

**Legislative Council Panel on Welfare Services**  
**Meeting on 14 September 1998**

**Consultancy Study on Needs of Elderly in Hong Kong  
for Community Support and Residential Care Services**

**PURPOSE**

To present to members the findings and recommendations of the consultancy study on needs of the elderly for community support and residential care services conducted by Deloitte and Touche Consulting Group.

**BACKGROUND**

**Objectives**

2. The Working Group on Care for the Elderly appointed in 1993 to review elderly services recommended, inter alia, that a comprehensive study should be conducted to assess the needs of elderly people for residential care and community support services” so that future planning of elderly services can be formulated on the basis of needs.

3. In accordance with the Working Group’s recommendations, Deloitte and Touche Consulting Group was commissioned in May 1996 to conduct a study on the needs of the elderly for residential care and community support services. The objectives of the study are :

- (a) to assess the needs of the elderly people in Hong Kong for residential care and community support services;
- (b) to propose whether and how current services should be modified or replaced by new services to meet the needs of the elderly; and
- (c) to propose ways in which the services identified could be provided in a cost-effective manner by Government, the subvented and private sectors.

4. The study is now complete. Enclosed at Annex A is a copy of the Executive Summary of the consultancy report for members' reference. Copies of the full report are deposited in the LegCo library.

### **Methodology**

5. The consultancy study conducted two surveys, one on elderly living in the community and the other on elderly in residential care institutions, followed by a series of focus group discussions. These studies aimed to obtain an understanding on elderly people's needs for residential care and community support services. The Community Survey covered over 2,000 elderly people aged 60 or above living in the community. The Residential Care Survey covered 120 residential care homes with a total of more than 8 000 residents. The Focus Group Discussions were held amongst selected groups of the soon-to-be old, i.e. those aged 50-59, to find out their expectations for care services when they grow old.

6. Two main factors were employed by the consultant to determine an elderly person's need for formal care, namely the levels of physical or cognitive impairment and the availability of informal carers. An elderly person's levels of physical impairments are measured on the basis of his ability to perform activities of daily living (ADL)<sup>1</sup>. A test, known as the Short Portable Mental Status Questionnaire, was used to determine the levels of cognitive impairment of the elderly.

## **MAJOR FINDINGS**

### **Health conditions**

7. The physical health of our elderly population is relatively good, with about 4 % of those living in the community requiring assistance with more than one ADL. However, 25% are found to have some degree of cognitive impairment, with 5% with moderate or severe impairment. The proportion of demented elderly aged 60 or more in Hong Kong is estimated at 5%. Almost 22% of the respondents achieved scores which implied a psychological state of "probable depression". This figure should, however, be treated with caution as a diagnosis of depression could only be made through a full clinical evaluation of an individual.

---

<sup>1</sup> The elderly's level of physical impairment is measured on the basis of his/her ability to perform six basic Activities of Daily Living (ADL), including bathing, toileting, transferring between bed and chair, mobility, eating and dressing.

8. 76% of the residents of care and attention (C&A) homes have varying degrees of impairment, with 23% carry some form of mental impairment. 82% of the residents of subvented homes for the aged are impairment free<sup>2</sup>. In comparison, residents of private homes have the worst health conditions, with over 50% having severe impairments<sup>3</sup>.

### **Preferences for Family Support**

9. The elderly people of Hong Kong enjoy strong family support, with 91% of them living with a spouse or other family members. About 9% reported that they were living alone, but many of them are helped by family members in activities such as shopping and household chores.

10. Most elderly people (76%) prefer to continue to live at home even if their health deteriorates. Only 19% prefer residential care. The majority of the caregivers (66%) also prefer to care for their elderly family members at home; only 20% prefer institutional care. Two-thirds of the latter group change their attitude when home assistance is available.

### **The Caregivers**

11. 94% of the primary caregivers surveyed are family members of the elderly. Amongst them, 36% are spouses, 39% are children and 14% are daughters-in-law. One-half of the primary caregivers receive assistance from other family members for caring the elderly. About one-third of the caregivers are in full time employment. A similar figure reported that they felt some or much stress in the two weeks prior to the interview. 62% of the caregivers are not in employment, and more than one-third of them consider themselves in need of financial support in caring for the elderly.

### **Financial disposition and ability to pay**

12. About half of the elderly people living in the community rely on their children's support as the main source of income, about one-fifth rely on CSSA or OAA, 15% are earning a salary, and less than 10% are of independent means even after retirement. 23% of those living in the community reported that they did not have

---

<sup>2</sup> Homes for the aged are originally designed to cater for the housing and social needs of the elderly people, as opposed to their care needs. Therefore a high proportion of impairment free residents should be expected.

<sup>3</sup> For comparison, 22% of residents of subvented C&A homes have severe impairments.

enough money to cover daily expenses. Only one-third of the respondents indicated a willingness to pay for care services when they need them. It is noted that the majority of residents of either subvented or private care homes (more than 70%) are receiving CSSA.

### **Need for assistance for elderly living in the community**

13. 41% of the elderly living in the community do not believe that they have any particular need for care services. 23% considered financial support to be most useful, followed by housing (14%). Only a very small number have expressed a need for care services.

14. Of the 531 elderly people found to have some impairments in the community survey, only 10% reported that they were using some type of formal care service. On the other hand, the majority of those using various types of non-residential care services, with the exception of grooming and bathing, do not have any impairment.

15. The above suggests that only a portion of those genuinely in need of care service are coming forward to demand for the service. However, as found out in the focus group discussions, there is a growing expectation in the soon-to-be old that they are entitled to services provided by Government because of the contributions they have made to Hong Kong's development. This group of soon-to-be old would be more aware of public services available as they are better educated.

## **CONSULTANTS' RECOMMENDATIONS**

16. The consultant's major recommendations comprise the following aspects:

### **(a) Ageing in place and role of the family**

17. The findings of the community survey provide monumental evidence that the majority of the elderly and their carers prefer to remain at home for as long as possible and that the family is the predominant provider for the elderly in meeting their various needs. The consultancy study reaffirms Government's policy of "Ageing in Place" and recommends that the Government should improve community support services to render assistance to families caring for elderly members at home. Informal care should be the mainstay of care to the elderly people and the traditional Chinese values of respect and care for the elderly should be promoted.

**(b) Continuum of care**

18. The consultancy study confirms the merit of the continuum of care concept in the provision of services for the elderly. Applying this concept to residential care and community support services, the consultants recommend :

- removing the distinction between nursing homes and care and attention homes;
- increasing the availability of medical and health professional support in the community and in the residential care sector;
- targeting infirmary services on elderly people in need of rehabilitation;
- increasing the provision of site-based and domiciliary rehabilitation services; and
- increasing the provision of weekend, holiday and after hour services for day services like day care centres.

**(c) Mixed economy of service provision**

19. The consultants endorse the concept of welfare pluralism advocated by the Working Group on Care for the Elderly and recommend pluralist provision of welfare services, i.e. services provided by a wide range of public, self-financing and private providers, as an efficient model of service provision in Hong Kong. Through a mixed economy of provision, users will benefit from wider choices being made available by a range of public and private providers. Users may also benefit through the lower costs and greater flexibility thus realised.

20. The Residential Care survey demonstrated the significant part played by the private sector in caring for highly dependent elderly people. However, the private sector's current limitations are widely recognised. The consultants recommend that Government should encourage development of a high quality private sector. The following initiatives should be considered :

- an extension of the Bought Place Scheme in the private sector, with prices paid that are comparable to the cost of supporting clients in the subvented sectors;
- assist the private sector in identifying suitable premises;

- increase CGAT and community nurse support to private homes; and
- increase primary medical care support.

**(d) Enhancement to services**

21. The consultants have also conducted a comprehensive review of the level and mode of delivery of services, and recommended the following enhancement of services :

(i) Care for the more severely impaired elderly in the community

22. In order that the “Ageing in Place” policy can be successfully implemented, the capability of community support and home help services to care for more dependent clients needs to be expanded. In this connection, the consultants recommend :

- extending the provision of day hospitals where elderly people can receive more intensive medical, nursing, and paramedical treatments;
- developing psychogeriatric day hospitals and increasing the provision of day care services for the cognitively impaired elderly people by rendering professional psychogeriatric support to day care centres;
- home-help service should be re-oriented towards providing long-term care and support to carers and assistance with ADL; and
- home-help service be supported by nurses and paramedical staff where necessary.

(ii) Residential Care

23. The consultants noted that more than one-half of the elderly people in subvented homes are ADL impairment free, which indicated that there is a need to tighten up the admission control to these homes so that only those in genuine need of residential care would be admitted in future. On the other hand, the study showed that about 55% of the residential beds provided were in private care homes, the standard of service of which varies. There is an urgent need to upgrade the quality of these homes.

(iii) Psycho-social support for the impairment-free elderly in the community

24. To provide better services to the healthy elderly in the community, the consultants recommend that a more dynamic model be adopted in developing the programmes and organisations of the social centres (S/Es) and multi-service centres for the elderly (M/Es). It is also suggested to integrate the social and recreational programmes in these centres with other community services that are provided by, for instance, the municipal councils. Furthermore, social centres should continue to act as a drop in facility for elderly people and that they should become a nucleus for :

- a citizens' advice service staffed by elderly volunteers who would use their pre-retirement work and life experience to provide support and advice on various matters;
- administration and organisation of outreach social programmes;
- training and development of social centre staff and volunteers;
- administration of elderly volunteer programmes such as networking, visiting and escort;
- better collaboration between the M/Es and S/Es with the latter operating as satellites of the former.

(iv) Medical Services

25. The consultants are of the view that the limited access to primary and outreach medical care is a barrier to the development of elderly care services based on community care and continuum of care. It is proposed that primary medical care to elderly people in the community should be enhanced by expanding the role of the elderly health centres by :

- charging them with the responsibility of managing the chronic medical conditions that are prevalent amongst the elderly i.e. diabetes, arthritis, hypertension, heart disease and depression;
- developing a domiciliary and institution visiting service; and
- charging them with the responsibility of providing primary medical support to other domiciliary services such as home help service.

## **FUNDING**

26. Based on their recommended mix of services to meet the needs of the elderly people, the consultants have calculated the total cost of providing these services using cost assumptions derived from the public sector. Compared with the current Government expenditure on elderly services, the study shows that the community as a whole would have to spend much more (about 150% of 1996 public sector expenditure) to obtain all the care services that are needed. The cost will escalate as the population continues to age. As it will be impossible for the Government to shoulder the full cost of all care services for the elderly, the consultants recommend that users with means should be expected and required to pay in future. As the majority of the elderly people in Hong Kong have always been relying on their family for financial support, the consultants recommend that means-testing should apply to the extended family of the elderly people.

## **ADMINISTRATION'S RESPONSE**

27. The Administration have considered the findings and recommendations of the consultancy report in details. We have earlier briefed the Elderly Commission and the Social Welfare Advisory Committee on the Report. We have vigorously pursued a number of recommendations. A list of the follow-up action undertaken is at Annex B. However, there are a number of recommendations that may involve longer term planning and we are considering their implications.

Health and Welfare Bureau  
September 1998

**Summary of recommendations from the consultancy study  
and follow-up actions by the administration**

Recommendations

Follow-up actions

**Policy**

(I) Ageing in Place

- To facilitate elderly with no or low impairment to remain at home by :

- providing more appropriate housing plus appropriate domiciliary care
- converting home for the aged (H/A) places to provide for clients with higher impairment

We plan to launch pilot projects in the coming years to upgrade the existing home help services through re-engineering the meal delivery service and provision of training and incentives to encourage home helpers to provide more home care services.

We have consulted the Ad Hoc Committee on Housing and Residential Care of the Elderly Commission on our proposal to apply the care-and-attention (C&A) home admission criteria to H/A. The proposal was endorsed in principle. We are following up on the detailed arrangement.

SWD is working with operators to convert planned H/A places into C&A places.

Recommendations

Follow-up actions

- Carers to be made a special focus of Government policy
  - access to training and counselling for carers
  - respite service in residential care homes or day care centres

We are considering introducing a new respite service in day care centre (D/Es). We will review the existing respite service in residential care homes to identify areas for improvement.

(II) Development of a quality private sector

- Extend the Bought Place Scheme (BPS)

Enhanced BPS to purchase 2 400 additional places. The first batch of bought places to be delivered in November 1998.

- Access to Government grants and land privileges
- Assistance in identifying and increasing the supply of suitable premises

) This is under consideration among  
) government bureaus and departments.  
) A Strategic Group chaired by Director  
) of Social Welfare has been tasked to  
) identify suitable premises for  
) operation of residential care homes.

- Strengthen Community Geriatric Assessment Teams (CGATs) and Community Nurse support

We have increased one CGAT in 1998/99. Further addition will be subject to resource availability.

- Strengthen primary medical care support

Visiting Health Teams (VHTs) were established in July 1998. They provide health education, health promotion, disease prevention, and annual influenza vaccination to residential care homes.

- Expand licensing scheme to include measures that relates to care of clients.

We are moving towards this direction. SWD is working on plans to extend quality assurance measures to private residential home.

Recommendations

Follow-up actions

(III) An entity to co-ordinate policies for the elderly

The Elderly Commission was set up in July 1997.

(IV) Means-testing

• Services to be provided to the most needy :

- current means-testing system to be applied rigorously

) We are working on the proposals and will seek consultation when we are ready.

- higher charges to be applied through means-testing

)  
)

- develop self-pay and self-financing private sector provision

On-going.

Suitable premises will be identified for subvented as well as private and self-financing home operators.

We will consider extending BPS to self-financing homes to provide a steady source of income to the operators.

The Elderly Commission will put forward recommendations to develop these sectors in its Report to the Chief Executive.

• Involvement of volunteer to provide care services, such as escort and meal delivery

Involvement of volunteers in the re-engineered home help services will be explored.

Recommendations

Follow-up actions

**Enhancement to Services**

Continuum of Care Model

Residential Service :

- |  |  |
|--|--|
| <ul style="list-style-type: none"><li>• Re-define the admission criteria for subvented C&amp;A homes to admit the more-impaired</li></ul>  | <p>Review of admission criteria to be conducted in consultation with the service sector.</p>   |
| <ul style="list-style-type: none"><li>• Retain the Infirmary Care Supplement and ensure amount of subvention paid for places reflect impairment and the likely intensity of services required.</li></ul> | <p>Infirmary Care Supplement for 460 cases has been allocated to care homes in 1998/99. The funding formula for pilot projects on continuum of care in residential services is being considered. This will enable the homes to provide care to elderly of different degrees of frailty. A pilot scheme in selected homes will be conducted in 1999/00.</p> |
| <ul style="list-style-type: none"><li>• Remove distinction between Nursing Homes and C&amp;A Homes.</li></ul>  | <p>The pilot projects on continuum of care will take care of elderly of different degrees of impairment.</p>   |
| <ul style="list-style-type: none"><li>• Increase the scale of pre-discharge planning programme</li></ul>   | <p>We are reviewing the manning ratio of Medical Social Workers.</p>   |

Recommendations

- Increase the availability of medical and health support to all residential care sectors. Position infirmary to focus on active rehabilitation rather than for long-term care.
- Planning ratios to be met in part by Government increasing the proportion of private sector bought places
- To remove distinctions between sectors and to move away from the current input control model to the output, service-purchase model
- Adopting a case management approach.

Community Services :

- Increase the availability of medical and health professional support in the community.

Follow-up actions

Physiotherapy support to residential care homes has been strengthened by the upgrading of physiotherapist posts and creation of the Physiotherapy Artisan rank. Elderly Health Centres (EHCs) and VHTs may provide additional health support. Further medical support can be purchased through the provision of more financial resources. The interface between infirmary and other residential care homes will be reviewed at a later stage.

2 400 Enhanced BPS places to be purchased over three years. We are looking into the possibility of further increasing the number of places to be bought, having regard to the response of the elderly and the private care home industry to the Enhanced BPS.

This will be further considered at a later stage.

We will adopt a structured approach to assess the care needs of the elderly.

EHCs expanded to become Integrated EHCs (IEHCs). The role of CGATs to be further considered.

Recommendations

Follow-up actions

- Increase the provision of site-based and domiciliary rehabilitation services
- Increasing the attention to district planning and deployment of community support services
- Increase the provision of weekend, holiday and after hours services

We plan to launch pilot projects in the coming years to upgrade the existing home help services through re-engineering the meal delivery service and provision of training and incentives to encourage home helpers to provide more home care services.

To be further considered in the on-going review of care services for the elderly living at home.

D/E service will be expanded to cover Saturday afternoons.

Changing Impairment Profile of Elderly in Residential Care

- Increasing proportion of places bought from the private sector
- Alter criteria of subvented care services to reflect higher impairment level
- Move towards bought place model for the subvented sector

2 400 Enhanced BPS places to be purchased over three years. We are looking into the possibility of further increasing the number of places to be bought, having regard to the response of the elderly and the private care home industry to the Enhanced BPS.

Review of admission criteria to be conducted in consultation with the service sector.

To be considered at a later stage.

Recommendations

Follow-up actions

**Medical Services**

Primary medical care

• Expanding the role of EHCs :

- to be responsible for managing chronic illness of the elderly

To be covered under the expanded IEHC service.

- as a base for CNS and domiciliary and institution-visiting service )

) These issues will be considered in the current review of care services for elderly people living at home.

- primary medical support for domiciliary service )

- integration with CGAT service through case management )

- special responsibility for:

• raising awareness and identifying depression among their clients; )

) Clinical psychological service will form part of IEHCs.

