Chapter 1

Residential services for the elderly

Audit conducted a review of the economy, efficiency and effectiveness of the Government's planning, provision and monitoring of residential services for the elderly, and identified room for improvement in the following areas:

- provision of subsidised care and attention (C&A) home places;
- provision of subsidised self-care, home for the aged (HFA) and Housing for Senior Citizens (HSC) places;
- provision of subsidised nursing-home and infirmary places;
- Government's financing of subsidised residential services for the elderly;
- the Social Welfare Department's (SWD's) licensing and monitoring of residential care homes for the elderly (RCHEs);
- the SWD's monitoring of subsidised residential services for the elderly; and
- healthcare services of RCHEs.

2. The Committee held two public hearings on 6 May and 4 July 2002 to take evidence on the issues examined in the Audit Report.

Evidence taken at the public hearing on 6 May 2002

Provision of subsidised C&A home places

3. The Committee understood from paragraph 2.9 of the Audit Report that the SWD had increased the supply of subvented C&A home places in recent years. However, as shown in Table 3, as at 31 March 2001, there were more than 16,000 applicants on the waiting list, and they needed to wait for an average of 35 months for such places. In contrast, the average waiting time for admission to subsidised home places, i.e. home places provided under the bought-places schemes, was 11 months. The Committee was concerned about the significant disparity in the waiting time for admission between subvented C&A home places and subsidised C&A home places and asked about the reasons for that.

4. In response, **Mrs Carrie LAM CHENG Yuet-ngor, Director of Social Welfare**, said that according to the latest information on the SWD's homepage, the waiting time for admission to subvented RCHEs was 34 months, whereas that for home places provided under bought-place schemes was 10 months only.

5. On the question of significant disparities in the service levels between subvented C&A home places and C&A homes places under the bought-place schemes, the Director of Social Welfare stated in paragraph 2.21 of the Audit Report that the perceived superiority of subvented C&A homes was mainly due to these homes being purpose-built and the users having a higher level of confidence in the home operators. The Committee enquired about the Administration's plans for the next ten years for increasing the supply of purpose-built RCHEs and ensuring that the level of services provided at private RCHEs was comparable to that at subvented C & A homes.

6. The **Director of Social Welfare** provided a detailed list of these planned RCHE premises vide the Annex to her letter of 23 May 2002, in ***Appendix 14***. She also informed the Committee that the SWD had embarked on a major programme to secure purpose-built RCHE premises from various sources. Through competitive bidding, purpose-built government premises would be available to non-governmental organisations (NGOs) as well as private homes for operating a mix of subsidised and non-subsidised services. As at April 2002, the SWD had successfully secured such premises for a total of 6,726 places over the next ten years. A summary breakdown by source of supply was as follows:

Source of supply	**Number of RCHE places**
Public housing estate developments	3,555
NGO sites	771
Government's Government/Institution/Community sites	764
Urban Renewal Authority/MTR Corporation Limited/Kowloon-Canton Railway Corporation developments	646
Private developments through land sale conditions	990
Total	**6,726**

7. The **Director of Social Welfare** further stated that:

- noting that public housing estate developments remained the main source of supply of purpose-built RCHEs premises, she had made an appeal to the Housing Authority to help supply such premises within public housing estates developments at suitable locations. A new funding arrangement had also been put in place to facilitate the provision of the premises with the SWD reimbursing the Housing Authority their construction cost through the Lotteries Fund;

- to further boost the supply of purpose-built RCHE premises, the Administration had devised a scheme to encourage private developers to incorporate RCHE premises in their developments. Under the proposed scheme, it would exempt eligible purpose-built RCHE premises in new private developments under lease modification, land exchange or private treaty grant from the calculation of gross floor area and assessment of premium of the development. In return, the developer would have to pay the full cost of constructing the RCHE premises, with such basic provisions as fire services installation and drainage connection, suitable for operation as a RCHE. These RCHE premises, once built, while remaining the property of the private developers, would have to be used exclusively as RCHEs. The Administration was finalising the legislative amendments needed to put the scheme in place. The supply of purpose-built RCHE premises over the next ten years reported above and in the Annex to her letter had not yet included any possible supply from this source;

- pending an increased supply of purpose-built RCHE premises, the SWD would continue to take various measures to improve the quality of private homes. These included upgrading the remaining Bought Place Scheme (BPS) places to Enhanced Bought Place Scheme (EBPS) standards, stipulating higher standards in the renewal of and purchase of additional EBPS places, and expanding training capacity for health workers and care staff working in private homes subject to the availability of resources. However, there was a need to strike a balance between imposing further requirements on the operation of private homes with a view to improving their standards and the commercial realities faced by these private homes. There was clearly a limit to how much public resources the SWD could mobilise to induce quality improvements in private homes through the Government directly purchasing places from these homes to operate as subsidised places; and

- consumer choice would also be a powerful tool to raise standards in private homes. The SWD had commissioned the Hong Kong Association of Gerontology to undertake a two-year project to develop and establish an accreditation system for RCHEs in Hong Kong to ensure the delivery of quality care and continuous improvement through promulgation of the quality process and outcome monitoring of RCHEs.

