment areas. This would also have the merit of developing a better collaborating network with district organisations involved in community based rehabilitation.

There are pros and cons in deciding whether the accommodation should be based on 3 regional centres only or having sub-centres in every district of the eighteen District Boards. The former arrangement saves administrative cost, but too wide span control would lead to problem of management hence affect the quality of the service. The latter option will enable better monitoring of quality at local level, but increases administrative cost. The proposed 3 regional centres and 5 stations attempts to strike a balance, and can be reviewed in future.

## **Phase of Development**

As an immediate step, one regional centre and two stations will be established in 1999 in New Territories to serve the population of 2.9 million, 17 hospitals with 13,295 beds and 416,603 discharges per year (Table 9.1). In Kowloon, the previous Kowloon East centre will be converted to become the regional centre. With closing down of the Clearing House, the space can be utilised to become the central office. The existing Kowloon West centre will become a station. A second station will be established at a later date as the existing population of Kowloon is nearly 2 million with 10 hospitals of 7,104 beds with 295,306 discharges per year (Table 9.1). The population in Kowloon will expand with new development in Tseung Kwan O and Kowloon West re-claimed areas so a second station is needed in near future.

In Hong Kong Island, the existing centre will become the regional centre. The services will be augmented by the additional of a station in due course to serve a population of 1.3 million and 15 hospitals of 6,691 beds with 238,255 discharges per year.

### ***Cost implication for proposed staffing provision***

Table 9.3 gives an analysis of manpower costs of existing CRN establishment, the development in phase I and II. During phase I development, the cost of manpower is \$18,716,683 which is only 3% increase from the existing budget, but enable the services to be extended territory wide with good coverage in New Territories. For phase II development the budget will be \$21,726,054 which is much less than \$29,261,673 if the CRN develops to have 5 centres based on existing structure. Before the service expands to phase II, it is recommended that full evaluation in terms of cost effectiveness and cost benefit analysis should be conducted based on the performance indicators recommended in chapter 7.

**Table 9.3. Cost Implications for Proposed Staffing Provision**

<b>Rank</b>	<b>Mid-point Salary 98 + 5% PF(\$)</b>	<b>3 CRN Centres</b>	<b>Rank</b>	<b>Mid-point Salary 98 + 5% PF(\$)</b>	<b>Phase I</b>	<b>Phase II</b>
SSWO	860,706	0.6	GM	860,706	0.6	1
EO II	353,745	0.6	EO II	353,745	0.6	1
SWO	693,000	3	Manager	693,000	3	3
ASWO	444,591	19	Officer	444,591	21	24
SWA	278,145	0	SWA	278,145	9	11
PTI	510,300	3	PTI	510,300	1	1
OTI	510,300	3	OTI	510,300	1	1
RN	321,678	4	NO	510,300	1	1
CLO II	353,745	1	CLO II	353,745	0	0
CO II	191,016	4	ACO	191,016	7	9
CA	148,932	4	CA	148,932	3	3
TP	148,932	3	TP	148,932	0	0
WM II	125,748	3	WM II	125,748	6	8
<b>Total Cost(\$):</b>		<b>18,140,989</b>			<b>18,716,682.6</b>	<b>21,726,054</b>

\*The cost implications for the staffing arrangement for 5 CRN centres will be \$29,261,673.

### ***Interfacing strategies***

There should be a closer interaction and collaboration in various committees and working parties of different institutions and organisations involved in community rehabilitation. Effective and efficient interfacing can only be possible if all parties concerned know the detail working plan of each party. The CRN should initiate the formation of a “Community Rehabilitation” committee at district level, and invite all interested parties involved in community rehabilitation to join in such as representative from the local hospitals (both public and private), community physician or representative from Department of Health, district social welfare officer, local doctors and allied health professionals, the self help groups, community leaders and any other district organisations or local concern groups.

This multidisciplinary and multi-sectoral approach provides closer interaction of different parties which will facilitate joint planning, and maximise the strength and supplement the weakness of particular institutions or organisation or professionals. This would also bring a closer interaction and collaboration between the general practitioners/family physicians and the organisations involved in community rehabilitation. Thus the general practitioners/family physicians will play a greater role in management of chronic disease to make community rehabilitation a greater success.

With closing down of clearing house, CRN must be given a speedy, unstrained access to information provided by the Department of Health and the Hospital Authority. The Hospital Authority should lay down a well defined central policy for the development of PRCs in hospitals.

The Social Welfare Department has already clearly defined the duties of medical social workers in terms of providing individual casework services to patients and their families. The PRC and CRN should be aware of this to avoid duplication of efforts. Also the Social Welfare Department and other NGOs are providing some home help service and carers supporting services, so CRN should make referral to those organisations rather than providing the services themselves. That is why there is every advantage in setting up a local committee as described in previous paragraph to avoid duplications and achieve better interfacing.

This local committee will also facilitate effective interfacing between the elderly health services of the Department of Health and CRN, and also other providers of community rehabilitative services for the elderly at district level.

## **Monitoring system**

1. Disease specific standards and criteria should be developed so action plan can be drawn up.
2. Outcomes and benefits rather than just outputs should be measured as performance indicators as discussed in Chapter 7.
3. The accounting system needs to be developed so costing by activities and disease programmes can be developed.
4. In future, there should be attempt to measure the indirect cost apart from direct cost.
5. It will also be useful for planning and monitoring if health care need of chronically ill patients can be comprehensively assessed.
6. A structured programme for continuing education and in service training for CRN workers or other workers involved in community rehabilitation should be organised. Please refer to Appendix 13 for detail.

Appropriate performance indicators and database for tabulating the different types of cost should be established in due course. Therefore a full cost effectiveness and cost benefit analysis can be conducted in near future before the services move towards phase II development.

It is recommended that the budget allocation to CRN should be a lump sum budget or one line budget. This will give the organisation a greater flexibility in deploying the optimal mix of staff and utilisation of resources according to need with greatest efficiency. With the development of appropriate database and performance indicators, the cost effectiveness and efficiency can be analysed and evaluated.

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