• including psychological health within their portfolio of health education and maintenance programme; and )

• providing counselling to elderly and carers )





Recommendations

Follow-up actions

- Explore further provision of transport resources for D/Es

One additional bus already provided in accordance with the recommendation of the Working Group on Care for the Elderly in 1995. Whether further transport resources should be provided to D/Es would depend on whether the scope of services provided by D/E will be expanded, e.g. to form a base for home help teams.

**Care for the Less Severely Impaired in the Community**

- Assistance with laundry and bathing provided through expanded domiciliary care services rather than Multi-Service Centres (M/Es)

To be further considered in the context of the pilot project to upgrade home help to home care.

**Psycho-social Care**

M/Es:

- Act as a major focus of social support
- To cease to provide laundry and bathing

) To be considered in a proposed review  
) of the relationship between M/Es and  
) S/Es and the scopes of their services.  
)  
)

Recommendations

Follow-up actions

S/Es :

- |   |   |  |
|---|---|--|
| • To act as satellites of M/Es  | ) | We will consider the role of S/Es vis- |
|   | ) | a-vis M/Es in the context of a review  |
| • Provide citizens' advice service by elderly volunteers  | ) | of the relationship between the two    |
|   | ) | bodies at a later stage. On the other  |
| • Administer and organise outreach social programmes  | ) | hand, we have been exploring the       |
|   | ) | possibility of S/Es working more       |
| • Train and develop social centre staff and volunteers  | ) | closely with relevant government       |
|   | ) | departments in providing recreational  |
| • Administer networking, visiting and escort  | ) | programmes for the elderly to help     |
|   | ) | meet their social and recreational     |
|   | ) | needs.                                 |
|   | ) |  |
| • Develop a more dynamic model for social and recreational programmes in the wider community with the involvement of the municipal councils | ) |  |
|   | ) |  |
|   | ) |  |
|   | ) |  |

**Outreaching**

- |  |   |
|--|---|
| • To be adopted as a service approach rather than a mode of service delivery | On-going. VHTs and social networking service carry a strong outreach element. To introduce domiciliary care service to reinforce this service approach. |
|--|---|

**Case Management**

- |  |  |
|--|--|
| • A case management model appropriate for Hong Kong be developed through pilot testing | We will be adopting a structured approach to assess the care needs of the elderly. |
|--|--|

Deloitte & Touche Consulting  
Group

# **Study of the Needs of Elderly People in Hong Kong for Residential Care and Community Support Services**

## **Executive Summary**

**20 NOVEMBER, 1997**

---

**Deloitte Touche  
Tohmatsu  
International**

---

**Table of Contents**

---

- 1. INTRODUCTION ..... 1**
  - BACKGROUND TO THE STUDY..... 1
  - SUMMARY OF RECOMMENDATIONS..... 1
  - STRUCTURE OF REPORT ..... 3
  
- 2. NEEDS BASED PLANNING APPROACH..... 4**
  - DEFINITION AND ASSESSMENT OF NEED..... 4
  - PLANNING MECHANISM ..... 10
  - PLANNING MODEL..... 11
  
- 3. SERVICE DEVELOPMENT ..... 7**
  - REASONS FOR SERVICE DEVELOPMENT: THE AGEING POPULATION..... 17
  - CURRENT FORMAL CARE SERVICES ..... 18
  - SUMMARY OF COMMUNITY SURVEY, RESIDENTIAL CARE SURVEY AND FOCUS GROUP STUDY RESULTS..... 21
  - COMMENTARY ON CURRENT SERVICES ..... 27
  - SERVICE DEVELOPMENT RECOMMENDATIONS..... 32
  
- 4. A BASE CASE SCENARIO ..... 34**
  - INTRODUCTION ..... 34
  - ALTERNATIVE PLANNING MECHANISMS..... 11
  - PREVALENCE OF IMPAIRMENT LEVELS AND INFORMAL CARE AVAILABILITY ..... 34
  - BASE CASE SCENARIO..... 35
  - ALTERNATIVE SCENARIOS ..... 40
  
- 5. FUNDING SCENARIOS ..... 46**
  - INTRODUCTION ..... 46
  - SOURCES OF FUNDS..... 46
  - SIZE OF THE FUNDING GAP ..... 50
  
- 6. ENCOURAGEMENT OF THE PRIVATE SECTOR..... 57**
  - EXISTING PRIVATE SECTOR ..... 57
  - BARRIERS TO ENTRY ..... 57
  - WAYS TO ENCOURAGE THE PRIVATE SECTOR ..... 57
  
- 7. SUMMARY OF RECOMMENDATIONS..... 59**
  - INTRODUCTION ..... 59
  - GOVERNMENT POLICY ..... 59
  - ENHANCEMENTS TO SERVICES..... 61
  - THE WIDER PICTURE..... 63

**Table of Figures**

---

FIGURE1: CLASSIFICATION OF PHYSICAL IMPAIRMENTS ..... 7

FIGURE2: CLASSIFICATION OF COGNITIVE IMPAIRMENT ..... 8

FIGURE3: LEVELS OF COMBINED IMPAIRMENT ..... 8

FIGURE4: THREE-DIMENSIONAL CARE MATRIX ..... 12

FIGURE5: POSSIBLE SERVICE PROVISION BY IMPAIRMENT BY CARER PROFILE ..... 13

FIGURE6: SERVICE PROVISION BASED ON IMPAIRMENT LEVEL AND AVAILABILITY OF  
INFORMAL CARE ..... 14

FIGURE7: AVERAGE ANNUAL GROWTH RATES FOR THE ELDERLY POPULATION ..... 17

FIGURE8: SUMMARY OF COMMUNITY SUPPORT SERVICES ..... 18

FIGURE9: SUMMARY OF RESIDENTIAL CARE SERVICES ..... 19

FIGURE10: DISTRIBUTION OF RESIDENTIAL CARE RESIDENTS BY IMPAIRMENT LEVEL.... 23

FIGURE11: RELATIONSHIP BETWEEN UPTAKE OF RESIDENTIAL CARE AND UPTAKE OF HOME  
HELP SERVICES ..... 28

FIGURE12: PREVALENCE OF IMPAIRMENT/CARE PROFILE IN ENTIRE ELDERLY POPULATION  
(SUM OF COMMUNITY AND RESIDENTIAL CARE POPULATIONS) ..... 35

FIGURE13: PROPOSED SERVICE PROVISION ..... 36

FIGURE14: PROPOSED PLANNING RATIOS FOR BASE CASE SCENARIO ..... 37

FIGURE15: UNIT COST OF SERVICE PER ANNUM ..... 38

FIGURE16: COST OF SERVICES ..... 39

FIGURE17: PERCENTAGE INCREASES IN SERVICE PROVISION - 1996 - 2006 ..... 40

FIGURE18: PROJECTED REQUIRED PROVISION OF SERVICES IN 2006 ..... 40

FIGURE19: IMPAIRMENT LEVEL VS. AVAILABILITY OF INFORMAL CARE (ALTERNATIVE  
SCENARIO 1) ..... 41

FIGURE20: IMPAIRMENT LEVEL VS. AVAILABILITY OF INFORMAL CARE (ALTERNATIVE  
SCENARIO 2) ..... 42

FIGURE21: PLANNING RATIOS (ALTERNATIVE SCENARIO 1) ..... 43

FIGURE22: PLANNING RATIOS (ALTERNATIVE SCENARIO 2) ..... 44

FIGURE23: ESTIMATE OF CURRENT GOVERNMENT EXPENDITURE ON WELFARE SERVICES  
FOR THE ELDERLY (1996/7) ..... 47

FIGURE24: SCOPE OF FEES-BASE CASE SCENARIO - 1996 ..... 48

FIGURE25: THE BASE CASE SCENARIO-SCOPE OF NEED FOR TRADE-OFFS ..... 51

FIGURE26: SUMMARY OF FUNDING SCENARIOS (BASE CASE SCENARIO) ..... 53

FIGURE27: SUMMARY OF FUNDING SCENARIOS (BASE CASE SCENARIO-ALTERNATIVE 2) ..... 53

## **1. Introduction**

---

### **Background to the Study**<sup>1</sup>

- 1.1 Over the next ten years, and beyond, Hong Kong faces new challenges with its rapidly expanding elderly<sup>2</sup> population. To meet these challenges, the Government needs a policy and planning framework which will ensure that the care needs of elderly people are met to the extent possible given its limited resources and its policy of ensuring growth in public expenditure does not exceed growth in gross domestic product.
- 1.2 Current planning ratios for elderly care services are based on estimated demand for services and may not necessarily reflect actual needs and, despite a recent expansion in the provision of elderly services, there is still an apparently high unmet demand for some services. A Working Group on Care for the Elderly was formed in November 1993 to conduct a general review of services for elderly people. One of its recommendations was that a comprehensive consultancy study be commissioned to assess the needs of the elderly for residential care and community support services.
- 1.3 Following this recommendation, Deloitte & Touche Consulting Group was commissioned to conduct a “Study of the Needs of Elderly People in Hong Kong for Residential Care and Community Support Services”.
- 1.4 The terms of reference of the consultancy study as set out in the Health and Welfare Branch Consultants’ Brief are outlined as follows.
  - (a) Assess the needs of elderly people in Hong Kong for residential care and community support services. Review the existing planning ratios for such services and formulate new planning ratios on the basis of the needs identified.
  - (b) Propose whether, and if so how, current services for the elderly should be modified or replaced by new services to meet the needs of the elderly as identified in objective (a) above.
  - (c) Propose ways in which the services identified in (b) could be provided in a cost-effective manner by the Government and the subvented and the private sectors. e.g. through the redeployment of existing resources and/or increasing available resources through fee-charging and the provision of self-financing services such that implementation would cause no significant increase in Government spending.

### **Summary of Recommendations**

- 1.5 Our recommendations are based on four principles:

---

<sup>1</sup> Volume 1, Section 1

<sup>2</sup> In this report, the elderly are defined as being those aged 60 and over.

## 1. Introduction (Cont'd)

---

- “Ageing in Place” - elderly people should stay as members of the community for as long as possible by means of family care and community support services, both formal and informal;
- “Role of the Family” - it is the responsibility of the family to provide “informal care” to the elderly, whilst it is the responsibility of the Government to supplement informal care with “formal care” only when needed;
- “Continuum of Care” - to provide a hierarchy of services to the elderly in a way which minimises the disruption to the elderly as their need for formal care increases; and
- “Mixed Economy of Provision” - elderly services will be delivered by a mixed economy of public, private and voluntary providers.

### 1.6 In summary we recommend that the Government:

- establishes an entity to oversee and co-ordinate policies that protect and enhance the interests of elderly people to address the issues of fragmented service delivery;
- becomes a purchaser of quality services from both the subvented and private sectors, rather than be funder of inputs to the subvented sector. This will reduce the distinction between providers and, thereby, increase healthy competition in the provision of services to care for the elderly;
- develops a continuum of care model by removing the distinction between types of residential care homes and improving community-based services, such as day care, domiciliary care and access to community centres;
- improves and increases the level of primary and specialised health care support to services under the continuum of care model to better serve the elderly population;
- develops alternative planning mechanisms to planning ratios. One proposed measure is to fund services on a per capita basis;
- considers options and trade-offs to support the needs of the elderly. The cost of elderly services is significant and Government funds and user contributions will not be able to support all the services the elderly population requires. There is, therefore, a need to consider the service mix to maximise coverage and determine who service recipients should be;
- formalises means testing to maximise the amount of fees which users can contribute to the cost of the services which they consume; and
- encourages the private sector to provide services to care for the elderly.

## **1. Introduction (Cont'd)**

---

1.7 The needs based approach to service provision which has been developed is sophisticated and comprehensive. The modelling and planning tools, which are key outputs of the study, should be used and refined on an ongoing basis by the Government as it seeks to match the needs for elderly care with appropriate types and levels of service and to understand the funding implications of such service provision.

### **Structure of Report**

1.8 The full report of the study is structured in three volumes as follows:

- Volume 1 - Review of Current Position and Needs Assessment;
- Volume 2 - A Base Case Scenario; and
- Volume 3 - Funding Scenarios.

1.9 This Executive Summary is structured in six sections in addition to this introduction as follows.

1.10 Section 2, Needs Based Planning Assessment, describes the methodology used in this study to determine the need for care and the level and types of services required to meet this need, the “Base Case Scenario”.

1.11 Section 3, Service Development, describes the ageing population and current formal care services and outlines the findings and implications of the three main methods of data collection: the Community Survey; the Residential Care Survey; and the focus group discussions. It also summarises our comments on current services and recommendations regarding types of service.

1.12 Section 4 describes the Base Case Scenario, a level of provision of services designed to meet the care needs of the elderly population.

1.13 Section 5, Funding Scenarios, identifies the “funding gap”, being the difference between the cost of the Base Case Scenario and current Government expenditure and summarises alternative funding scenarios.

1.14 Section 6, Encouragement of the Private Sector, explains ways in which the private sector can be encouraged to provide care services to the elderly.

1.15 Section 7, Summary of Recommendations, summarises our recommendations.

## 2. Needs Based Planning Approach

---

### **Definition and Assessment of Need**<sup>3</sup>

2.1 Defining needs is extremely complex. Needs are not static and absolute, but “involve statements of values and preferences that are influenced by the existing socio-political environment, standards of living, and the resources and technology that are available to improve the quality of life”<sup>4</sup>. In the context of elderly needs for residential care and community support services, needs can be categorised as:

- needs that can be met by trained health care professionals;
- personal and home care (i.e., assistance with activities of daily living such as bathing, toileting, eating and household chores including shopping and washing etc.<sup>5</sup>);
- conditions requiring supervision (e.g., dementia, incontinence, poor vision or near blindness, etc.); and
- activities to maintain psychological well-being and social interactions with others.

2.2 These needs have been considered in this study. Other needs such as financial, housing, political, spiritual, cultural and the need for activity are beyond the scope of this study.

2.3 Appropriate needs assessments are required to identify the care needs of the elderly. The assessment of care needs should identify:

- the individual’s level of independence, functional mobility and cognitive abilities;
- the quality and amount of informal support that is available to the individual.

2.4 The appropriate service response is often affected by other factors such as available financial resources, family support and housing. Through understanding the effects of these factors and making appropriate assumptions, services can be planned to better suit the needs of the elderly.

### **Distinguishing Need from Demand**

2.5 The “need” for services is different from the demand for services. This distinction is made in the study to identify functional care “needs” of the elderly population. Ideally, resources should be used to provide elderly care to meet “need” and discourage consumption of resources by those who may want or demand service, but who may not need it or who need relatively less than someone else.

---

<sup>3</sup> Volume 1, Section 3

<sup>4</sup> Diwan, Sadhna and Moriarty, David, “A Conceptual Framework for Identifying Unmet Health Care Needs of Community Dwelling Elderly”, *Journal of Applied Gerontology*, Vol.14, No.1, March 1995, 47-63.

<sup>5</sup> As categorised by the U.S. City of New York Department for the Aged (Engler, 1989).

## 2. Needs Based Planning Approach (Cont'd)

---

- 2.6 There will never be a way to identify inappropriate demand and unmet need with a high degree of accuracy. However, the mechanism proposed in this report is a useful tool for macro planning.

### Needs Assessment Methodology

- 2.7 There is no standardised methodology or foundation for needs assessment<sup>6</sup>. A study conducted in the U.S. analysed 79 needs documents and found that 54% of the methodologies had deficiencies<sup>7</sup>.
- 2.8 In this study, a methodology which focuses on understanding the needs of the elderly for residential care and community support services was used. The methodology, modified from that used in a Japanese study<sup>8</sup>, incorporates inputs from surveys of the elderly, analysis of secondary data, interviews with key professionals and experts, public consultations and analysis of service utilisation.
- 2.9 The methodology provided a systematic way to determine the quantity of services required for the elderly population. The approach analysed the availability of care provided by family or informal caregivers to elderly people and the level of physical and cognitive impairment of the elderly and considered the need for psycho-social support.
- 2.10 There are four principal steps to the methodology, each building on the previous one to provide a ground-up, fact based methodology for planning. The following is a summary of the approach. Details of the application of the model and the assumptions used are presented in the Volume 2 of the report.
- 2.11 **Step 1: Data Collection.** This comprised a Community Survey of elderly people, a survey of elderly people in residential care and focus group discussions designed to gauge the attitudes and expectations of the soon-to-be-old with regard to needs and preferences for provision of elderly care. The surveys collected information on the elderly person's independence, physical state, cognitive functioning, level of informal care giving (i.e. family care giving) and psychological status. Other factors such as physical environment and social circumstances were also collected. Recognised and validated assessment scales were used to collect information required. These assessment scales are summarised below and details of the methodology and findings are presented in Volume 1, Sections 5, 6 and 7.

---

<sup>6</sup> Cheung, Kam-fong Monit, "Needs Assessment Experience Among Area Agencies on Ageing", *Journal of Gerontological Social Work*, Vol. 19 (3/4) 1993.

<sup>7</sup> Cheung, Kam-fong Monit, "Needs Assessment Experience Among Area Agencies on Ageing", *Journal of Gerontological Social Work*, Vol. 19 (3/4) 1993.

<sup>8</sup> Two studies, "Measurement of the Needs of the Impaired Elderly and Their Families for Social Care Services" and "Needs Estimation of Social Care Services for the Impaired Elderly in a Rural Area of Japan" by Hiraoka et al and The New Gold Plan published by the Ministry of Health and Welfare of Japan, Health and Welfare Bureau for the Elderly.