8. The Committee noted Audit's recommendation in paragraph 2.20(b) of the Audit Report that the Director of Social Welfare, in conjunction with the Secretary for Health and Welfare[1], should take action to provide, as far as possible, a uniform level of service for all places at government subsidised C&A homes in certain aspects. The Committee enquired:

- about the timetable for, the financial implications of and the main constraint on the provision of a uniform level of service for all such places, e.g. the feasibility of raising the standards of private RCHEs in terms of minimum area per resident, qualification and number of staff and physical facilities;

- whether the implementation of measures to provide a uniform level of service would cause closure of private RCHEs and, if so, how the Government would assist such homes in meeting the requirements for higher service standards; and

- whether the Government had set up a fund to assist the operators of private RCHEs in raising their service standards and, if so, the criteria for application to the fund, the terms and conditions of the subsidy and the respective numbers of applications received by and approved by the Government in the past few years.

9. In her letter on 23 May 2002, the **Director of Social Welfare** stated that:

- the C&A services subsidised by the Government were provided through the traditional NGO homes operating on recurrent subventions from the Government, places purchased from private homes under the BPS or the EBPS and subsidised places provided in contract homes arranged through competitive bidding. With the exception of a few homes developed by NGOs with or without Government subventions, the policy intent was to put all future homes under competitive bidding. The contract homes would be

[1] With the implementation of the Accountability System for Principal Officials, the major statutory functions exercisable by the Secretary for Health and Welfare have been transferred to the new Secretary for Health, Welfare and Food with effect from 1 July 2002.

subject to the same set of quality standards, output and outcome indicators and other requirements. In other words, the Administration was confident that all new RCHEs would offer a uniform level of service and be provided at a competitive cost achieved through open tendering;

- the level of service and the cost of the service were two sides of the same coin. In the case of the traditional subvented NGO homes, given the high personnel cost they carried, it would be extremely difficult to reduce their cost over a short period. Instead, the SWD had been trying to enhance their productivity through in-situ expansion or inviting them to make use of the premises to provide added services. In the case of private homes providing subsidised services, the SWD had narrowed the disparity by raising the minimum space and staff requirements for EBPS and intended to phase out all BPS places. As regards staff competency, the SWD had revamped the course for care staff and obtained additional resources for providing more training to care staff in elderly services from both the subvented and private sectors. Details of these initiatives were as follows:

  (a) the SWD had secured resources of $11.8 million annually to upgrade a total of 1,200 BPS places to EBPS places by 2003;

  (b) the SWD had earmarked $8 million to provide 2,160 multi-skilled training places for care staff by 2004-05. Of the 400 training places provided in 2001-02, there were a total of 100 trainees from the private sector; and

  (c) the SWD had adopted a new schedule of accommodation for all new homes optimising the use of premises and narrowing difference in space standards between subvented homes and private homes;

- the Administration had no plans to resort to imposing further requirements through statutory means. Actually, it had taken the Administration and the sector as a whole over five years to bring all existing homes up to the licensing standards since the implementation of the Residential Care Homes (Elderly Persons) Ordinance. This licensing regime had helped ensure that residents in care homes received services of acceptable standards that were of benefits to them physically, emotionally and socially. The licensing scheme regulated the operation of all care homes in terms of staff requirement, space standard, building and fire safety requirement and the provision of health and care services at acceptable and minimum level. The complete licensing of all private homes in March 2001 was achieved through vigorous efforts on the part of the SWD and operators and supported by the Lotteries Fund grants to

subvented homes for upgrading and a financial assistance scheme for private homes. Since the completion of licensing, the Administration had been pursuing various measures to further improve the standard of services. Mindful of the overall business environment, reduced affordability for non-subsidised services as a result of the economic downturn and rising unemployment, the Administration had doubts about the practicability of contemplating legislative amendments to stipulate higher space and manpower standards at this juncture. The last thing the Administration would like to see was massive closures of private homes caused by the toughened operating environment and, as a result, large numbers of elderly being displaced; and