## 2. Needs Based Planning Approach (Cont'd)

---

- 2.12 **Step 2: Determining Needs.** Groupings of elderly people with similar levels of impairment were developed to facilitate modelling and analysis. The need of the elderly for care was determined by the level of physical and cognitive impairments and the availability of informal caregivers. This is explained further below and in Volume 1, Section 3.
- 2.13 **Step 3: Estimating Levels of Service Provision.** Service provision for residential care and community based services including day care, domiciliary care and community centres was defined in terms of places per service type to meet the needs of the elderly population. Volume 1 of this report defines these services and Volume 2 discusses the planning mechanism.
- 2.14 **Step 4: Determining Planning Ratios.** Planning ratios were calculated based on the needs identified and the estimated levels of service provision required to meet these needs. These are presented in Volumes 2 and 3 for different service provision scenarios.

### **Strengths and Shortcomings of the Methodology**

- 2.15 The methodology used to assess needs in this study is a multi-dimensional assessment of well-being, incorporating validated tools to measure risk factors of elderly persons. The approach collects input from the elderly population, caregivers, experts and officials.
- 2.16 Studying unmet needs highlights issues that are not addressed by the current delivery system and provides information to evaluate and prioritise services for the elderly.
- 2.17 The specific methodology has no direct comparator in another study although it has adapted a Japanese study. Care has been taken to use locally and internationally validated approaches whenever possible. A consultative process with experts and international benchmarking was conducted based on available data to maximise accuracy. Despite this process, there is room for debate and discussion and there are no “right” answers.
- 2.18 The planning mechanism and analysis of care availability is based on the findings from the Community and Residential Care Surveys. The complexity of the analysis has resulted in small sample sizes upon which estimations of family support to the highly dependent were based. The sample size of the Community Survey was determined by the Health and Welfare Branch, in conjunction with the Census and Statistics Department, and the level of different types of service provision to meet needs are at best guidelines and should not be used as operational targets.

### **Assessment Scales**

- 2.19 In order to assess the health conditions of the elderly population, internationally and locally validated assessment instruments were used in the surveys. These are:

## 2. Needs Based Planning Approach (Cont'd)

---

- an adapted **Barthel ADL Index (BAI)** to measure the difficulty experienced in performing primary activities of daily living including eating, transfer (getting in and out of bed and a chair), dressing, grooming, bladder control, bowel control, mobility, going to the toilet, bathing and climbing stairs; and
- a mental test **Short Portable Mental Status Questionnaire (SPMSQ)** to measure the level of cognitive impairment. This test assesses the level of memory and cognitive impairment which is a critical dimension in the assessment of an individual's ability to function.

2.20 It was not feasible to use the mental test SPMSQ that was used in the Community Survey in the Residential Care Survey since such an assessment would have required a large number of resources at each facility to complete the questionnaire. As a result, a relatively subjective assessment based on a set of behavioural conditions was completed by the caregivers of residents in residential care facilities.

### Levels of Combined Physical and Cognitive Impairment

2.21 The grading system shown in Figure 1 was developed to classify the severity of the physical impairment of an elderly person. The physical impairment was based on the ability to perform 6 basic Activities of Daily Living (ADLs) from the BAI. These are bathing, toileting (i.e., going to the toilet, changing pants, using toilet paper and flushing), transferring between a bed and a chair, mobility (walking), eating and dressing.

**Figure 1: Classification of Physical Impairments**

Physical Impairment	
Grade	ADL Score
Level 4	5-6 ADL impairments
Level 3	3-4 ADL impairments
Level 2	1-2 ADL impairments
Level 1	0 ADL impairments

2.22 The grading system shown in Figure 2 was developed to classify the severity of the cognitive impairment of an elderly person. The cognitive impairment classification for those in the community was based on the score from the SPMSQ adjusted for educational attainment. The criteria for classifying people in residential care into the same levels were modified to reflect the different method of data collection.

## 2. Needs Based Planning Approach (Cont'd)

**Figure2: Classification of Cognitive Impairment**

<b>Mental Impairment</b>		
<b>Grade</b>	<b>Community Survey: Mental State Test (Short Portable)</b>	<b>Residential Care Survey: Mental State</b>
<b>Level 4</b>	Makes 7 or more errors (score: <4)	Always confused and disruptive to others
<b>Level 3</b>	Makes 5-6 errors (score: 4-5)	Always confused, but not disruptive to others; or has long standing diagnosis of psychiatric illness
<b>Level 2</b>	Makes 3-4 errors (score: 6-7)	Sometimes confused
<b>Level 1</b>	Makes 0-2 errors (score: 8+)	No mental impairment

2.23 Based on the physical and cognitive assessments, an overall impairment grading system was developed to combine physical and cognitive disabilities. This scale was used to indicate the intensity of need for supervision and assistance to perform functional activities and is based on similar grading categories developed in a Japanese study<sup>9 10</sup>. Figure 3 presents the classification used for this study.

**Figure3: Levels of Combined Impairment**

<b>Level</b>	<b>Description of Combined Impairment</b>
<b>5b</b>	Level 4 cognitive impairment with no physical impairment
<b>5a</b>	Level 4 physical impairment with cognitive impairment Level 4 physical impairment with no cognitive impairment Level 4 cognitive impairment with physical impairment
<b>4</b>	Level 3 physical impairment with cognitive impairment (level 2 or 3) Level 3 physical impairment with no cognitive impairment
<b>3</b>	Level 3 cognitive impairment with level 2 physical impairment Level 3 cognitive impairment with no physical impairment (level 1)
<b>2</b>	Level 2 physical impairment with level 2 cognitive impairment Level 2 physical impairment with no cognitive impairment (level 1)
<b>1</b>	Level 2 cognitive impairment only
<b>0</b>	No cognitive or physical impairment (level 1 for both cognitive and physical impairment)

<sup>9</sup> Shimizu et al., "Measurement of the Needs of the Impaired Elderly and Their Families for Social Care Services", Recent Advances in Ageing Science, 1993 pp. 2251-2260.

<sup>10</sup> This study refined the four category classification of impairments defined in the Japanese study to seven levels.

## 2. Needs Based Planning Approach (Cont'd)

---

### Psycho-social Need<sup>11</sup>

- 2.24 Unlike the dimensions of physical and cognitive impairment there are no widely accepted tools to measure psycho-social need. Although difficult to quantify, professionals<sup>12</sup> suggest that a minimum of an hour a day of psycho-social support is necessary for all people regardless of age or impairment level, whether in the form of someone to talk to and provide emotional support and advice on difficult matters, or simply someone to engage in a leisure activity.

### Availability of Informal Care<sup>13</sup>

- 2.25 As there are no validated methods for measuring the amount of informal care provided, data gathered through the Community Survey on the employment status and living arrangements of the informal caregiver and the living arrangements of the elderly person were used to determine the *most likely* level of informal care available.
- 2.26 Based on data gathered through the Community Survey, the elderly were classified into five categories of potentially available informal care.
- **At least one caregiver available who lives in and has no other employment.** Caregivers who live in and who have no other job would be available most of the day and night for supervision.
  - **At least one caregiver available who lives in but has part-time employment outside the home.** Caregivers, who live in but have a part-time job outside the home, would only be available part of the day to provide meals and assist with feeding and toileting. They would be available to provide assistance with bathing and perform household chores and shopping. They could also provide overnight supervision.
  - **At least one caregiver available who lives in but has full-time employment outside the home.** Caregivers, who live in but have full-time jobs outside the home, are not generally available during the day to provide meals or assist with feeding and toileting. However, they would be available to provide some assistance with activities of daily living, such as bathing, each day and could perform household chores and shopping. They could also provide overnight supervision.
  - **At least one caregiver available who lives out.** Caregivers, who do not live in, irrespective of employment status, would provide limited support with shopping and household chores. The extent of supervision they would provide would be

---

<sup>11</sup> Volume 2, Section 3.

<sup>12</sup> Members of a CGAT and Social Studies' Academics.

<sup>13</sup> Volume 2, Section 3.

## 2. Needs Based Planning Approach (Cont'd)

---

limited to a daily visit to measure the dependant's well being, Supervision would also be limited to their availability.

- **None available.**

2.27 Due to a lack of information on the availability of informal care of those in residential care, these elderly were considered to have no informal care support available.

### **Planning Mechanism**<sup>14</sup>

2.28 The Planning Mechanism proposed in this report is based on planning ratios per 1,000 of the elderly population for each recommended type of service. These planning ratios should be used to guide Government's planning of the provision of services, both in funding the subvented sector and in the encouragement of the private sector. They should not be used rigidly, nor should they be used as a basis of allocating funds to the Health and Welfare Branch, since the needs of the elderly population will change over time as levels of income, living arrangements and levels of education change and as new ways in which to meet the needs of the elderly are found. An alternative way of allocating funds to the Health & Welfare Branch would be on the basis of dollars per elderly person.

2.29 Planning ratios developed from this study include those for residential care, day care centres, domiciliary care and community centres for the elderly as described in Volume 1 of this report and summarised in Section 3 of this Executive Summary. Medical and health services are not included in the planning mechanism since they are beyond the scope of this study.

2.30 The planning ratios currently used by the Government relate to the services to be provided by the Government and subvented sector. However, the planning mechanism proposed in this report is designed to produce planning ratios per 1,000 of the elderly population for each recommended type of service, irrespective of which sector, whether public or private, provides the service.

2.31 In developing planning ratios, the goal is to create a tool which enables focused planning, yet allows for flexibility as circumstances and demographics change. Based on analysis of data collected through the Community and Residential Care Surveys, this report provides four sets of planning ratios, one for each age band and overall, thereby achieving greater sensitivity in planning as the age composition of Hong Kong's elderly population changes over time. Future need is projected by multiplying the planning ratios for each age band by estimates of the size of the respective age bands in future years.

2.32 Needs are not static and the needs of the elderly have been based on an assessment conducted at one point in time. Many factors may affect the aggregate need for

---

<sup>14</sup> Volume 2, Section 2.

## **2. Needs Based Planning Approach (Cont'd)**

---

formal social services. It is important to remember the limitations of a Planning Mechanism which uses planning ratios derived at one point in time and population projections for a ten year period. Frequent review is necessary to revise both assumptions and ratios.

### **Application of Planning Ratios<sup>15</sup>**

- 2.33 The planning ratios derived in this study improve on those currently used to plan for the provision of services to the elderly as they are based on a thorough study of the needs of elderly people. However, due to the limitations of a Planning Mechanism which uses planning ratios derived at one point in time and population projections for a ten year period, the planning ratios determined in this study are at best targets which Government may choose to achieve. Rigid use of such planning ratios may not result in meeting the needs of the elderly in the most appropriate way as needs change and new or modified services are introduced over time.
- 2.34 The Planning Mechanism used by Government to plan for the provision of services to the elderly should be based on Government policy with respect to the resources which it is able to devote to the care of the elderly and key goals in the provision of care for the elderly. The mechanism would entail an overall strategy by which to achieve these goals and a long term plan to implement the strategy. Such long term plans are used in the provision of services in other countries, such as the New Gold Plan in Japan<sup>16</sup> for the provision of services to the elderly, and in other areas of the Hong Kong Government, such as the Long Term Housing Strategy of the Housing Authority.
- 2.35 Overtime, these long term plans would need to be reviewed periodically in the light of changing circumstances and the results achieved. It will also provide the framework within which to develop more detailed annual plans and the budgets required to meet these annual plans.

### **Planning Model**

#### **Service Provision to Meet Needs<sup>17</sup>**

- 2.36 The Community Survey and Residential Care Survey were key inputs to determining the needs and the availability of informal care support of the elderly population. Based on the information collected, categories of elderly people with similar impairment and care profiles were identified and appropriate formal services (care plans) were designed for each group. Figure 4 shows the three-dimensional care matrix used to group similar elderly people in the community and in residential care.

---

<sup>15</sup> Volume 2, Section 2

<sup>16</sup> New Gold Plan, Health and Welfare Bureau for the Elderly, Ministry of Health and Welfare of Japan.

<sup>17</sup> Volume 2 Sections 3 and 4.

## 2. Needs Based Planning Approach (Cont' d)

Figure 4: Three-dimensional Care Matrix

Overall						
Level of Impairment	Care Profile					Total
	At least one carer who lives in and has no other employment	At least one carer who lives in but has other part-time employment	At least one carer who lives in but has other full-time employment	At least one carer, but who lives out	None Available	
5b						
5a						
4						
3						
2						
1						
0						

2.37 Appropriate services for each impairment/care profile of elderly people were defined. Services which could be provided to meet the needs of the elderly population based on caregiver availability and impairment are summarised in Figure 5.

## 2. Needs Based Planning Approach (Cont'd)

**Figure 5: Possible Service Provision By Impairment By Carer Profile**

Impairment Level	Care Profile				
	At least one carer who lives in and has no other employment	At least one carer who lives in but has other part-time employment	At least one carer who lives in but has other full-time employment	At least one carer, but who lives out	None Available
<b>5b</b>	RC / DC/none	RC / DC / DE	RC / DE	RC	RC
<b>5a</b>	RC / DC/none	RC / DC / DE	RC / DE	RC	RC
<b>4</b>	DC / none	DC / DE	RC / DE	RC	RC
<b>3</b>	DC / none	DC / DE	RC / DE	RC	RC
<b>2</b>	CC / none	CC / none	DC / CC / none	DE / CC / none	DC / DE / none
<b>1</b>	CC / none	CC / none	CC / none	DE / CC / none	DC/DE/CC / none
<b>0</b>	CC / none	CC / none	CC / none	CC / none	CC / none

Note: RC=Residential Care; DC=Domiciliary Care; DE=Day Care; CC = Community Centres

- 2.38 For planning purposes, only one kind of service has been provided to meet the needs of each impairment/care profile group. In practice, people are likely to receive a combination of services. However, stringent assessment should be in place to ensure that people do not receive more services than they need, and to the extent possible, take into account preferences.
- 2.39 In general, based on an ageing in place policy and the philosophy that family support should be the backbone of care provided to the elderly population, residential care would only be provided to those who do not have access to informal caregivers or who have access to caregivers who have limited time to care for the elderly. Based on the principle of providing support to informal carers, domiciliary care and day care should be used to supplement the care informal caregivers are providing. Psycho-social care should be provided to those who would not be accessing formal care on the basis that those receiving such services would be provided with some psycho-social support.
- 2.40 The model gives no indication of the quality of care which would be provided by service providers. For purposes of estimating service provision, it has been presumed that formal care will be provided at a consistent and acceptable level.

## 2. Needs Based Planning Approach (Cont'd)

### Level of Service Provision<sup>18</sup>

2.41 As discussed, elderly needs not met by informal caregivers can be met by a mix of community and residential care services. For the purpose of this study, a Base Case Scenario of service provision was determined. Figure 6 summarises services which would be provided to each impairment/care profile regardless of age group in the Base Case Scenario.

**Figure 6: Service Provision Based on Impairment Level and Availability of Informal Care**

Impairment	Care Profile				
	At least one carer who lives in and has no other employment	At least one carer who lives in but has other part-time employment	At least one carer who lives in but has other full-time employment	At least one carer, but who lives out	None Available
5b	DC	DC	RC	RC	RC
5a	DC	DC	RC	RC	RC
4	DC	DE	RC	RC	RC
3	DC	DE	RC	RC	RC
2	CC	CC	CC	CC	DC
1	CC	CC	CC	CC	CC
0	CC	CC	CC	CC	CC

Note: RC = Residential Care; DC = Domiciliary Care; DE = Day Care; CC = Community Centre for the Elderly

2.42 The Base Case Scenario plans for:

- residential care services to be provided to elderly people with impairment levels 3 and above who have no caregiver, a caregiver who lives out, or a caregiver who lives in but has other full time employment;
- day care services to be provided to elderly people with impairment levels 3 and 4 who have a caregiver who lives in but has other part-time employment. This assumes that elderly people with higher levels of impairment and the same level of informal care available find it difficult to attend day care centres on a regular basis;
- domiciliary care services to be provided to assist all caregivers of elderly people with impairment levels 5a and 5b who are not in residential care, to assist

<sup>18</sup> Volume 2 Section 4

## 2. Needs Based Planning Approach (Cont'd)

---

caregivers of elderly people with impairment levels 3 and 4 who live with the elderly person they are caring for and who have no other employment. and to elderly people with level 2 impairment who have no caregiver available;

- community centres for the elderly to be made available to elderly people who do not receive informal care or other forms of formal care and to a proportion of elderly people who live with at least one carer. This proportion is equivalent to the proportion of elderly people who are currently members of social centres and multi-service centres for the elderly<sup>19</sup>.

### Cost of Services<sup>20</sup>

- 2.43 The cost of services has been estimated by type of service irrespective of the funding source. Assumptions have been made to estimate these costs and these assumptions are presented below.
- 2.44 The costs presented in this scenario are for the purposes of planning. They should be refined before they are used for budgeting purposes.
- 2.45 The cost of a place in **residential care** for those with impairment levels 3 and 4 is based on the current cost of a place in a care and attention home. The cost of a place in residential care for those with impairment levels 5a and 5b is based on the budgeted cost of a place in a nursing home plus an allowance for the infirmary care supplement which will be paid for infirmary cases in nursing homes. This allowance is based on the budgeted cost of the infirmary care supplement and an estimate of the current number of infirmary places in care and attention homes and long term care places in infirmaries.
- 2.46 The cost of a **day care place** is based on the current cost of operating a day care centre with a capacity of 40 places, 5 days per week, 50 weeks a year<sup>21</sup>.
- 2.47 The cost of a **domiciliary care team** is based on the current costs of operating a home help team and the ability of one team to support 65 cases.
- 2.48 The cost of **community centres for the elderly** is based on the current costs of operating a multi-service centre for the elderly less the costs of operating home help services from the centre and on the assumption that a community centre for the elderly can meet the psycho-social needs of 1,042 people<sup>22</sup>.