- the Financial Assistance Scheme for private homes was introduced in 1995. It aimed at assisting those already in existence upon the implementation of the Residential Care Homes (Elderly Persons) Ordinance in complying with safety precaution, design and structural requirements as stipulated under the Ordinance. It was not confined to private homes providing subsidised services under the BPS and EBPS schemes. As a matter of fact, it was doubtful whether the existing premises occupied by private homes could be upgraded to reach the standards similar to those of subvented homes without total reprovisioning. The SWD had received a total of 233 applications from private homes under the Scheme. Grants totalling some $20 million were made to 154 successful applications.

Phasing out of subsidised HFA places

10. According to paragraphs 3.6 and 3.7 of the Audit Report, in 1997, the Elderly Commission conducted a comprehensive assessment on the long-term demand of the elderly for housing and residential care and recommended a strategy to meet the long-term needs. In its report published in September 1998, the Elderly Commission considered that residential care services should be directed to elderly persons with genuine needs. The Commission recommended that able-bodied elderly persons and those who could take care of themselves should remain in the community.

11. Nevertheless, paragraph 3.12 of the Audit Report revealed that the SWD was still accepting applications for HFA places. As at 31 March 2001, there were nearly 6,200 elderly persons on the waiting list, and the average waiting time for admission to an HFA was 19 months. The Committee considered that if the SWD could phase out existing HFAs and provide community support services to meet the needs of the potential applicants for HFA places, huge savings could be achieved and used to subsidise new C&A home

places. The Committee wondered why the SWD had not actively implemented the Elderly Commission's recommendation.

12. The **Director of Social Welfare** explained that:

- since the Elderly Commission had made the recommendation, the SWD, under the guidance of the Health and Welfare Bureau[2], had made considerable effort in this regard. Although the SWD was still accepting applications for HFA places, it agreed that the issue should be dealt with in the near future;

- from 1998 onwards, the SWD had acted on the recommendations made and the strategy formulated by the Elderly Commission. The indisputable policy objective was to enable elderly persons to receive a continuum of care in the community with a view to reducing, as far as possible, the demand for residential care homes. In the past few years, the SWD had reduced the number of self-care places from 1,225 to 260 in 2001. In addition, the HFA places continued to decrease as a result of the conversion into C&A places. Thus both self-care and HFA places were not included in the new RCHE developments;

- a package of enhanced home and community care services was introduced in 2001. After much publicity, 1,750 elderly persons were currently receiving the services. In fact, their health conditions might necessitate their admission to residential care homes but their families were taking care of them;

- in fact, the work was in progress and the SWD could not phase out the more than 7,000 HFA places in one go as many elderly persons were residing there. The elderly persons had a strong sense of belonging to the environment which they were used to. The SWD could not have them displaced for the sake of implementing some policies. However, in order to prepare for the implementation of Audit's recommendations, the SWD had conducted an analysis in early 2002 of the more than 6,500 elderly persons on the waiting list of the HFA. The findings revealed that most of them were still living with their families and did not have housing needs; and

[2] With the implementation of the Accountability System for Principal Officials, the statutory functions relating to health and welfare exercisable by the Health and Welfare Bureau have been transferred to the new Health, Welfare and Food Bureau with effect from 1 July 2002.

- the SWD had conducted an assessment of the HFA cases received in the first three months of 2002. For instance, it received about 300 new cases during the period from 1 to 31 March 2002 and found that 23% of the applicants were able-bodied and did not need care services and housing and financial assistance. They considered their applications as a form of psychological and social insurance. They were concerned that when their health conditions or their relations with their families deteriorated, they would lose the roof over their head. Of the more than 6,500 applicants on the waiting list, more than 1,000 were inactive cases, who would not move into HFAs upon immediate approval of their applications. In the light of these issues, the SWD was undertaking preparatory work and hoped to submit to the Elderly Commission later in 2002 proposals concerning the implementation of Audit's recommendations.

13. According to the Director of Social Welfare's above reply, of the more than 6,500 applicants on the waiting list of the HFA places, more than 1,000 were inactive. The Committee asked whether the remaining applicants had housing needs.