---

<sup>19</sup> Based on the average membership of social centres and multi-service centres per centre as of 31 March 1996 (most recent figures available) from the Social Welfare Department, it is estimated that 13% of the population utilise these facilities.

<sup>20</sup> Volume 2, Section 4

<sup>21</sup> Day care centres do not operate on public holidays and on average provide service only 50 weeks per year.

<sup>22</sup> Based on the 31 March, 1996 (most updated figures available) multi-service centre membership. Source: Social Welfare Department.

## 2. Needs Based Planning Approach (Cont'd)

---

2.49 The costs of services include:

- subvented and non-subvented operating expenses (including staffing costs, other charges and rates);
- market value of premises;
- cost of fixed assets, other than land and buildings, and other one-time capital costs.

2.50 Unit costs cannot, therefore, be compared with current published costs to Government which only include subvented expenses.

### *Market Value of Premises*

2.51 The market value of the rent for premises used to provide care services to the elderly was included in the estimate of the cost of services to reflect the opportunity cost of these premises to the Government.

2.52 The market value of premises for community services was calculated based on standard space allowances set by the Social Welfare Department and an average market rent for residential premises in the private sector.

2.53 The market value of premises for residential care is based on the gross floor area of each nursing home<sup>23</sup> and the gross floor area of each care and attention home reported to the Social Welfare Department by each home<sup>24</sup>, multiplied by a market rental price.

2.54 The opportunity cost of residential care homes in public rental housing estates was assumed to be the domestic rental of public rental housing units. This is based on the assumption that premises in public rental housing estates would be used as domestic rental units as an alternative to welfare premises. This is a reasonable assumption since it is probable that the residents of residential care homes in public housing estates are eligible for public housing.

2.55 The opportunity cost of residential care homes not in public rental housing estates was assumed to be an average market rent for residential premises in the private sector. The use of rent for private residential premises is based on the assumption that premises would be used for private residential buildings in place of purpose built residential care and community support facilities.

---

<sup>23</sup> Source: Department of Health.

<sup>24</sup> Source: Social Welfare Department

### 3. Service Development

---

#### **Reasons for Service Development: The Ageing Population**<sup>25</sup>

- 3.1 Hong Kong has been and will be faced with a significant growth in its elderly population. Between 1986 and 1996, the population aged 60 or over grew by 39%. By 2006, it is estimated that there will be a further increase of 23% over 1996.
- 3.2 Furthermore, Hong Kong will also be faced with an ageing elderly population as indicated in Figure 7. This is important since it is those aged 75 and over who make the heaviest demands on health and social services.

**Figure 7: Average Annual Growth Rates for the Elderly Population**<sup>26</sup>

<b>Age Group</b>	<b>1996-2001</b>	<b>2001-2006</b>
<b>60-64</b>	(0.54)%	0.89%
<b>65-74</b>	2.51%	0.27%
<b>75+</b>	5.16%	4.59%
<b>Total 60+ Population</b>	2.40%	1.77%

- 3.3 As the number of elderly has grown, the traditional patterns of family care for the elderly have changed<sup>27</sup>. From the focus group sessions, it has been identified that there is a shift in family living arrangements towards smaller household sizes and that the financial burden is requiring more family members to seek employment. Local writers have also noted that many elderly people are left to care for themselves<sup>28</sup>. This trend is important as it suggests that the ability of families to provide the care required is declining.
- 3.4 This change in demographics with changing family structures and values will have far reaching implications on social policies in Hong Kong. In Western countries, the impact is already being felt in financial, social and political terms<sup>29</sup>. Expenditures on programmes for the elderly have been increasing rapidly in many countries<sup>30</sup>. Hong Kong, already providing a wide range of elderly services, will be faced with

---

<sup>25</sup> Volume 1, Sections 1 and 2

<sup>26</sup> Calculated using the annual compound growth rate formula.

<sup>27</sup> Philips, David R., "Accommodation for Elderly Persons in Newly Industrialising Countries: the Hong Kong Experience", *International Journal of Health Services*, Vol. 8, No. 2, 1988.

<sup>28</sup> Chi, Iris, "Family Structure and Family Support of the Old-Old in Hong Kong", in the *Proceedings of the International Conference on Family and Community Care, Hong Kong: Hong Kong Council of Social Services*, 1994, pp 313-318

<sup>29</sup> Jenkins, Robert and Hill, Stephen, "Chronic Care: Long-term Care in an Ageing Society", *Financial Times Management Reports*, 1996.

<sup>30</sup> Johnson, Paul and Falkingham, Jane, *Ageing and Economic Welfare*, Sage Publications Ltd., London, 1992. pp. 133-138.

challenges of a growing elderly population on the dimensions of social support and expenditure and increasing burden on carers.

### **Current Formal Care Services**<sup>31</sup>

- 3.5 Existing elderly services were examined to understand the types of provision and service recipients. Figure 8 and Figure 9 summarise the current formal community and residential care services respectively.

**Figure 8: Summary of Community Support Services**<sup>32</sup>

<b>Service Type</b>	<b>Scope</b>	<b>Current Planning Ratio</b>	<b>Number of Teams/Centres</b>	<b>Current Total Capacity</b>
<b>Social Centre</b>	To meet the social and recreational needs of people aged 60 and over who are living in the community.	1 centre per 2,000 persons aged 65 and above	198*	Unlimited enrolment
<b>Multi-service Centre for Elderly</b>	To provide social and community education programmes, counselling, home help, canteen, bathing and laundry services.	1 centre per 17,000 persons aged 65 and above	27	1,620 meal places Unlimited enrolment
<b>Out-reaching Service</b>	To identify and provide welfare services to vulnerable elderly people who are not in contact with formal health and welfare services.	Not applicable	2	-
<b>Home Help Service</b>	To assist the elderly and their families in looking after themselves and maintaining the normal functioning of the households that they live in.	65 cases per team, demand estimated at 0.698% population	122	8,882**
<b>Day Care Centre</b>	To provide personal care and limited nursing care, on a daily, part day or other part time basis.	1 centre per 17,000 persons aged 65 and above	26	1,040

Note: Although planning ratios for elderly community services, with the exception of Home Help Services, are developed based on the elderly population aged 65 and over, these services are accessible to those aged 60 and over.

\* Multi-service centres also provide services provided by social centres. 2 social centres are non-subsidised.

\*\* Home help service is currently assisting an average of 91 people per team/centre totalling 11,102 cases per year, of which 80% are elderly cases.

<sup>31</sup> Volume 1, Section 4

<sup>32</sup> All figures are as of April, 1997 provided by the Social Welfare Department.

**Figure 9: Summary of Residential Care Services<sup>33</sup>**

<b>Facility Type</b>	<b>Scope of Service</b>	<b>Planning Ratio</b>	<b>Number of Facilities</b>	<b>Current Total Capacity</b>
<b>Hostels for the Elderly</b>	Provide communal living accommodation for elderly people who though capable of self-care are psychologically in need of support and supervision in their daily living	No planning ratio	21*	987*
<b>Homes for the Aged</b>	Provide accommodation, meals, laundry services and a limited degree of personal care. Some homes are purpose-built whilst others comprise places provided in conjunction with self-care hostel places in public housing estates	15 places per 1,000 persons aged 65 and over	75*	6,659*
<b>Care and attention Homes</b>	Provide accommodation with meal services, general personal care and limited nursing care to elderly people who suffer from poor health or physical/mental disabilities	17 places per 1,000 persons aged 65 and over	72	7,629
<b>Long Stay Care Homes<sup>34</sup></b>	Provide a sheltered environment with a rehabilitation focus to people of any age who have mental illness	Based on the projection of demand and shortfall	3	570
<b>Self Financing Homes</b>	Provide accommodation, meals and varying levels of care to elderly people who can perform self-care activities or who suffer from poor health or physical/mental disabilities.	Not applicable	40	2,041
<b>Private Homes</b>	Provide accommodation meals and varying levels of care to elderly people who can perform self-care activities or who suffer from poor health or physical/mental disabilities.	Not applicable	430	22,800 <sup>35</sup>

\* The capacity includes 1 home operated by the Social Welfare Department which provides 69 hostel places and 88 home for the aged places.

<sup>33</sup> Social Welfare Department, as at April 1997.

<sup>34</sup> Elderly admitted to long stay care homes are in good health with the potential for rehabilitation.

<sup>35</sup> As of 1 April, 1997, there were 1,200 bought places in private homes.

Facility Type	Scope of Service	Planning Ratio	Number of Facilities	Current Total Capacity
<b>Infirmaries</b>	Provide for patients who no longer require intensive medical treatments, but who are still in need of long term hospitalisation	Not applicable. An alternative statistical method is adopted based on information such as waiting list data, actual utilisation etc.	16	1,772

Note: Although planning ratios are developed based on the elderly population aged 65 and over for care and attention homes and homes for the aged, these services are accessible to those aged 60 and over.

- 3.6 A central waiting list for subvented residential care is managed by the Social Welfare Department. Applications are submitted through family service centres, medical social workers and other elderly services. Community Geriatric Assessment Teams (CGATs) assess all people on the waiting list for infirmary placement and some people on the waiting list for care and attention placement.
- 3.7 The figures for residential care show that over 50% of all residential care places are provided by the private sector.
- 3.8 The Government also provides medical health services to the elderly population. These health services include the “general” primary, secondary and tertiary care services such as general out-patient services, and specialist in-patient and out-patient services. A full review and critique of these services is beyond the scope of this study. However a brief description of the services which are used mostly by or are targeted towards the elderly is provided below.
- 3.9 **Elderly Health Centres:** There are now seven Elderly Health Centres, most being co-located with general outpatient clinics. Their broad aim is to promote the health and well-being of elderly persons in the community.
- 3.10 **Geriatric Service<sup>36</sup>:** The Hospital Authority provides a specific geriatric service which is supported by inpatient beds, day hospital places and out-patient clinics. It was estimated in 1994 that elderly people consumed 37% of all hospital bed days and constituted 21% of all patients attending specialist clinics.
- 3.11 **Psychogeriatric Service<sup>37</sup>:** There were eight psychogeriatric teams in service in 1996. They provide visiting services to care and attention homes and homes for the aged to assess and treat residents with mental illness and a consultation and advice service to general hospitals and infirmaries. The service is community-centred and

---

<sup>36</sup> Based on the Report of the Working Group on Care for the Elderly and information provided by the Hospital Authority.

<sup>37</sup> Based on information provided by the Hospital Authority.

supported by a limited infrastructure of day hospitals, in-patient beds and out-patient clinics.

- 3.12 **General Infirmatory Services<sup>38</sup>**: General infirmatory services are provided by the Hospital Authority for patients who no longer require intensive medical treatment, but who are still in need of long term hospitalisation. There are 17 facilities providing 1,927 places has at end of March 1997.
- 3.13 **Community Geriatric Assessment Teams (CGATs)<sup>39</sup>**: There are currently 9 CGAT teams, each operating differently depending on the profile of the service area and the available supporting resources. The teams' primary responsibilities are to act as gatekeeper to welfare and medical residential services by undertaking pre-admission assessments of all infirmatory applicants and some care and attention applicants on the central waiting list.
- 3.14 **Community Nursing Services<sup>40</sup>**: Community Nursing Services provide nursing care and treatment for patients in their own homes. 250 specially trained and qualified nurses from 14 centres administer proper nursing care to patients through home visits and at the same time imbue patients and their families with the knowledge of preventing and fighting disease.
- 3.15 Other services provided to the elderly population include respite services, community education, senior citizen card scheme, pool bus service, holiday centre for the elderly, older volunteers programme, volunteer workers programme and social networking services for the elderly.

#### **Summary of Community Survey, Residential Care Survey and Focus Group Study Results<sup>41</sup>**

- 3.16 Critical inputs to understanding the needs of the elderly were a large scale Community Survey of 2,000 elderly people conducted under the Census and Statistics Department General Household Survey, a Residential Care Survey of residents of 120 facilities in both the private and subvented sectors and 14 focus group sessions of those in the 50 to 59 age group. These studies provided essential information as data on the level of impairment of Hong Kong's elderly population was not available<sup>42</sup>,
- 3.17 The Community Survey was one of the largest exercises of its kind undertaken in the world to plan social services. However, the needs assessed from this study can only represent the current needs and serve as a reference point for future estimates of need and planning. The survey sample size of the Community Survey, determined by the

---

<sup>38</sup> Source:Hospital Authority.

<sup>39</sup> Based on information from the Hospital Authority for 1997/98.

<sup>40</sup> Based on information provided by the Hospital Authority.

<sup>41</sup> Volume 1, Sections 5,6,7,9

<sup>42</sup> Unlike Australia which has 100% assessment information of all elderly people over 70.

Health and Welfare Branch, in conjunction with Census and Statistics Department, also posed some limitations as some of the more complex analyses resulted in small sample sizes on which some projections were based.

- 3.18 Important findings and implications from the studies, which in conjunction with our observations on current services form the basis of our recommendations, are highlighted in this section. Detailed descriptions of the methodologies and analyses of the studies are presented in Volume 1 of the report.

## **Health Conditions of the Elderly Population**

### ***Health Conditions of the Community Population***

- 3.19 Hong Kong has a relatively healthy and self-sufficient community population of elderly people. The results of the Community Survey indicate that approximately 4% of the elderly in the community needed assistance with more than one Activity of Daily Living (ADL) as measured by an internationally and locally validated assessment scale<sup>43</sup>.
- 3.20 A much higher proportion of the elderly population had some degree of cognitive disability based on an internationally and locally validated assessment tool<sup>44</sup>. The Community Survey found 25% of the elderly population having some degree of cognitive impairment, including 5% having moderate or severe cognitive impairment. Dementia is a complex disorder that is characterised by cognitive impairment. Based on the assumption that cognitive impairment is a relevant indicator of dementia, the proportion of demented people aged 60 or more in Hong Kong could be estimated at 5%.
- 3.21 Despite the level of good health found by the survey, there is a high utilisation of medical health services. 80% of respondents reported that they were suffering from at least one chronic illness<sup>45</sup>. This places a high burden on medical care services.
- 3.22 As expected, the elderly become more impaired both physically and mentally with age.

---

<sup>43</sup> An elderly person in the community was considered to have some form of physical impairment if he/she had difficulty in performing at least one activity of daily living in the Barthel Activities of Daily Living Index. The ADLs used were eating, transfer (getting in and out of bed and a chair), dressing, grooming, bladder control, bowel control, mobility, going to the toilet, bathing and climbing stairs.

<sup>44</sup> Mental status was measured based on the scores obtained from the Short Portable Mental Status Questionnaire (SPMSQ).

<sup>45</sup> Diagnosed chronic illnesses identified were arthritis/rheumatism (including back pains, pain at knee joints), heart disease (including heart attacks, weakening of the heart), high blood pressure, shortage of breath (including chronic bronchitis & emphysema, asthma), gastrointestinal problems (including ulcer), diabetes, bone fractures, mental illness (other than demented), stroke, Parkinson's disease, cancer (any type), eye disease (including cataract) and other chronic illnesses.

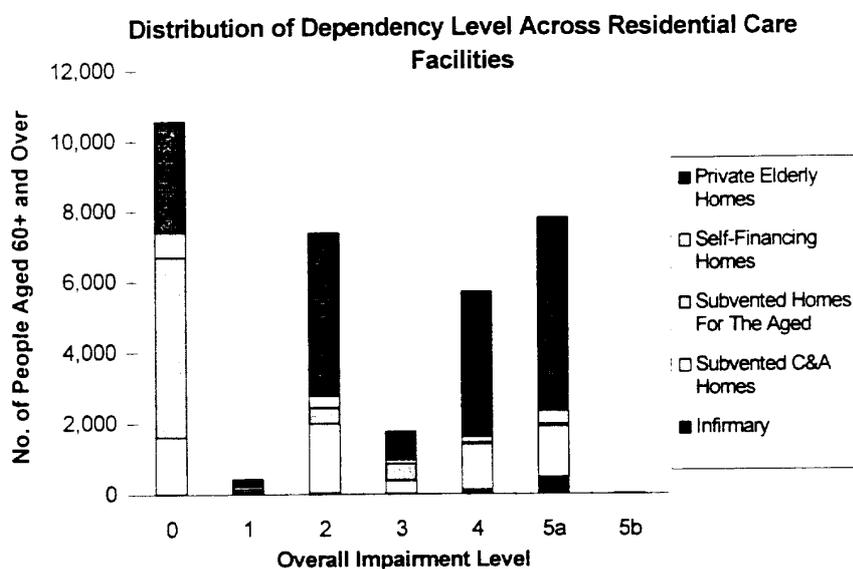
### 3. Service Development (Cont' d)

3.23 The relatively physically healthy and mobile elderly population of Hong Kong suggests the need to maintain this status and to give priority to supporting the needs of the cognitively impaired in the review of services.

#### *Health Conditions of the Residential Care Population*

3.24 Based on the combined impairment grading, the distribution of elderly in residential care varies by the type residential care facility as presented in Figure 10.

**Figure 10: Distribution of Residential Care Residents By Impairment Level**



Note: The number of people aged 60 and over with Level 5b impairment in residential care is estimated to be 15.

3.25 The findings from the Residential Care Survey show that there are relatively more people with higher grades of impairment in private homes than in subvented care and attention homes. 52% of the elderly in private homes have level 4 impairment or higher (c.f. 45% in subvented care and attention homes and infirmaries). This indicates that the private sector is a crucial component of residential care for elderly in Hong Kong.