14. The **Director of Social Welfare** replied that there were a total of 5,500 active cases. Half of the applicants were already living in public housing estates, whereas the remaining were living in private buildings. A total of 3,139 applicants were living with families or relatives. However, 3,792 applicants were found to be not having extensively used the day care services for the elderly, elderly activity centres and home care services. They were not aware of the wide range of support services available, e.g. home cleaning or medical consultation escort services. The SWD could inform them of existing support services and ask them whether they still needed the psychological insurance. Nevertheless, in changing the policy, the SWD must respect the reasonable expectations of the elderly. If they opted to wait for HFA places, the SWD might have to let them continue waiting.

15. Noting the Government's direction to phase out HFA places, the Committee enquired about the change in the actual provision of HFA places in the past few years. The **Director of Social Welfare** said that:

- in 2000, there were 88 HFA places under the SWD and the number had remained unchanged. At that time, there were 7,449 places provided by subvented HFAs. At the end of the 2001-02 financial year, the number had decreased to 7,143;

- under the current strategy, when individual elderly persons in the HFAs needed a higher level of care, the SWD would propose that their places be converted to C&A places and additional resources be provided accordingly. Under the circumstances, the elderly persons would not have to leave the HFAs, but the disadvantage was that the conversion was a slow process. Moreover, as some hardware of the existing HFAs could not be changed, there was a need to conduct further analysis to ascertain the number of places which were suitable for conversion, so as to formulate a better strategy; and

- there was only one HFA run by the SWD, which was in Shatin. She had visited the HFA a couple of times soon after assuming office. On those occasions, she had talked with the residents there and indicated that the SWD hoped to close down the HFA. Some residents were almost in tears when requesting her not to have them relocated and hoped to stay there for the rest of their life.

16. The Committee understood from paragraph 3.19 of the Audit Report that there was a large number of vacant HSC units. As the SWD was still accepting applications for HFA places, the Committee wondered why the SWD had not referred the applicants, as far as possible, to the Housing Department (HD) to apply for HSC units.

17. The **Director of Social Welfare** responded that:

- she had discussed with the HD the use of HSC units or self-contained units to tackle the problem. However, the findings of the survey of the 300 HFA cases received during the first quarter of 2002 showed that only two applicants had a housing need. It seemed that many HFA applicants were in need of social and psychological support services. In the past two years, the SWD had launched a network to provide support to the elderly. It would have the 139 home help teams upgraded at a later stage, with a view to providing comprehensive services to more elderly persons to fully meet their social and psychological needs. Moreover, the SWD had been operating a uniform mechanism for assessing the care needs of the applicants for residential care services to ascertain whether they had a genuine need for admission to C&A homes; and

- as the SWD would consult the Elderly Commission in the near future and cease accepting applications for HFA places, it needed to better its complementary services. The SWD hoped to inform the applicants upon ceasing acceptance of new applications that it could provide immediately social support, cooking and cleaning services.

18. **Dr E K YEOH, Secretary for Health and Welfare**, added that:

- there had been discussions at the Elderly Commission on the overall policy on the demand for care services for the elderly. The Administration would submit to the Elderly Commission some of Audit's recommendations, the issues discussed at this hearing and the follow-up actions. The policy had been formulated. The implementation would involve the adoption of complementary measures. The Administration would look into their feasibility and work out the timetable; and

- as far as the policy was concerned, the Administration was planning to provide only one type of RCHE so that the elderly persons would age in the same place. It hoped to maintain a central waiting list for all applicants for care services. There would be a uniform assessment to determine whether an applicant needed home or residential services. The present arrangement of providing three to four types of residential care homes for the elderly was not ideal. The majority of the applicants, while waiting, were receiving some form of home services. The waiting numbers did not reflect the situation.

19. Regarding the Administration's plan to provide only one type of RCHE, i.e. the policy of "one-stop service", the Committee enquired about the details of the policy and whether a consultation exercise had been conducted. The **Secretary for Health and Welfare** informed the Committee in his letter of 24 May 2002, in ***Appendix 15***, that:

- the Administration had introduced a standardised care need assessment tool since November 2000. The tool helped to make more precise matching of services to care needs in both the community and residential settings. As a next step, the Administration was considering to establish a single point of entry for all subsidised community and residential care services. The concept was to no longer require elderly people to queue up for different services. Instead, there would be one central waiting list for all subsidised long-term care services, and services for elderly people would be matched in accordance with their care needs as assessed by the standardised tool. At this stage, the Administration was working out the details of the proposal; and

- in implementing any major new strategy, the Administration would consult and take into account the views of relevant parties and pay heed to the appropriate pace of introduction.