3.26 Care and attention homes are caring for severely impaired elderly even though eligibility criteria for admission excludes the severely impaired. 40% of people in care and attention homes have level 4 impairment or higher. Many who become severely impaired whilst in a care and attention home cannot be moved out because

### 3. Service Development (Cont'd)

---

there is no where for them to go. This suggests that there are service gaps which could be filled with nursing or infirmary type places.

- 3.27 A proportion of residents in residential care have no or low physical and mental disabilities. 82% of people in homes for the aged (meal places) required no assistance with ADLs nor had any cognitive impairment; and 24% of people in care and attention homes required no assistance with ADLs nor had any cognitive impairment. Since these individuals could be supported adequately in the community with more formal care, there is scope for “re-profiling” the residents of elderly homes and de-institutionalising the elderly with low levels of impairment to ensure that people are appropriately placed according the principle of ageing in place. However, this process could only be done over a period of time and once adequate housing and community support services are in place.

#### *Impairment Distribution Among the Elderly Population of Hong Kong*

- 3.28 The overall health conditions of the elderly population in Hong Kong are good. About 73% of the population aged 60 or above do not have any physical or cognitive impairment. Only 3% of the elderly population have severe cognitive and/or physical impairment (levels 5a and 5b).
- 3.29 The prevalence of elderly people with level 3 or level 5b, being those who are only or primarily cognitively impaired, is high in the community as compared to in residential care. As elderly with severe cognitive impairment are under represented in the residential care population, there may be a service gap for the cognitively impaired elderly population, particularly given that the admission criteria for subvented facilities explicitly exclude those not deemed suitable for community living. However, going forward, it may be appropriate to continue to support this group of elderly in the community with supporting services.
- 3.30 There is a high prevalence of elderly people in the community with impairment levels 4, 5a and 5b who require a great deal of care. The fact that these elderly people are able to cope in the community suggests that there may not be a need to increase the institutionalisation rate for residential care in Hong Kong, particularly if the level of formal community care is increased.

#### **Psychological Status**

- 3.31 The level of possible depression in the elderly population in the community is high. 22% of elderly people in the survey had scores on a psychological assessment scale<sup>46</sup> which would be consistent with a diagnosis of depression, although a definitive diagnosis of depression cannot be made on this basis alone. The survey suggests that socio-economic status, physical health conditions and type of housing may contribute

---

<sup>46</sup> The Geriatric Depression Scale - Short Form (GDS-15) assessment tool was used to assess the prevalence of possible depression. Clinical depression requires further diagnosis by professionals.

### 3. Service Development (Cont'd)

---

to depression among elderly in Hong Kong. Other sources have reported that Hong Kong has one of the highest elderly suicide rates in the world, despite having an average rate for other age groups<sup>47</sup>.

- 3.32 While the survey may overestimate the prevalence of clinical depression among the elderly, steps to strengthen awareness of professionals of mental well-being in the old and to develop psycho-social support services in the community should be taken.

#### **Strong Family Support and Preferences to Remain At Home**

- 3.33 The Community Survey identified strong family support for the elderly in the community. Most care for elderly persons in Hong Kong is provided by informal carers, mainly family. 88% of the elderly in the community are living with a spouse or other family member and 92% of the elderly responded that they have children in Hong Kong. 71% of the elderly people surveyed reported that they are likely able to access informal care and attention when needed in the future.

- 3.34 66% of the caregivers who were interviewed would like to continue caring for the elderly person even if the elderly person becomes more dependent. 65% of those who would prefer their dependent to move into residential care when the elderly person becomes increasingly dependent would continue to provide care if sufficient community support was available to assist them.

- 3.35 The elderly themselves have a strong preference to remain at home even when they become more dependent. 87% of the respondents of the Community Survey were satisfied with current living arrangements, whilst 89% had not considered moving out of their current type of residence. Of those who had considered moving out, only 13% considered residential care homes as an option.

- 3.36 These findings suggest that the Government policy of ageing in place is one that is favoured by the population. In order to support this policy, the Government should provide services that would support caregivers to sustain the current level of informal care.

#### **Expectation of Government Provision of Elderly Services**

- 3.37 The elderly population has a high expectation of the Government to provide services to the elderly. Between 71% and 89% of respondents of the Community Survey felt that the Government should provide certain services, although they also felt that services should be provided by themselves and the family as well. For five of the seven services examined (financial support, housing, residential care, transportation, medical services, but not home help, social/recreational/educational services), between 17% and 31% more respondents felt the service should be provided by

---

<sup>47</sup> Chi, Iris, Yip, Paul S.F., and Yu, Gabriel K.K., *Elderly Suicides in Hong Kong*, Befrienders International, 1997.

### **3. Service Development (Cont'd)**

---

Government rather than by family or themselves. This view was supported by focus group participants who felt that they had an entitlement to Government provided services, having paid taxes. Many focus group participants felt that the Government might be a more reliable source of support than family in the future.

- 3.38 Expectations of the Government to provide elderly services need to be managed through education programmes to clarify the responsibility and obligation of the Government. Emphasis on informal care based on the traditional Chinese values should be reflected through Government policy positioning formal services only as a support to existing care arrangements.

#### **Living Arrangements of Elderly in the Community**

- 3.39 Despite a strong presence of family support, the Community Survey identified a significant proportion of elderly people who lived alone or had limited access to informal care. 9% of the population aged 60 or over were identified as living alone and 13% of the elderly population live with only their spouse or one sibling. The focus group discussions also highlighted that the next generation of the elderly prefer to live apart from their children to maintain their independence and good relationships with their children.
- 3.40 As a vulnerable group with limited informal care support, priority for services should be given to this group.

#### **Lack of Awareness of Formal Services**

- 3.41 A portion of the elderly people in the community who think they have a need for community services were not using available services because they were unaware of formal services or did not know how to apply for them. This was the reason given by 15% of the elderly respondents of the survey who thought they needed assistance with household chores and gave a reason for not receiving it. 48% of the people who felt that they needed medical or nursing attention at home reported that they did not know that this service is available. 50% of those who felt they required day care support and gave reasons for not receiving it, reported that they were unaware of this service or how to apply for it.
- 3.42 The lack of awareness of formal services suggests a requirement to enhance community education and information programmes to increase awareness of services. However, the elderly in the community have a generally low level of educational attainment, 84% having less than a secondary school education. This makes them more vulnerable and makes community education programmes more challenging.

#### **Reasonable Level of Income Support**

- 3.43 The Community Survey collected information on the income of the elderly population. Assets and the level of family support available in terms of financial

### 3. Service Development (Cont'd)

---

assistance, other than that reported as income by the elderly person, was not collected. However, 76% of the elderly respondents said that they have just enough, enough, or more than enough funds to make ends meet.

- 3.44 Based on this information, there is scope to expand means testing to focus public funding on the most financially dependent. The focus group discussions revealed that users would be willing to contribute to the cost of care, providing individual financial circumstances permit. However, the Residential Care Survey revealed that 71% of the total residents in residential care are receiving Comprehensive Social Security Assistance (CSSA). This suggests either a high level of poverty or loose application of means testing amongst the residential care population.

#### **Commentary on Current Services**<sup>48</sup>

- 3.45 The following observations on the existing profile of services were drawn from the interview programme, site and service visits, the Report of the Working Group on Care for the Elderly, submissions from non-governmental organisations (NGOs) and other interested parties, evidence from the surveys and focus group discussions and literature research.

#### **Comparison of Service Provision and Funding With Those of Other Countries**

##### ***Service Provision***

- 3.46 Many industrialised countries are emphasising care in the community rather than in residential settings in support of an ageing in place policy. As a result, there is a shift towards providing services to complement family care in these countries. Like Hong Kong, these countries depend on significant input from informal and unpaid caregivers to care for their elderly population.
- 3.47 Main trends in service provision in the industrialised countries surround the development of alternative facilities outside hospitals for long-term nursing care with the expansion of domiciliary nursing services, the expansion and specialisation of home care services, development of an improved housing infrastructure for older people, and extension of cash support available to disabled people and to those who give up work to care for disabled people.
- 3.48 The standard of subvented and self-financing facilities in Hong Kong is generally regarded as good which is supported by our own observation. However, in comparison to other countries such as the U.K. or U.S., residents in care and attention homes, in particular, did not appear to be as dependent. Furthermore, the homes visited had no links with other community-based services as they do, for example, in the U.K. Such links can provide the opportunity for service providers to benefit from economies of scale and scope.

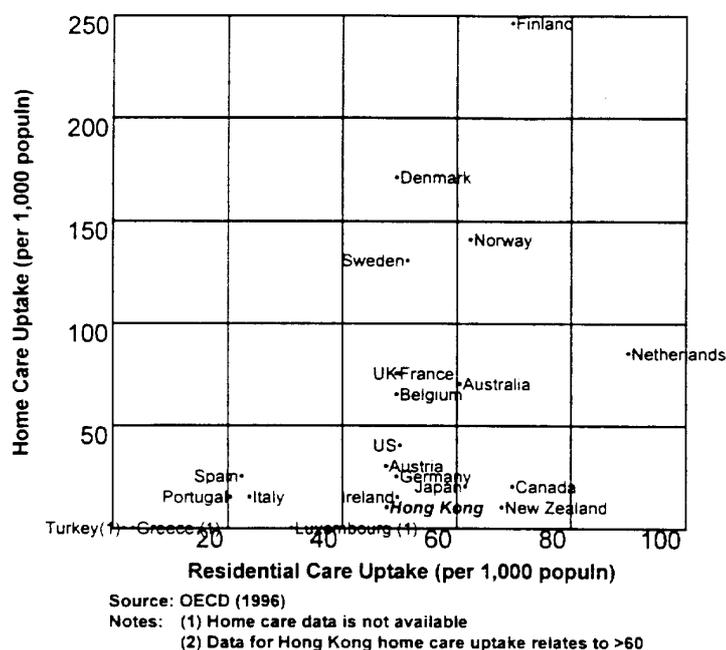
---

<sup>48</sup> Volume 1, Section 8

### 3. Service Development (Cont'd)

- 3.49 Hong Kong has an institutionalisation rate of 3.8% for those aged 60 and above (or 5.1% for those aged 65 and over). The proportion for those aged 65 and over is comparable to many industrialised countries, as the median figure for the proportion of elderly people (those aged 65 or above) receiving institutional care for 20 OECD countries is 5.5%. Countries such as Australia, Denmark, France and Sweden have a strong policy emphasis on expanding home care services and have reduced the proportion of elderly in residential care.
- 3.50 The extent of home care services varies amongst many OECD countries. Home help services in Hong Kong are provided to less than 1% of the elderly population aged 60 or above.<sup>49</sup> Although data on the level of specialised non-institutional services is very limited, Hong Kong appears to be providing a significantly lower level of home care than other developed countries, especially given the expressed policy of ageing in place.
- 3.51 Figure 11 shows the relationship between the level of home care and the rate of institutionalisation for 12 OECD countries and Hong Kong.

**Figure 11: Relationship Between Uptake of Residential Care and Uptake of Home Help Services**



<sup>49</sup> Estimated figures for those aged 65 and over receiving home help services is not available.

### **3. Service Development (Cont'd)**

---

#### *Nature of Funding*

- 3.52 There is a range of user contribution schemes to support the cost of elderly services in other countries. Some countries, such as Australia, Canada and Nordic countries, supply social services to elderly people with no user charge, other than a proportion of the public retirement pension. In other countries, such as France and Singapore, financial responsibility is extended to family members where a significant part of the cost is met by the user, with only low-income elderly receiving long-term care without charge on social assistance terms.
- 3.53 Means testing on income and assets is widely used in other countries to determine the level of user contributions to the cost of services. Some countries require the running down of assets to a considerable degree before public assistance is provided.

#### **Fragmentary Delivery Of Services**

- 3.54 Hong Kong has developed a wide range of elderly services. However, the provision of services is fragmentary and often lacks co-ordination in terms of policy and implementation resulting in limited flexibility and comparatively low volume of provision. The existing delivery model tends to compartmentalise elderly needs, which in fact are often interconnected. The fragmentation is often between services and district boundaries. There is a sense of confusion of roles of services and a lack of co-ordination and understanding among different service providers. For example, home help services to escort an elderly to a day care centre may be available at 7 a.m. whereas day care centres do not open until 8 a.m.
- 3.55 There is also a lack of co-ordination between Government departments and non-governmental organisations (NGOs). Examples of this are in the conflicting objectives of the Hospital Authority and Social Welfare Department on the hospitalisation and timely discharge of frail elderly people when home help or community nursing support is unavailable, the overlap between the Social Welfare Department and Housing Authority on the responsibility for accommodating non-dependent elderly people, and the overlap between the elderly services division and rehabilitation division of the Health and Welfare Branch on responsibility towards the elderly mentally infirm. As a result, there is a need for a centralised co-ordinating body in the Government to oversee the delivery of elderly services.

#### **Continuum of Care Model vs. Current Provision of Services**

- 3.56 Despite the wide acceptance of a continuum of care model as an optimal model proposed in the recommendations of the 1994 Working Group on Care for the Elderly, there is little evidence that this is being realised. In the residential care sector, the model is in existence in the private sector given the range of dependent clients these facilities support based on the findings of the Residential Care Survey and in the subvented sector through infirmary care supplements. However, the quality of care

### 3. Service Development (Cont'd)

---

provided by the private sector is considered to be poor and the care and attention infirmity care supplements are theoretically an interim measure.

- 3.57 The continuum of care model is less apparent in the community based services. Services are fragmented and delivered by different Government organisations. Most of the elderly services are under the jurisdiction of the Elderly and Medical Social Services Branch of the Social Welfare Department. However, domiciliary care, which is a cornerstone of a successful ageing in place policy, is currently delivered through home help services under the Family and Child Welfare Branch of the Social Welfare Department.
- 3.58 Other community based services such as day care, multi-service centres and social centres are able to provide varying degrees of care to support the needs of the elderly in the community. Day care, in particular, is designed to cope with those who are impaired and require a high level of care and supervision. However, the service has limited opening hours and clients need to be reasonably mobile to access the service. Home help services, which seem to serve mutually exclusive yet similar groups of clients to day care, are not formally linked to day care services. Elderly in the community with care needs and restricted carer availability could benefit from a tailored package incorporating both types of services.
- 3.59 For example, an elderly person who has an informal carer who is a part-time worker and works two full days a week, may require day care when the informal carer is at work, whilst during the remainder of the week the carer may require support in the form of domiciliary care. Under the current situation, home help and day care services would be applied for and providers would assess needs separately. Our proposed recommendation suggests integrating the application and referral into a single delivery mechanism so that a package that meets the needs of the elderly can be coordinated.
- 3.60 There is also some duplication of service delivery between existing social centres and multi-service centres in terms of the social recreational activities provided to the ambulatory and independent elderly. These services are the main vehicles for delivery of psycho-social support to the elderly population in Hong Kong as there are 198 social centres and 27 multi-service centres located across the territory. There is more limited support in terms of canteen services, education programmes and counselling to the population as these are primarily offered in multi-service centres.
- 3.61 The distribution of elderly services in Hong Kong varies by district. The discrepancy in residential care is in part attributable to the availability of suitable sites for residential care facilities. Among the community based services, many elderly people are denied service due to service resource constraints or the requirement to be relatively mobile.

### 3. Service Development (Cont'd)

---

- 3.62 It will be critical to the sustainability of the continuum of care model in the community that services are integrated and inter-agency referrals are efficient to reduce service boundaries so that clients are able to access the most appropriate combination of services to meet their needs and the nearest services, even if they are technically in another service catchment area.

#### **Service Gap to the Cognitively Impaired**

- 3.63 The continuum of care model extends services to those with any degree of impairment, yet there seems to be a service gap for the cognitively impaired. From the survey results and interview and site visitation programme, elderly people with cognitive impairment have limited access to care services and are provided with limited care services from which to choose. Most residential care facilities are reluctant to accept elderly people with severe cognitive impairment as they are not seen to be “mentally suitable for communal living”. This is borne out by the evidence from the Residential Care Survey that a much smaller proportion of elderly with a high degree of cognitive impairment are in residential care compared to those with high physical dependence. Other community support services also find it difficult to care for those with moderate or severely cognitive impairment.

#### **Medical Care Support**

- 3.64 There is limited access to primary and outreach medical care in Hong Kong which is perceived to be an issue by many professionals and service providers. In our view, a lack of adequate medical support to existing community based services and dependent elderly people in their homes poses a barrier to developing community based care services and impacts the development of a continuum of care model.
- 3.65 The delivery of existing outreach medical care in the community is primarily provided by the Community Geriatric Assessment Teams (CGATs) and community nurses.<sup>50</sup> CGATs provide a valuable service to subvented residential care facilities, although only limited support is provided to private homes. Likewise, community nurses make access to medical care easier, especially to those who find it difficult to attend outpatient clinics and require nursing care and treatment. However, these nurses are dependent on hospital specialists to provide them with advice and support with respect to patients who they are visiting.
- 3.66 A lack of medical domiciliary care limits the scope to pursue an ageing in place policy and creates a higher burden on residential care places and a high utilisation of accident and emergency services. The difficulty in escorting frail elderly to outpatient clinics hinders attendance for medical care and potentially jeopardises the health conditions

---

<sup>50</sup> Other modalities of community care include psychogeriatric teams, community psychiatric nursing, domiciliary occupational therapy and domiciliary physiotherapy services and outreaching services provided by medical social workers.

### 3. Service Development (Cont'd)

---

of these people. It also imposes a heavy burden on escort services. With a demand for home help services and limited resources, services compete with each other for staff time.

#### **Service Development Recommendations** <sup>51</sup>

- 3.67 Under a revised system of delivery, formal health and welfare care should be delivered by the following services.
- 3.68 **Residential care**, which will be provided for people with a high level of disability and limited available informal care. This will be developed along a continuum of care model under which there will be no distinction between that which is provided by private and subvented organisations. There will also be little distinction between the types of facilities, with all facilities designed to care for residents for the remainder of their lives and as their disabilities increase.
- 3.69 **Day care**, which will be provided for people with moderate levels of disability who have care givers who are unable to provide care during the day. These will be based on the existing day care service, but will have additional regular medical and psychogeriatric support from Community Geriatric Assessment Teams (CGATs) and Psychogeriatric Assessment Teams (PGATs).
- 3.70 **Domiciliary care**, which will be provided to assist carers of moderately and severely impaired elderly people, who are not accommodated in residential care, with activities of daily living. The emphasis of these services will be on providing more support to carers and, in particular, providing assistance with activities of daily living. The new service will be based on the existing home help service teams, but with lower case loads to enable them to provide more intensive personal care, and with more volunteer support to provide meal delivery and escort services. This volunteer support will be co-ordinated through the revised social centre model.
- 3.71 **Community centres for the elderly**, which will act as a drop in facility for elderly people but will also become a nucleus for a citizens' advice service. The existing **multi-service centres** will be retained in a modified form as expanded social centres providing meals and social support. Social and recreational programmes will be specifically designed to fulfil emotional and leisure needs, and will be taken out into the wider community.
- 3.72 **Elderly primary care centres**, which will be the focus for co-ordinating and delivering primary medical care and community nursing services to elderly people living in the community and in residential care. Specifically they will provide primary medical advice and support to domiciliary day care services, day care centres,

---

<sup>51</sup> Volume 1, Section 10

### **3. Service Development (Cont'd)**

---

and residential care facilities to support the assessment and secondary medical care activities of the CGATS. Elderly primary care centres will be developed from the existing Elderly Health Centre model and will run on a membership basis.

## 4. A Base Case Scenario

---

### **Introduction**

- 4.1 A Base Case Scenario built on a continuum of care residential care and assisted community living model has been developed to project the quantity of services needed to care for the elderly population in Hong Kong. The projections are for long term planning purposes only and should not be used as operational guidelines. The scenario is a snapshot of what the mix of provision would be for the 1996 population of elderly people based on a number of assumptions described in Section 3. Age specific planning ratios have been developed to allow projections of provision for future population sizes.
- 4.2 Two alternatives to the Base Case Scenario have also been built in order to explore the effects on volume and cost of services of alternative service mixes, based on judgements about what would be the most appropriate mix to support the four principles of ageing in place, the role of the family, continuum of care and a mixed economy of provision.

### **Prevalence of Impairment Levels and Informal Care Availability**<sup>52</sup>

- 4.3 As discussed in Section 2, translating needs into formal services is achieved by determining the prevalence of impairment levels and informal caregiver availability by age group for the elderly population using data from the Community and Residential Care Surveys.
- 4.4 Figure 12 presents an analysis of the elderly population by level of impairment and by care profile<sup>53</sup>.

---

<sup>52</sup> Volume 2, Section 4

<sup>53</sup> Equivalent analyses for each age band are included in the Appendix to Volume 2.

**4. A Base Case Scenario (Cont'd)**

**Figure 12: Prevalence of Impairment/Care Profile in Entire Elderly Population (Sum of Community and Residential Care Populations)<sup>54</sup>**

Aged 60 and Over						
Level of Impairment	Care Profile					Total
	At least one carer who lives in and has no other employment	At least one carer who lives in but has other part-time employment	At least one carer who lives in but has other full-time employment	At least one carer, but who lives out	None Available	
<b>5b</b>	5,156	0	3,874	0	14	9,043
<b>5a</b>	6,438	437	3,437	873	7,811	18,995
<b>4</b>	2,564	0	873	0	5,710	9,147
<b>3</b>	13,360	1,282	7,765	437	3,045	25,888
<b>2</b>	10,669	845	5,976	0	7,770	25,260
<b>1</b>	85,589	7,712	50,485	1,282	16,698	161,765
<b>0</b>	569,099			70,518		639,617
						889,717

N.B. The numbers have been rounded to the nearest whole number

**Base Case Scenario**

**Service Provision<sup>55</sup>**

4.5 The prevalence of impairment/care profile in the entire elderly population combined with the care plans devised for the Base Case Scenario<sup>56</sup> translate into the proposed volume of services presented in Figure 13.

<sup>54</sup> See Figures 4, 5, 6 of the Appendix to Volume 2 for Number of Elderly in the Community and Residential Care.

<sup>55</sup> Volume 2, Section 5

<sup>56</sup> Executive Summary, Section 2, Figure 6

#### 4. A Base Case Scenario (Cont'd)

**Figure 13: Proposed Service Provision**

**Base Year:1996**

Type of Formal Care	Unit	Proposed Provision					Current Provision	Estimated Provision for 65+ <sup>57</sup>
		60-64	65-74	75+	60+	65+	31 March, 1997	31 March, 1997
Residential Care	Elderly Person	1,954	7,043	24,842	33,839	31,885	41,243[1]	42,357[2]
Day Care	Elderly Person	0	409	873	1,282	1,282	1,040[3]	1,480[3]
Domiciliary Care	Elderly Person	2,438	9,021	24,264	35,723	33,285	8,882[4]	6,344[5]
Community Centres for the Elderly	Elderly Person	46,675	82,923	53,849	183,447	136,773	111,888[6]	172,345[7]
<b>Total</b>	Elderly Person	<b>51,067</b>	<b>99,396</b>	<b>103,828</b>	<b>254,291</b>	<b>203,225</b>	163,053	222,526

[1] Includes 6,659 places in homes for the aged, 7,629 places in care and attention homes, 987 places in hostels for the elderly, 2,041 places in self-financing homes, 1,772 infirmary beds and 22,155 places in private homes (of which 1,200 are bought places).

[2] Includes 20,202 subvented places (based on a planning ratio of 32 places per 1,000 population aged 65 or over) and 22,155 existing private home places.

[3] Based on a capacity of 40 people at each day care centre.

[4] Based on existing number of 122 teams, each team supporting 91 cases, where 80% of all home help cases are elderly cases.

[5] Based on existing number of 122 teams, each team supporting 65 cases, where 80% of all home help cases are elderly cases.

[6] Based on 31 March 1997 figures of 27 multi-service centres with 1,042 members per centre and 198 social centres with 423 members per centre. Membership figures are as of 31 March, 1996 as updated figures are not available.

[7] Based on the planning ratios of social centres (1 centre per 2,000 65+ elderly, each centre supporting 423 members as of 31 March, 1996) and multi-service centres (1 centre per 17,000 65+ elderly, each centre supporting 1,042 members as of 31 March, 1996). The combined planning ratio is 273 members per 1000 elderly population aged 65 and over.

4.6 There is adequate gross provision of residential care based on the proposed volume of services under the Base Case Scenario and current provision. However, the model proposes services that are targeted towards elderly who differ from the current recipients of residential care. In the Base Case, services are only provided for those with impairment levels 3 and above. The re-profiling of residents in residential care and converting homes to provide suitable care according to the proposed model will

<sup>57</sup> Based on applying current planning ratios to the 1996 mid-year population estimates of elderly people aged 65 or over (631,300 based on 1997 Census and Statistics Population Projection).

#### 4. A Base Case Scenario (Cont'd)

only be achieved over time when new admission criteria are implemented and the existing elderly with lower impairment levels die or are rehoused in the community.

- 4.7 The proposed volume of community services is much higher than current provision. This suggests that community based services are most in need of expansion as already highlighted in the discussion of the need for a continuum of care service delivery model.

#### Planning Ratios

- 4.8 Figure 14 shows the proposed planning ratios for the Base Case Scenario which have been derived from the volume of proposed services and the size of the elderly population in 1996.

**Figure 14: Proposed Planning Ratios for Base Case Scenario**

		Proposed Planning Ratios By Age Group					Current Planning Ratios (as of 31 March 1997)	Actual Provision to 1,000 Population Aged 65+ (as of 31 March 1997)
Type of Formal Care	Unit	60-64	65-74	75+	60+	65+	65+	65+
Residential Care	Place Per 1,000 Elderly Population	8	18	109	38	54	32*	54 <sup>⊕</sup>
Day Care	Place Per 1,000 Elderly Population	0	1	4	1	2	2	2
Domiciliary Care	Person Per 1,000 Elderly Population	9	22	106	40	57	-	14
Community centres for the elderly	Place Per 1,000 Elderly Population	181	206	235	207	291	273	177

N.B. Figures are rounded to the nearest whole number.

\* Subvented only.

⊕ Including private sector.

#### 4. A Base Case Scenario (Cont'd)

---

- 4.9 The planning ratios increase with age, with a significant increase in provision to those aged 75 or over. This reflects the link between impairment and age. As expected, a low level of services is required for those aged 60 to 64.

##### **Cost of Proposed Service Volume**

- 4.10 The estimated unit costs of services are summarised in Figure 15. These figures are based on a set of assumptions summarised in Section 2 of this Executive Summary and presented in detail in Volume 2 of the report.

**Figure 15: Unit Cost of Service Per Annum**

Type of Service	Unit	Operating Cost Less Cost of Premises	Cost of Premises [Market Value]	Total Cost Per Unit
Residential Care	place	\$120,288	\$48,101	\$168,389
Day Care	place	\$70,768	\$24,734	\$95,502
Domiciliary Care	person	\$29,855	\$5,268	\$35,123
Community Centre for the Elderly	place	\$2,825	\$1,248	\$4,073

- 4.11 The unit cost of residential care is based on a weighted average of the cost of a place in a care and attention home of \$124,926 per annum and the unit cost of a place in a nursing home of \$212,968 per annum, plus an allowance for the infirmary care supplement.
- 4.12 Given that people will require different levels of domiciliary care, depending upon their levels of impairment and informal care, it is likely that there would be a wide range of costs per person for domiciliary care.
- 4.13 The proposed volume of services and the estimated unit costs of services result in the total cost of services in Figure 16.

**Figure 16: Cost of Services**

Type of Formal Care	Units	Unit Cost	Annual Cost of Proposed Provision (\$ million)			
		(\$ p.a.)	60-64	65-74	75+	Total
Residential Care	Place	168,389	262.5	1,169.9	4,265.6	5,698.1
Day Care	Place	95,502	0	39.0	83.4	122.4
Domiciliary Care	Person	35,123	85.6	316.9	852.2	1,254.7
Community Centres for the Elderly	Place	4,073	190.1	337.8	219.4	747.3
<b>Total</b>			<b>538.3</b>	<b>1,863.6</b>	<b>5,420.6</b>	<b>7,822.5</b>
<b>Average Cost Per Elderly Person (\$ Per Annum)</b>			<b>2,082</b>	<b>4,630</b>	<b>23,691</b>	<b>8,791</b>

- 4.14 The total cost of services to meet the needs of elderly people is approximately \$7.8 billion. Of the \$7.8 billion, 69% would be used to provide services to those over 75 years of age. This figure cannot be compared directly with current Government spending because it includes: the cost of services provided by the private sector; fees paid by recipients; other unsubvented costs; and the cost of land and premises not reflected in Government expenditure figures.
- 4.15 Residential care accounts for 73% of the total cost and residential care for those aged 75 and over accounts for 55% of the total cost.
- 4.16 Despite these high cost figures, cost savings may arise from improved co-ordination of providing access to services, improved co-ordination of the services themselves, moving away from the current inputs control model of purchasing to a bought place model, and moving long term care patients from infirmaries to residential care.

**Projected Service Volume and Cost**

- 4.17 A ten year projection of service volume and cost by type of service, by year and by age group was prepared by applying the proposed planning ratios to population projections of the elderly and to unit costs stated in 1996 prices. Figure 17 shows the annual average percentage increases in service volume for each type of service, by age group, over the planning time frame. Figure 18 shows the projected required provision of services in 2006 by type of service, by age group.

#### 4. A Base Case Scenario (Cont'd)

**Figure 17: Percentage Increases in Service Provision - 1996 - 2006**

Type of Formal Care	Annual Average Percentage Increase			
	60-64	65-74	75+	Overall
Residential Care	0.21%	1.39%	4.88%	4.00%
Day Care	0%	1.39%	4.88%	3.88%
Domiciliary Care	0.21%	1.39%	4.88%	3.81%
Community Centres for the Elderly	0.21%	1.39%	4.88%	2.26%

4.18 Overall, the average annual increase for each type of service has been estimated to be approximately 4% with the exception of community centres for the elderly, with a small increase in service provision of 0.21% in the 60 to 64 age group. The demand for additional services is driven by the need for services to meet the needs of those aged 75 and over.

4.19 Assuming a stable unit cost, the planning model predicted an average annual real increase in total service cost of 4% over the next 10 years. The annual percentage increase in cost directly reflects the increase in the volume of service.

**Figure 18: Projected Required Provision of Services in 2006**

Type of Formal Care	Unit	Provision of Services			
		60-64	65-74	75+	60+
Residential Care	Place	1,988	8,081	39,999	50,067
Day Care	Place	0	469	1,406	1,875
Domiciliary Care Services	Place	2,480	10,350	39,069	51,900
Community centres for the elderly	Place	47,487	95,140	86,705	229,332

#### **Alternative Scenarios**<sup>58</sup>

4.20 The Base Case Scenario presents one combination of care plans designed to meet the needs of the elderly. There are many such combinations<sup>59</sup> and views as to which is the most appropriate will differ between professionals. Each Scenario involves

<sup>58</sup> Volume 2, Section 6

<sup>59</sup> Volume 2, Section 5, Figure 23.

#### 4. A Base Case Scenario (Cont'd)

---

choices of service provision based on policy decisions and requires debate on priorities which are complex and which must involve many stakeholders.

- 4.21 The report presents two alternatives to the Base Case Scenario to illustrate the effect that two examples of the many alternatives that are available to Government would have on the level of provision and cost of services to support the care needs of the elderly population.

#### Service Provision

- 4.22 As indicated by Figure 19, Alternative 1 shifts the burden of care from informal caregivers to providers of formal care, by increasing provision of services to those with lower levels of impairment who have no or limited access to informal care and extending residential care services to those highly impaired with a caregiver who is employed part-time.
- 4.23 As indicated by Figure 21, Alternative 2 reduces the level of institutionalisation by providing community support services to a portion of elderly people who would receive residential care under the Base Case Scenario.

**Figure 19: Impairment Level vs. Availability of Informal Care (Alternative Scenario 1)**

Impairment	Care Profile				
	At least one carer who lives in and has no other employment	At least one carer who lives in but has other part-time employment	At least one carer who lives in but has other full-time employment	At least one carer, but who lives out	None Available
5b	DC	RC	RC	RC	RC
5a	DC	RC	RC	RC	RC
4	DC	DE	RC	RC	RC
3	DC	DE	RC	RC	RC
2	CC	CC	DC	DE	DE
1	CC	CC	CC	DE	DE
0	CC	CC	CC	CC	CC

Note: RC=Residential Care; DC=Domiciliary Care; DE=Day Care; CC = Community Centres

#### 4. A Base Case Scenario (Cont'd)

**Figure 20: Impairment Level vs. Availability of Informal Care (Alternative Scenario 2)**

Impairment	Care Profile				
	At least one carer who lives in and has no other employment	At least one carer who lives in but has other part-time employment	At least one carer who lives in but has other full-time employment	At least one carer, but who lives out	None Available
<b>5b</b>	DC	DC	RC	RC	RC
<b>5a</b>	DC	DC	RC	RC	RC
<b>4</b>	DC	DE	DE	RC	RC
<b>3</b>	DC	DE	DE	RC	RC
<b>2</b>	CC	CC	CC	CC	DC
<b>1</b>	CC	CC	CC	CC	CC
<b>0</b>	CC	CC	CC	CC	CC

Note: RC=Residential Care; DC=Domiciliary Care; DE=Day Care; CC = Community Centres

#### Planning Ratios

4.24 The service provision under Alternative Scenario 1 results in the planning ratios for domiciliary care and community centres for the elderly being lower than those under the Base Case Scenario. The planning ratio for residential care remains the same as the Base Case Scenario, despite the provision of residential care to those of level 5 impairment who have a live in carer who has other part-time employment. This is because of the low number of people with these characteristics. However, there is a significant increase in the provision of day care to the elderly population from 2 places per 1,000 population aged 65 and over in the Base Case to 43 places per 1,000 population aged 65 and over (Figure 21).

#### 4. A Base Case Scenario (Cont'd)

**Figure 21: Planning Ratios (Alternative Scenario 1)**

		Planning Ratios						
		Alternative Scenario 1					Base Case	Current (as of April 1997)
Type of Formal Care	Unit	60-64	65-74	75+	60+	65+	65+	65+
Residential Care	Place/1,000 elderly	8	18	110	39	54	54	32*
Day Care	Place/1,000 elderly	8	21	73	30	43	2	2
Domiciliary Care	Person/1,000 elderly	12	24	90	38	53	57	-
Community Centres for the Elderly	Place/1,000 elderly	174	190	191	185	261	291	273†

N.B. Figures are rounded to the nearest whole number.

\* Subvented only

† Based on Social Centres for the Elderly and Multi-service Centres.

4.25 Alternative Scenario 2 significantly increases the requirement for day care centres compared to the Base Case, whereas the need for residential care places is reduced as community support is provided in place of residential care. This is reflected in the planning ratios for this alternative (Figure 22).