Residential services for the elderly

20. According to paragraph 3.15(c) of the Audit Report, having regard to surplus HSC flats of the Housing Authority, the SWD was exploring the option whether the SWD and the Housing Authority could jointly offer a package of residential-cum-social/community support services to existing and potential HFA residents. The Committee enquired about the progress of the matter.

21. The **Director of Social Welfare** informed the Committee that:

- the community support services had expanded considerably in the past two years. Under fiscal pressure, she could not undertake to expand the services infinitely. Nevertheless, the existing network was extensive, consisting of several hundred social centres and multi-service centres. The SWD would discuss with the operators later in 2002 how to help more needy people through rationalising or re-engineering the services and better the coordination of services. For example, the multi-service centres organised many recreational activities. The Leisure and Cultural Services Department (LCSD) also organised many such activities. She had discussed with the Director of Leisure and Cultural Services in this regard, e.g. whether Tai Chi classes could be offered in parks by the LCSD. It was hoped that more resources of the multi-service centres could be used in services to elderly persons with social and psychological needs. The SWD would report regularly to the LegCo Panel on Welfare Services the progress of the enhancement of services for the elderly; and

- she regularly discussed with the HD the option of offering a package of residential-cum-social/community support services to existing and potential HFA residents. In preparation for the discussion, she had visited three or four HSC units. She found that the units were well-designed. The only disadvantage was that the kitchen and the washroom were shared. The HSC in Tin Shui Wai was of the latest design. There was a washbasin in each room. Although the washroom was shared by three residents, it was partitioned into three cubicles. The HSC units were also provided with warden service. She was aware that the vacancy rate was higher in Tin Shui Wai due to its remote location. Many elderly persons were concerned that if they moved there, they would lose their familiar environment.

Provision of HSC units by the Housing Authority

22. Paragraphs 3.18 and 3.19 of the Audit Report revealed that as at 31 March 2001, 887 of the 9,383 HSC units provided by the Housing Authority were vacant, resulting in wastage of housing resources. Regarding the distribution of the 887 units, the Committee noted from the supplementary information, in ***Appendix 16***, provided by the Director of Housing that the vacancy rates of HSC units in certain new housing estates were quite high. For example, 81 of the 197 HSC units in Sheung Tak Estate were vacant. The Committee understood that most elderly persons would prefer not sharing the units with strangers. It therefore asked whether the HD would offer the applicants a choice of sharing the units with their friends or relatives who were also on the waiting list of HSC units, with a view to shortening the vacant periods of the units.

23. **Mr Marco WU, Acting Director of Housing**, explained that:

- the high vacancy rate was attributable to an increased supply of HSC units and single-person flats in recent years. If elderly persons were given a choice, they would like to take up self-contained small flats. Those housing estates with a high vacancy rate of HSC units were mostly far from the urban area. Hence, the Housing Authority had decided more than a year ago to stop further production of HSC units and allow Waiting List applicants aged below 60 to apply for vacant HSC units; and

- the number of vacant HSC units in Sheung Tak Estate had decreased to 20. Moreover, the HD recently launched the Express Flat Allocation Scheme for vacant HSC units. Elderly persons who wished to be expeditiously allocated HSC units for sharing with friends or relatives could contact the HD. Nevertheless, the HD needed to take into account their respective priorities on the waiting list in processing their applications, so as to ensure a reasonable allocation of resources.

24. In response to the Committee's request, the **Director of Housing** provided, vide his letter of 15 May 2002 in ***Appendix 17***, the position of the 887 vacant HSC units as at 30 April 2002, as follows:

Let	Under offer	Still vacant	Total
383	210	294	887

The Director also stated that vacant HSC units were being offered to eligible applicants, including non-elderly applicants. A total of 1,253 offers were made since the units had become vacant. Should the less popular units be not taken up, the HD would put these flats under the Express Flat Allocation Scheme for selection by all eligible Waiting List applicants. Under the Scheme, applicants could get earlier rehousing than their normal turn if they were prepared to take up the less popular flats. Regular exercises were being conducted under the Scheme.

25. In view of the above reply, the Committee asked about the timetable for making full use of the 294 units which were still vacant.