#### 4. A Base Case Scenario (Cont'd)

**Figure 22: Planning Ratios (Alternative Scenario 2)**

		Planning Ratios						
		Cost Neutral					Base Case	Current (as of April 1997)
Type of Formal Care	Unit	60-64	65-74	75+	60+	65+	65+	65+
Residential Care	Place/1,000 elderly	2	12	86	28	40	54	32*
Day Care	Place/1,000 elderly	5	6	27	11	16	2	2
Domiciliary Care	Person/1,000 elderly	9	22	106	40	57	57	-
Community Centres for the Elderly	Place/1,000 elderly	181	206	235	207	291	291	273†

N.B. Figures are rounded to the nearest whole number.

\* Subvented only

† Based on Community Centres for the Elderly and Multi-service Centres.

#### Cost of Services

- 4.26 The estimated cost of services for Alternative Scenario 1 is \$10.2 billion, which includes the cost of premises. The shift of the burden from the family increases the need for day care places significantly. Day care places, being the second most expensive service provided under this model, contribute the most to the large increase in the cost of services.
- 4.27 However, under this scenario, the level of support provided by day care centres could be different between those supporting elderly people with impairment levels 3 or 4 and those with impairment levels 1 or 2. As the elderly who have level 1 or 2 impairment are less dependent than those with levels 3 or 4 impairment, they may be able to be supported in day care centres designed to meet their particular care needs at lower cost. The Planning Model has not taken into account any decreased cost of these day care centres.
- 4.28 As less expensive services are provided to support the elderly in the community as an alternative to expensive residential care, the total cost of Alternative Scenario 2 is reduced to \$7.6 billion as compared to the Base Case Scenario.
- 4.29 Under this scenario, the level of support provided by day care centres will need to be different between those supporting elderly people with impairment levels 3 and 4 and those with impairment levels 5a and 5b. As the elderly who have level 5a or 5b impairment are more dependent than those with levels 3 and 4 impairment, they may need to be supported in day care centres designed to meet their particular care needs.

#### **4. A Base Case Scenario (Cont'd)**

---

The Planning Model has not taken into account any increased cost of these day care centres.

## 5. Funding Scenarios

---

### **Introduction**

- 5.1 In Hong Kong, the Government meets most of the cost of elderly services. Recipients of services currently contribute a small portion of the cost of care and charitable donations also provide some support.
- 5.2 Given the size of the difference between the cost of the Base Case Scenario and current Government expenditure, Government's limited resources and its policy of ensuring growth in public expenditure does not exceed growth in gross domestic product, Government must consider alternative levels of provision and the impact of the trade-offs between services and clients which must be made in determining the most appropriate level of provision.
- 5.3 This section identifies the sources of funds available to meet the cost of care for the elderly and estimates the size of the funding gaps for two service provision scenarios and different funding scenarios to meet the cost of services. It also highlights the need to reduce the unit cost of provision as a way to reduce the funding gap.

### **Sources of Funds**<sup>60</sup>

- 5.4 The sources of funding identified for the provision of residential and community services to the elderly are:
- Government expenditure;
  - funds from users, i.e., service fees; and
  - charitable donations.

### **Government Expenditure**

- 5.5 The estimated current Government expenditure on elderly social welfare services for the base year 1996 is \$2.3 billion per annum. Figure 23 summarises the components of Government expenditure<sup>61</sup>.

---

<sup>60</sup> Volume 3, Section 2

<sup>61</sup> The estimated annual Government expenditure on elderly services does not include allocations of the Lotteries Fund as the funds allocated are primarily used to pay for the capital costs of new projects. Since the total estimate of Government expenditure includes the opportunity cost of premises, there would be an element of double counting if the amounts allocated from the Lotteries Fund were also included.

## 5. Funding Scenarios (Cont'd)

**Figure 23: Estimate of Current Government Expenditure on Welfare Services for the Elderly (1996/7)**

Description	Reference	Annual Expenditure (\$ million)
Financial provision for elderly services	1996/7 Controlling Officer's Report and adjusted by the Finance Division of the Social Welfare Department	1087.8
Financial provision for medical social services	1996/7 Controlling Officer's Report and adjusted by the Finance Division of the Social Welfare Department	72.8
Financial provision for home help services to the elderly	1996/7 Controlling Officer's Report and adjusted by the Finance Division of the Social Welfare Department	178.8
Estimated annual recurrent cost of proposed nursing homes	Department of Health-Nursing Home Projects	199.6
Financial provision for infirmary beds in hospitals	Hospital Authority-1996/7 Allocation for 500 Infirmary Beds <sup>62</sup>	171.9
Market cost of premises	Rating and Valuation-Average Rentals of Private Domestic Premises 40 to 69.9 sq. m. (April 1997) <sup>63</sup>  Public rental housing estates domestic rent	568.0
<b>Total</b>		2,278.9

5.6 \$2.3 billion per annum is equivalent to \$2,561 per elderly person based on the population published by the Census and Statistics Department<sup>64</sup>. If Government continues to spend this amount per annum per elderly person, based on the population projections published by the Census and Statistics Department<sup>65</sup>, total Government expenditure on welfare services for the elderly will increase at an annual average of 2% over the period 1996 to 2006. This would result in total expenditure in 2006 amounting to \$2,799 million.

5.7 An annual average increase in expenditure of 2% compares with an annual average increase in the cost of the Base Case Scenario over the same period of 3.82%. The

<sup>62</sup> Based on information from the Health and Welfare Branch.

<sup>63</sup> Hong Kong Monthly Digest of Statistics, April 1997, Census and Statistics Department, Hong Kong.

<sup>64</sup> Hong Kong Population Projections - 1997-2016, Census and Statistics Department.

<sup>65</sup> Hong Kong Population Projections - 1997-2016, Census and Statistics Department.

## 5. Funding Scenarios (Cont'd)

annual average increase in expenditure of the Base Case Scenario is higher than that of Government expenditure since it takes into account both the increasing size of the elderly population and the increasing average age of the elderly population, whereas the annual average increase in Government expenditure only takes into account the increasing size of the elderly population.

### Funds from Users

- 5.8 We have assessed the ability of elderly people to pay for services they use based on data collected through the Community and Residential Care Surveys and on the premise that elderly people should pay for their use of services to the extent that they are able to do so. From this assessment, which is subject to a number of limitations, we have estimated the funds which are potentially available from users to contribute to the cost of services.
- 5.9 Based on data from the Community and Residential Care Surveys and a number of assumptions, we have estimated that funds available from fees for the base year 1996 may amount to \$935 million based on the level of provision of services as per the Base Case Scenario. This total is analysed by age band and type of service in Figure 24 below.

**Figure 24: Scope of Fees - Base Base Scenario - 1996**

Type of Formal Care	Units	Average Contribution/ User Per Annum (\$)	Annual Fee Contribution to Proposed Provision (\$ million)			
			60-64	65-74	75+	Total
Residential Care	Place	12,361	32.1	92.6	293.6	418.3
Day Care	Place	3,692	-	3.1	1.7	4.7
Domiciliary Care	Person	3,706	18.7	59.1	54.6	132.4
Community Centre for the Elderly	Place	2,071	150.8	170.1	59.1	380.0
<b>Total</b>			<b>201.6</b>	<b>324.9</b>	<b>409.0</b>	<b>935.4</b>
Average Fee Contribution per Elderly Person (\$/Annum)			780	807	1,788	1,051

- 5.10 As the analysis used to estimate the potential for fee charging is based on data which is subject to a number of limitations, the results may not accurately reflect the ability of the elderly to contribute to the cost of services they use.

## 5. Funding Scenarios (Cont'd)

---

- 5.11 The income of those in the community is based on self-reported information by respondents in the Community Survey<sup>66</sup> which may be inaccurate, excludes assets and does not take into account support from the family. Furthermore, although the total sample used in the Community Survey is representative of the total population, the numbers of elderly in each level of impairment are relatively small, particularly at the higher levels of impairment by age band.
- 5.12 The only data collected by the Residential Care Survey on the income level of residents was the number of residents who were in receipt of CSSA. Furthermore, the survey did not collect data on the relationship between the level of impairment and those in receipt of CSSA.
- 5.13 To determine the income profile of those in residential care the following assumptions were made:
- the penetration of CSSA found in the Residential Care Survey is representative of that for all elderly people in residential care and was evenly distributed across all impairment levels and age bands;
  - the income level of the 71% of residents receiving CSSA falls within \$2000-2999 per month;
  - the monthly income level of the remaining 29% in residential care falls within the income band of \$3,000 to \$3,999 per month.
- 5.14 The income profiles derived from the data collected by the Residential Care Survey and these assumptions may not accurately reflect the ability of the elderly currently in residential care to contribute to the cost services they use.
- 5.15 The calculations above do not take into account the elasticity of demand for services. In practice, those in need of services who can afford to contribute to the cost of the services they use, or who can afford to pay for the full cost of these services, will decide whether they want to pay the fee, or whether they will meet their need by means other than through the use of formal services. For example, a person who is eligible for residential care may choose to be supported by a live in maid rather than leave his/her home if he can afford to do so. Similarly, someone who is eligible to use a community centre because they live alone may choose to rely on his/her own network of friends and relatives for psycho-social support rather than pay to attend a community centre.
- 5.16 If people choose not to use a service because they are not willing to pay the fee, the fee income will be less than if they choose to use the service. However, the total cost

---

<sup>66</sup> Income sources reported in the survey included: salary (self), pension (self), savings/investments (self), rental income (self), spouse, children/son-in-law/daughter-in-law, grandchildren, relatives, Comprehensive Social Security Assistance, Old Age Allowance, Disability Allowance, and other.

## 5. Funding Scenarios (Cont'd)

---

of provision would also decrease and, to the extent that the people who choose not to use the service are those who could only afford to contribute part of the cost of the services they need, the total cost of provision would fall by more than the total fees since the unit cost of service is less than the fee which these people would have paid.

- 5.17 Given that there will be elasticity of demand for services, fees can be used to influence behaviour and affect the total cost of formal services which need to be provided. For example, fees for more expensive services, such as residential care, may be set so as to encourage people to purchase less expensive services, such as day care or domiciliary care, which provide an alternative means of meeting need.
- 5.18 The analysis for the Base Case scenario suggests a potential fee income of \$935 million. Although this figure is based upon data which is subject to a number of limitations and cannot be relied upon as being an accurate indication of the scope for fees, given the current “recognised fee income”<sup>67</sup> of only \$242 million per annum<sup>68</sup> and that the assets of the elderly and the income of the families of the elderly in need of formal services have not been fully taken into account in the analysis, we believe that there is scope for further user contributions, especially for community based services.

### **Funds from Charitable Donations**

- 5.19 The amount of charitable donations is difficult to determine and is relatively insignificant in comparison to the total cost of services. Thus, these funds have not been considered to contribute to the cost of services.

### **Size of the Funding Gap**<sup>69</sup>

- 5.20 This section identifies the gap between the cost of services required to meet the need of the elderly for formal care and the funds available, and demonstrates the need to examine the impact of trade-offs regarding which services are provided and to whom they are provided.
- 5.21 The size of the funding gap for different scenarios varies. As shown in Figure 25, the shortfall in funds available to meet the cost of the Base Case Scenario is estimated to be \$4.6 billion, including the cost of premises.

---

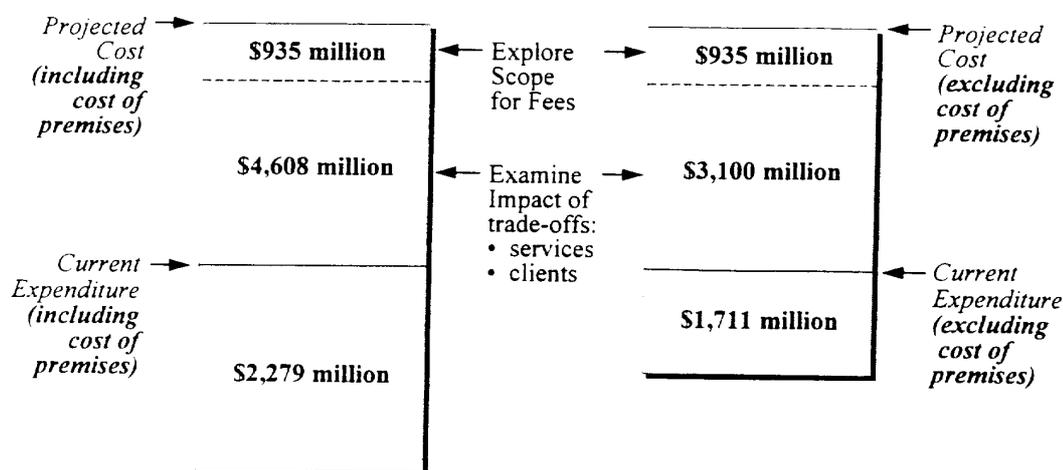
<sup>67</sup> Recognised Income/Expenditure: “This refers to the income or expenditure which is taken into account in working out the level of subvention for any service unit and in assessing subvention surplus. The recognised income/expenditure may not be the same as the actual income/expenditure.” (Guide to Social Welfare Subventions, Social Welfare Department.)

<sup>68</sup> Based on figures reported by the Social Welfare Department.

<sup>69</sup> Volume 3, Section 3

## 5. Funding Scenarios (Cont' d)

Figure 25: The Base Case Scenario - Scope of Need for Trade-offs



- 5.22 This gap is projected to increase over the next 10 years as the elderly population ages. In the long term, people must be encouraged to plan and save for their retirement years so that greater funds are available to pay for fees. However, any increase in saving for retirement will have minimal, if any, impact on the ability of the elderly to contribute to the cost of services during the next ten years. Consequently, on the presumption that Government will not increase current expenditure to fund the gap completely, the Government must consider alternative levels of provision to that determined by the Base Case Scenario.
- 5.23 The cost of provision can be reduced by limiting the number of people to whom services are provided, by providing alternative lower cost services to those in need or some combination of these two ways.
- 5.24 There are many alternatives that Government could pursue, each requiring discussions within Government to develop a hierarchy of needs and service provision. One risk group that could be a priority group are those aged 75 and over. These elderly people as they become older and frail, would use more services, yet their level of income is less compared to that of other age groups. Potential alternative funding scenarios are presented below to demonstrate the potential level and mix of services which could be provided given different increases in Government expenditure on services for the elderly.

**Alternative Funding Scenarios<sup>70</sup>**

- 5.25 We have presented several illustrative scenarios to vary the volume of services by limiting the number of people to whom services would be provided on the premise that those in greatest need in terms of both need for care and financial support are given priority in the provision of services. The results of these scenarios is a reduction in the funding gap.
- 5.26 Our analysis covered a cost neutral scenario and increases in Government expenditure of 50%, 100% and 150% for each of the Base Case Scenario and Alternative Scenario 2 to the Base Case Scenario. Cost neutral is defined as retaining the current level of real Government expenditure per elderly person<sup>71</sup>.
- 5.27 In each of the scenarios, the elderly would receive services according to a hierarchy of financial and care needs. Services would be first provided to those with an income of less than \$3,000 per month who are most in need of care until the cost of provision is equivalent to the target expenditure. If there are sufficient funds to pay for the cost of providing the service required by all those with an income of less than \$3,000, the excess would be used to pay for the cost of those who can afford to contribute to the cost of the service they need who are most in need of care, until the cost of provision is equivalent to the target expenditure.
- 5.28 No services are provided in each scenario to those who can afford to pay for the full cost of the service they require. This has the effect of increasing the funding gap if the cost of premises is not included in the cost of provision or in current Government expenditure. This is because the fees which would be paid by these people are equivalent to the full cost of the service, including the cost of premises, and therefore exceed the cost of provision if the cost of premises is excluded from such cost.
- 5.29 The funding gap of each scenario has been calculated as follows:

Total cost of the Base Case Scenario less the fees which would be received under the Base Case Scenario from those who would not receive services under the funding scenario

less

the fees which would be received under the funding scenario

less

Government expenditure as per the funding scenario

- 5.30 The impact on the provision of services and the funding gap of each funding scenario are summarised in Figure 26 and Figure 27.

---

<sup>70</sup> Volume 3, Section 4

<sup>71</sup> The current level of Government expenditure includes the opportunity cost of premises.

## 5. Funding Scenarios (Cont'd)

**Figure 26: Summary of Funding Scenarios (Base Case Scenario)**

	Provision (number of elderly)				Funding Gap	
	Residential Care	Day Care	Domiciliary Care	Community Centres	(incl. Premises) \$ million	(excl. Premises) \$ million
<b>Base Case</b>	33,839	1,282	35,723	183,447	4,608	3,100
# Paying Full Fee	0	0	2,495	93,286		
Net Base Case	33,839	1,282	33,228	90,161	4,608	3,102
	% of Net Base Case					
<b>Cost Neutral</b>	32%	0%	0%	0%	100%	106%
<b>50%</b>	60%	0%	0%	0%	75%	81%
<b>100%</b>	73%	57%	50%	0%	51%	52%
<b>150%</b>	79%	78%	78%	100%	26%	25%

**Figure 27: Summary of Funding Scenarios (Base Case Scenario - Alternative 2)**

Scenario	Provision (number of elderly)				Funding Gap	
	Residential Care	Day Care	Domiciliary Care	Community Centres	(incl. Premises) \$ million	(excl. Premises) \$ million
<b>Alternative 2</b>	25,201	9,920	35,723	183,447	4,393	2,960
# Paying Full Fee	0	0	2,495	93,550		
Net Alternative Cost	25,201	9,920	33,228	90,161	4,393	2,960
	% of Net Alternative Cost					
<b>Cost Neutral</b>	44%	0%	0%	0%	100%	107%
<b>50%</b>	74%	23%	0%	0%	74%	80%
<b>100%</b>	74%	70%	60%	0%	48%	49%
<b>150%</b>	85%	70%	78%	100%	22%	20%

5.31 The results of the cost neutral scenario suggest that Government expenditure would only fund a small proportion of the residential care which is needed. In the Base Case, 10,981 elderly people compared to 33,839 elderly in need of this service would be provided with residential care. In Alternative Scenario 2, which includes a lower level of institutionalisation, the same number of elderly people as in the Base Case would receive residential care. There would be no funds available for other services.

## 5. Funding Scenarios (Cont'd)

---

- 5.32 The reason for the funding to only allow for such limited provision of residential care and for no community care is the number of highly impaired people, most of whom are currently in private residential care, for whom the Government currently provides no assistance, other than CSSA. Furthermore, the cost per person of providing adequate residential care to these people is greater than the current average cost per person in subvented residential care due to the number of elderly of low impairment in subvented residential care.
- 5.33 Scenarios which would provide residential care to only a few and which would provide no community care are likely to increase the cost of providing medical services to the elderly, as those in need seek to obtain such services as a substitute for community services, and increase the need for residential care as the lack of community services may result in increasing levels of impairment.
- 5.34 This indicates the need to focus increases in Government spending on the provision of residential care of adequate quality for those who are most in need in terms of both need for care and financially, whilst at least maintaining the current level of community services.

### **Other Potential Ways of Reducing the Funding Gap<sup>72</sup>**

- 5.35 In addition to examining the impact of trade-offs between service provision and recipients of services to reduce the funding gap, the Government should explore ways to minimise the cost of provision and increase the fees paid by users of services.
- 5.36 Introducing competition into the market place by the Government moving towards the role of a purchaser and removing the distinction between the subvented and private sectors, is likely to improve cost efficiency and improve the quality of services provided. In other countries, the introduction of competition has resulted in a lowering of costs of provision as providers seek more efficient means of delivery.
- 5.37 Once a competitive market is in place, the Government, as a main purchaser of services, would be in a position to negotiate longer term contracts and lower fees which reflect the real costs of care.
- 5.38 Creative ways of reducing the cost of premises should be explored as this cost component is a main factor contributing to the high unit cost of services.
- 5.39 Over time, Government should consider the redevelopment of residential homes which are in the more expensive private residential areas and replace them with facilities in public rental housing estates, given that the opportunity costs are lower in public rental housing estates and that 50% of the elderly population live in public rental housing. The feasibility of providing such facilities in the same buildings as

---

<sup>72</sup>Volume 3, Section 4

## 5. Funding Scenarios (Cont'd)

---

housing for the unimpaired elderly population and the population below the age of 60 should be explored, in accordance with the ageing in place policy and to help remove the stigma attached to residential care.

- 5.40 Measures to encourage more families to live with their elderly relatives so that more informal carers are available to care for the elderly will help reduce institutionalisation and reduce the cost of service provision. This should be suitably reflected in the public housing allocation policy and existing family life education programmes should be strengthened to encourage more families to live with their elderly relatives.
- 5.41 Government policies to increase the fees paid by users of services to reduce the funding gap should be considered to reduce the funding gap. The Community Survey highlighted the significant role that the families of the impaired elderly play in caring for and financially supporting the elderly members of the family. For example, the survey revealed that 71% of the elderly surveyed were receiving or expected to receive financial support from their children. Given the current level of support provided by the family, Government should consider adopting the policy of determining the ability of the elderly to pay for formal services, based on:
- the assets, as well as the income, of the elderly; and
  - the income and assets of the elderly person's family.
- 5.42 Many countries operate an income and assets test, which may entail the running down of assets to a considerable degree before public assistance is provided, and some countries, e.g. France and Singapore, extend financial responsibility for long-term care to members of the wider family.
- 5.43 To minimise the cost of providing formal services it is essential that assessment criteria be clearly defined and rigorously applied to ensure that only those in need of a particular service receive it, unless the recipient is willing to pay the full cost of the service, including the cost of land.

### **Funding Priorities<sup>73</sup>**

- 5.44 The Funding Scenarios illustrated in this section have been modelled based on the premise that those in greatest need in terms of both need for care and financially are given priority in the provision of services. Based on this premise, and the level of current Government expenditure, the volume of services required to meet need and the cost of providing these services, many of the alternatives result in there being insufficient funds to provide all types of services.
- 5.45 Given that an increase in all types of services is needed, in planning the allocation of funding to individual services, it would be reasonable to maintain the allocation of

---

<sup>73</sup>Volume 3, Section 4

## 5. Funding Scenarios (Cont'd)

---

current funds and base the allocation of additional funds on certain priorities. Furthermore, in allocating funds to services, it will need to be recognised that improvements to and increases in services can only be made over a period time due to the constraints of obtaining the resources required, such as premises and staff, even if funds are available.

5.46 Our suggested priorities are as follows:

- encourage the private sector to provide residential care of an acceptable quality, initially in public housing estates, and enable the residents of private homes, which provide an unacceptable standard of care, to move into the new homes through purchasing places at a price which reflects the cost of providing the level of care required;
- enable the less severely impaired to remain in the community, or return to the community, through provision of suitable housing by the Housing Department and through the increase in community based services, particularly domiciliary care;
- as the availability of residential care places increases, renovate existing homes for the aged so that they are able to care for the more severely impaired and move the residents of homes in expensive residential areas, who would qualify for public housing, into residential homes in public housing estates. These homes could then be sold for redevelopment and the funds used to purchase residential care places or increase the level of community support services.

## 6. Encouragement of the Private Sector<sup>74</sup>

---

### Existing Private Sector

- 6.1 The current private sector comprises over 50% of the residential care sector, which provides services primarily to lower income groups, and domestic helpers, who primarily serve the higher income groups. 35% of the elderly in the community who reported an income of \$20,000 or more received care from domestic helpers and only 13% of those with an income less than \$8,000 had a maid.
- 6.2 It is widely recognised by the Health and Welfare Branch, the Social Welfare Department and many others that the existing private sector residential care is of relatively low quality and that there is a lack of formal community services. There is therefore a need to improve the private sector provision by upgrading the quality of residential private homes and to further develop formal community based services.

### Barriers to Entry

- 6.3 There are a number of barriers to the provision of private sector care services in Hong Kong. These can be summarised as follows.
- 6.4 **A small market for self-paying residential care.** Based on the Community Survey and assumptions made in the planning model, there are no people who need residential care who can afford to pay the full cost of such care.
- 6.5 **High costs of entry vs. competition from low cost/quality providers.** The cost of purchasing/leasing premises is expensive in Hong Kong which makes operating residential care an unattractive investment to many potential service providers. Staff shortages add to the financial burden of establishing operations.
- 6.6 **Difficulty in finding suitable sites/premises.** Premises of existing private residential homes are generally unsuitable for an acceptable quality of service. The Social Welfare Department has also set stringent guidelines for premises thus making the search for suitable sites more difficult for providers who need to meet licensing requirements. Normal residential accommodation requires renovation at best. Discussions with architects and developers suggest that the ideal type of facility would be purpose built to satisfy the requirements of the Government and of quality service providers.

### Ways to Encourage the Private Sector

- 6.7 As a supply driven industry, Government involvement is required to encourage the development of this sector. Stating that it is the Government's policy to encourage private sector provision is crucial to setting the stage and a key indicator of the commitment and support providers will receive from the Government.

---

<sup>74</sup>Volume 3, Section 5

## 6. Encouragement of the Private Sector (Cont'd)

---

- 6.8 We have recommended that the Government changes its role to become a purchaser of services from both private and subvented sector providers who meet minimum quality standards. This would increase the market size and make it more attractive to private sector providers of residential care. The risks of entry to private sector providers would be further reduced if the distinction between sectors is removed. On this basis, both the private sector and existing NGOs could provide the additional services required. Competition would also improve the quality of services.
- 6.9 In conjunction with the purchasing of services, the Government should minimise competition from low cost/quality providers by setting and policing minimum operating standards. The new licensing scheme for residential care homes is crucial; this should be expanded over time to include measures that relate to the care of clients.
- 6.10 Risks of entry would be further reduced if the Government entered into long term contracts with providers who meet defined quality criteria. Under a long term contract, providers are given time to recover their investment as long as they continue to meet the required quality standards. Contracts of sufficient scale would also make the training of staff cost effective.
- 6.11 The most significant cost of entry is the cost of premises. As the Government owns the freehold of all land in Hong Kong it can:
- allow the private sector to purchase land at a price which the purchaser believes would result in a return equivalent to the cost of capital, perhaps through a tendering process; and
  - rent the land/premises to the private sector at a price which the tenant believes would result in a return equivalent to the cost of capital, perhaps through a tendering process.
- 6.12 The Government could also assist the private sector to locate suitable sites/premises by allocating space for the provision of services to the elderly in public housing estates or imposing lease conditions in the sale of land for private sector residential care property development, such as requiring the developer to provide accommodation for the provision of elderly services. There are already conditions in some land leases which require the purchaser to develop certain social welfare premises for elderly services, a concept which could be extended to residential care.
- 6.13 The sites allocated by the Government would need to be carefully chosen so that the size of the site would support elderly services of an economic size, and the income level of the users of the elderly services matches that of the residential estate to minimise the impact on the market value of the estate and surrounding properties. This would apply primarily to residential homes since the home might accommodate residents brought in from other locations.

### **Introduction**

7.1 Our recommendations are based on four principles:

- “Ageing in Place” - elderly people should live with their families or in an environment which they are used to as they age;
- “Role of the Family” - it is the responsibility of the family to provide “informal care” to the elderly, whilst it is the responsibility of the Government to supplement informal care with “formal care” only when needed;
- “Continuum of Care” - to provide a hierarchy of services to the elderly in a way which minimises the disruption to the elderly as their need for formal care increases; and
- “Mixed Economy of Provision” - elderly services will be delivered by a mixed economy of public, private and voluntary providers.

7.2 Ageing in place has been the foundation of social welfare policy since 1977 and was reaffirmed in the 1991 White Paper. This policy is guided by the principle of care in the community, which enables service recipients to stay as members of the community as long as possible by means of family care and community support services. The 1994 Report of the Working Group on Care for the Elderly articulated that long-term residential care should only be provided when family care and community care can no longer support the needs of the frail elderly. This was also the expressed preference of the elderly in the Community Survey and Focus Groups.

7.3 The recommendations are at a policy level to provide an overall picture of the services required to meet the needs of the elderly. These recommendations are primarily modifications to existing services under a continuum of care model. In implementing these enhancements, further discussions within Government will be necessary to address implementation and operational issues. A review of staffing levels and locations, will be required to deliver the recommended services to the elderly in need.

### **Government Policy**

7.4 On the basis of ageing in place, Government policy should position formal services not as an alternative to absent family care, but as a support to existing care arrangements. Informal care is the mainstay of care to elderly people in Hong Kong, and the traditional Chinese values of respect and care for the elderly should be preserved and nurtured. The planning recommendations in this study have been developed with this philosophy in mind.

---

<sup>75</sup>Volume 1, Section 10

## 7. Summary of Recommendations (Cont'd)

---

- 7.5 Our recommendation on a pluralist provision of services has been accepted by the Working Group and Steering Group of this study as the optimal form of provision for Hong Kong. With a mixed economy, users benefit from a wider choice of service types, provided by a wider range of public, voluntary and private providers. Purchasers of services also benefit through the lower costs and greater flexibility that can be realised by a mixed provider market.
- 7.6 Hong Kong currently has a wide range of services and a large private sector. However, the limitations of caring for the highly dependent elderly in the existing private sector are recognised. Given the benefits of a mixed economy and the characteristics of the clients identified in the private sector, we recommend that the Government consider the development of a high quality private sector to meet the needs of the elderly by developing and implementing quality standards that address process and outputs in residential care. The following initiatives should be considered:
- an extension of the Bought Place Scheme in the private sector, with prices paid that are equivalent to the real unit costs of supporting clients in the subvented sector under long-term contracts;
  - removal of the distinction between the subvented and private sectors;
  - expansion of the new licensing scheme for residential care homes over time to include measures that relate to care of clients;
  - provision of suitable sites for the provision of services at a price which the purchaser or tenant believes would result in a return equivalent to the cost of capital, perhaps through a tendering process; and
  - increase in medical care support.
- 7.7 The issues of fragmented provision and inadequate co-ordination of policy formulation and implementation have been discussed and presented in this report. We recommend that Government build on the success of the creation of the Elderly Services Division of the Health and Welfare Branch and establish an entity with authority over relevant Government departments to co-ordinate and execute policies that protect and enhance the interests of elderly people in Hong Kong.
- 7.8 Planning ratios are currently used to plan for the provision of subvented elderly services and revised planning ratios have been determined in this study based on meeting the care needs of the elderly population. These ratios are helpful as guidelines in planning services. However, they tend not to allow flexibility in provision as needs change and will become less meaningful over time as the Government becomes a purchaser of services and moves away from the current inputs control model. A planning approach based on per capita expenditure would be more meaningful and allow for flexibility in provision.

## 7. Summary of Recommendations (Cont'd)

---

- 7.9 Our analysis shows that the cost of services to meet the needs of the elderly population is significantly greater than current Government expenditure. To minimise this funding gap, users should be charged fees based on the extent that they can afford to contribute to the cost of services they need. Our analysis suggests that there is scope to increase user contributions to the cost of services, especially for community support services. This would mean more rigorous means testing than is currently in place. To maximise fees in the long term, Government should encourage people to save for their old age.
- 7.10 Even with user contributions, the high cost of care makes it difficult for the Government to bridge the entire funding gap. It must therefore make choices between the mixes of services to be provided and who the recipients of services should be. Services should first be provided to those who are most in need of care and financial support. Some choices would increase the burden on the elderly person's family, whilst others would increase costs. Government must choose a balance of services and users of services which it believes to be the most appropriate in the long-term given its budgetary constraints.

### **Enhancements to Services**

- 7.11 A continuum of care model has been accepted by the Working Group and Steering Group of this study as the desirable delivery model for Hong Kong. We recommend the removal of the distinction between nursing homes and care and attention homes, the withdrawal of homes for the aged places and converting places to provide for clients with higher impairment. This would require redefining admission criteria for residential care homes, vesting the gate keeping role for residential care in the CGATs and an increase in funding to care for the more highly impaired. Infirmary places would focus on active rehabilitation of elderly rather than substituting for some part of long-term care.
- 7.12 We also propose that the continuum of care model should be developed for community support services by:
- a significant increase in the volume of domiciliary care;
  - increasing the availability of medical and health professional support in the community by expanding the role of the elderly health centres;
  - enabling the integration of day care centres and home help services into a single flexible delivery mechanism; and
  - adopting a case management approach.
- 7.13 Case management can be cost effective in delivering high quality long term care and can be effective in reducing institutionalisation and hospital lengths of stay. A case

## 7. Summary of Recommendations (Cont'd)

---

management model appropriate to the Hong Kong health and welfare system should be developed through pilot testing.

- 7.14 Under the revised system, health and welfare will be provided through residential care services, day care services, domiciliary care, elderly community centres and elderly primary care centres. The objectives are to develop better support services in the community with residential care being provided to only those who have high levels of disability and limited informal care support.
- 7.15 Domiciliary care should be provided by the home help teams, but the goals, objectives and resources of this service should be re-orientated towards providing long-term care and to providing support to carers and assistance with activities of daily living. To relieve the work load of the home help teams, the scope to develop a network of volunteers to provide escort services, the contracting out of meal preparation and delivery and a voucher system which would allow elderly people to eat in restaurants should be investigated.
- 7.16 Multi-service and social centres should be integrated into a “hub and spoke” model, with what are now social centres operating as satellites of the multi-service centres, which should be renamed community centres for the elderly. Under this model, the larger community centres, i.e. the current multi-services centres, would manage and co-ordinate the staff and activities of the the smaller centres, i.e., current social centres, attached to them. Community centres should also operate under a more dynamic model than at present that takes social and recreational programmes, specifically designed to fulfil emotional and leisure needs, out into the wider community, integrating these with other community services that are provided by, for instance, the Urban Council.
- 7.17 Community centres for the elderly should act as a drop in facility for elderly people and become a nucleus for:
- a citizens’ advice service staffed by elderly volunteers;
  - administration and organisation of outreach social programmes;
  - training and development of social centre staff and volunteers; and
  - administration of elderly volunteer programmes such as networking, visiting and escort.
- 7.18 Outreaching should be widely adopted as a service approach rather than being limited to a mode of service delivery as is currently being done through outreaching teams. The concept extends centre-based services to the provision of services to the elderly at home through, for example domiciliary care, the “outreach” of medical teams based in elderly primary care centres, and the use of Volunteers and Social Networking programmes for the elderly.

## 7. Summary of Recommendations (Cont'd)

---

7.19 Primary health care support is essential to the new service model. Primary medical care and community nursing services to elderly people should be delivered in their own homes and in private and subvented residential care homes. These services will be based from a network of elderly primary care centres.

### **The Wider Picture**

7.20 The implementation of these recommendations will result in a health and welfare system that:

- is designed around the community services of domiciliary care, centre based day care and community centres with residential care being provided only to people with high levels of disability who have limited available informal care;
- has a single entry point, with access to all welfare services managed by multidisciplinary assessment teams that design care plans tailored to the needs of the elderly person and his/her carer(s), and delegate the responsibility for implementing these care plans to case managers;
- is supported by strong primary medical care delivered through a network of dedicated elderly primary care centres that can provide primary medical care and community nursing services to elderly people in their own homes and in private and subvented residential homes;
- meets the needs of elderly people through a mix of services provided by the private, non-governmental organisations and government sector, that are maintained to acceptable standards of quality; and
- is funded by a mixture of government and user contributions.