26. The **Director of Housing** informed the Committee vide his letter of 10 June 2002, in ***Appendix 18***, that:

- since relaxation of the age restriction from 60 to 55 in April 2001 and subsequently total lifting of the age limit in November 2001, 223 non-elderly applicants had been rehoused to HSC units as at 31 May 2002. In addition, 229 HSC units were under offer to non-elderly applicants as at 31 May 2002 with intake dates in early June 2002; and

- all vacant HSC units, including the 294 units, were under a continuous process of allocation although some of them might not be accepted by the applicants for one reason or another. In order to expedite the letting of vacant HSC units, the HD would be sending individual invitations around mid-June 2002 to all applicants who were at the end of the queue, including those not satisfying the Residence Rule, to join the Express Flat Allocation Scheme. The application period would be from 24 June to 8 July 2002. At the time of arranging flat selection under the Scheme in early August 2002, all the said 294 units, if still vacant, would be put up for selection by eligible applicants. The HD hoped that many of the vacant HSC units would be taken up by the end of the selection period in September 2002.

27. The Committee further enquired:

- about the measures taken by the HD to encourage elderly applicants to take up vacant HSC units;

- whether the HD would consider allocating vacant HSC units to those elderly applicants whose families were residents of the public housing estates in which the vacant units in question were located; and

- if public housing units which had not been taken up one time, two times, three times, four times or five times would be put under the Express Flat Allocation Scheme, how far the average waiting time could be reduced for an elderly applicant or a Waiting List applicant in each of five scenarios.

28. In his letter of 22 May 2002, in ***Appendix 19***, the **Director of Housing** said that:

- a video to promote HSC had been produced and was being shown to elderly applicants non-stop at the enquiry counter of the Housing Authority's Customer Services Centre. It was also played regularly at all the seven Housing Information Centres throughout the territory. The video highlighted to the elderly applicants that 24-hour warden service and social activities were provided at the HSC. All the HSC units were fitted with the emergency alarm system and purpose-built fittings. Guided tours were arranged for interested applicants to visit the HSC;

- the HD would, as far as possible, allocate HSC units according to the elderly applicants' preference, including allocating to applicants those HSC units close to their families, subject to availability of suitable premises. In addition, the HD had the Families with Elderly Persons Priority Scheme in place giving priority in allocation of flats to those families with elderly persons included in their applications; and

- making one offer to an elderly applicant, allowing time for viewing the flat and subsequently considering to accept or reject a housing offer would take four weeks to complete. Therefore, under the five scenarios prescribed by the Committee, four weeks' time was required for each scenario. With the Express Flat Allocation Scheme in place, the shortest waiting time for ordinary Waiting List applicants and elderly applicants had been reduced to about three months against the current average waiting time of 3.2 years and 1.3 years for the respective groups. The existing arrangements under the Scheme had proved to be effective in maximising the utilisation of available public housing resources as well as reducing the waiting time of applicants.

29. The Committee asked:

- whether the HD had implemented any administrative arrangements in relation to the allocation of vacant HSC units according to the elderly applicants' preference, e.g. the issuance of notices to residents of public housing estates;

- whether the HD would consider adopting the following two proposals to make full use of vacant HSC units:

  (a) if there were some residents of public housing estates whose parents were already on the waiting list for HSC units and there were vacant HSC units in their housing estates, their parents would be invited to apply for these vacant units; and

  (b) if there were two or more applicants who wished to share a unit but they were at different places on the waiting list for HSC units, whether priority would be given to them in the allocation of vacant HSC units; and

- if the answer to the preceding inset was in the affirmative, the number of applicants for HSC units who would get earlier rehousing than their normal turn.

30. The **Director of Housing** informed the Committee vide his letter of 10 June 2002 that:

- there was already in place an established policy to facilitate special transfer for elderly tenants near to his or her family members already living in public housing so that the younger members could look after them. The policy was laid down in Chapter 4 of Section A of the General Housing Policies issued to all District Council members. The General Housing Policies were made known to Estate Management Advisory Committees (EMAC) and regular EMAC newsletters to tenants of the estates had adequate coverage of such policies;

- during the vetting interview of the elderly persons before allocation, an elderly applicant's request to be rehoused to specific HSC near his or her relatives in public housing would be recorded in the interview form for follow-up by the allocation team. Matching could normally be made to the HSC units concerned, especially those in the more remote estates with higher vacancy rates;

- the elderly parents had to be successfully registered on the Waiting List in the first instance. During the vetting interview, the rehousing preference of the elderly applicants would be noted in the interview form. Offer of rehousing to specific HSC could normally be made as far as resources permitted;

- only 333, i.e. 3.5%, out of the total stock of 9,580 HSC units were two-person units. They were suitable for couples, related persons or unrelated elderly persons who opted to live together. Two or more related or unrelated elderly persons were encouraged to apply together under one single application. Under the Elderly Persons Priority Scheme implemented since 1979, related or unrelated elderly persons could apply together for public housing and be rehoused together earlier. If individual applications from the elderly persons occurred in the process of waiting, the later applications could be advanced through combining with the earlier one. Since 1979, about 15,000 elderly applicants had benefited from the Scheme;

- compared with the current average waiting time for families at three years, the current average waiting time for single elderly persons at 1.2 years was obviously more favourable. This was far ahead of the Government's target of two years by 2005. The HD was already adopting the Committee's proposals in the allocation of flats for elderly persons. As the HD was planning to promote the general awareness of the Elderly Persons Priority Scheme, it would take the opportunity to publicise the measures in place so as to ensure that all prospective elderly applicants were fully aware of the Scheme; and

- depending on the locations of HSC, elderly applicants choosing the less popular HSCs could have earlier rehousing. The shortest waiting time at the moment was about three months. These less popular HSCs were all open to the existing 8,016 elderly applicants registered on the Waiting List. The potential beneficiaries of the Committee's proposals would be these 8,016 elderly applicants.

Provision of subsidised nursing-home and infirmary places

31. Paragraph 4.4 of the Audit Report stated that the Government had not determined a planning ratio for the provision of nursing-home places. The Committee asked when the Government would adopt a planning target in this regard.

32. In her letter of 23 May 2002, the **Director of Social Welfare** explained that:

- in line with the concepts of "ageing in place" and "continuum of care" and to ensure flexible and optimal use of resources, the Administration did not see the advantage of pursuing separate planning targets for the provision of nursing-home places. The intention was to enable residential care homes to

be able to continue to take care of their residents when their health conditions deteriorated. To achieve the objective, all homes put out for competitive tendering would include such requirements for continuum of care. However, noting that there were now a considerable number of elderly persons on the waiting list for nursing-home places, the SWD was planning to provide additional nursing-home places in some of the new contract homes so that these homes might admit elderly persons on the waiting list immediately to provide them with better care. The SWD would closely monitor the proportions of nursing-home places versus C&A places in the new contract homes to ensure an optimal mix and to reduce the waiting times for admission to nursing homes; and

- with further development of enhanced home and community care and taking account of elderly persons' preference, the Government might be able to take care of elderly persons with C&A level of impairment at home and only elderly persons whose health conditions necessitated their admission to nursing homes would in future require admission to residential care homes. The entire long-term care scene would undergo some significant changes with the benefit of recent developments, including the findings and recommendations of the Audit Report. It would not be timely to settle on planning targets for services one way or the other without drawing reference from those likely changes.

33. Turning to the planning target for infirmary places adopted by the Hospital Authority, the Committee noted from paragraph 4.6 of the Audit Report that for many years, it was five places per 1,000 population aged 65 or over. Figure 7 of the Audit Report revealed that the actual provision of infirmary places had consistently been well below the planning target in the past few years. As at 31 March 2001, the actual provision was 1.5 places per 1,000 elderly persons. The Committee further noted from the Hospital Authority's response in paragraph 4.9(e) that given the uncertainty of the policy, the Hospital Authority had not revised the planning target until the policy direction was clear.

34. Against this background, the Committee asked:

- when a planning target was first adopted for infirmary places; and

- whether respective targets were also set at that time regarding the average waiting time for an infirmary place and the reduction of the average waiting time.

Residential services for the elderly

35. The **Secretary for Health and Welfare** informed the Committee at the public hearing and in his letter of 24 May 2002 that:

- the planning ratio of five infirmary beds per 1,000 elderly persons aged 65 or above was adopted by the Medical Development Advisory Committee (MDAC) of the former Medical and Health Department in 1981. There was no target set for the average waiting time or reduction of average waiting time for infirmary beds at the time;

- since then, there had been significant developments in the provision of medial and care services for frail elderly persons. The Hospital Authority, which was established in 1991, conducted a review every three to five years of the requirement for different types of hospital beds, including infirmary beds, on a territory-wide basis. In conducting such reviews, the Hospital Authority had taken into account a number of factors, including population statistics, observed changes in disease patterns, and the prevailing utilisation patterns of hospital services. The reviews formed the basis for the Hospital Authority's discussion with the Administration on capital and recurrent funding, in order to meet the changing needs of the population. In the context of these reviews, a target to provide 1,000 infirmary beds in the next five years was set in 1997-98. The Administration was meeting this target. Two years ago, the Hospital Authority had reached an agreement with the Administration on moving away from a facility-based funding mechanism to a population-based funding mechanism. Emphasis had been put on post-discharge care and community-based services to support patients to remain in the community;

- in light of the developments in the planning mechanism for provision of hospital beds and the changing needs for infirmary beds, the Administration regarded that the original planning ratio was no longer appropriate. With experience gained in practising "continuum of care" in both community and residential care services for frail elderly persons, the Administration would review in due course the role of the Hospital Authority in the provision of infirmary care; and

- he agreed with the Director of Audit that infirmary care should not be provided in a hospital setting. However, the policy direction had not been set regarding the setting appropriate for providing infirmary care. The provision of elderly services by the SWD was a complicated matter. Its staff needed to receive training in order to provide infirmary services. At present, some of the infirm patients were transferred from the acute hospital and started receiving infirmary care in the hospital setting after suffering from stroke or other illnesses. The remaining patients were from the Central Infirmary

Waiting List (CIWL). Hence, the Hospital Authority needed to conduct an in-depth analysis of the size of these two groups of infirm patients and the financial implications. It would ascertain the number of infirm patients who could be taken care of in non-hospital setting.

36. In response to the Committee's concern over the failure of the Hospital Authority to reach the planning target of five places per 1,000 elderly persons, **Dr William HO, Chief Executive, Hospital Authority**, said that:

- the Hospital Authority would reach a consensus with the Government when setting the planning ratio in the future. The Hospital Authority had noted the direction of government policies. For example, it was mentioned in the Audit Report that consideration might be given to the provision of infirmary beds by the SWD instead of by the Hospital Authority;

- there were two types of infirmary places. The Hospital Authority provided infirmary places for applicants on the CIWL and 1,421 infirmary places for patients transferred from acute hospitals. When the Hospital Authority applied for funding from the Government every year, it needed to state the category of beds to be increased. The annual discussion with the Government on the use of resources also covered the classification of infirmary places into those for CIWL applicants and those for infirm patients. Currently the policy might be in transition. When the policy had been established for taking the provision of infirmary care out of the hospital setting, the planning target would be revised; and

- the future direction of the policy was based on the concept of "Ageing in Place", which meant that the Hospital Authority would provide some outreach medical services so that elderly persons could stay at the same residential home when their health conditions deteriorated. In fact, the Hospital Authority had vigorously developed geriatric service and psychiatric service for the elderly in the past few years. The services involved frequent deployment of staff to provide support to private residential homes. However, the Hospital Authority's efforts could not be fully reflected in the planning ratio.

37. According to Figure 7 of the Audit Report, the Hospital Authority provided the same number of infirmary places as at 31 March 2000 and as at 31 March 2001. In view of the growing elderly population, the Committee asked about the reasons for this and the number of infirmary places provided vis-à-vis the number of applicants from 1996 to 2001.

The Committee further noted from Notes 10 and 11 of the Audit Report that during the period from 1997-98 to 1999-2000, more than 7,000 elderly persons passed away while waiting for infirmary places. The average waiting time was as long as 36 months in March 2000. The Committee enquired about the average waiting times for an infirmary place in March 2001 and March 2002 respectively.

38. The **Secretary for Health and Welfare** provided the statistics on applicants on the CIWL from 1996-97 to 2000-01 and infirmary places provided during the same period vide his letter of 24 May 2002. He also said that:

- the majority of applicants on the CIWL were already receiving some form of public services, as reflected from the breakdown of their place of residence in Annex II of his letter:

  (a) 20% of the applicants were living in subvented care homes. 50% were in private or self-financing care homes. In addition, the Hospital Authority's Community Geriatric Assessment Teams provided outreach geriatric care to all subvented care homes and the majority of the private care homes. Infirmary Units were set up and Infirmary Care Supplement was provided to enable a number of subvented C&A homes to take care of elderly persons assessed to be in need of infirmary care;

  (b) about 10% of the applicants were receiving other types of hospital services; and

  (c) for the remaining 20% of the applicants living in their own homes, community care and support services were available and provided mainly by the welfare sector as required. These included Community Nurses and enhanced home and community care services, which was a package of centre and home-based services tailor-made to meet the individual care needs of frail elderly persons;

- the total number of infirmary beds increased from 1,915 in 1996-97 to 2,851 in 2001-02. A total of 68 beds were added in 2000-01 over the previous year, and were allocated for use by post-acute patients instead of by applicants on the CIWL. The reason for giving priority to patients in the hospital sector was to lessen the pressure on acute beds, the costs of which were much higher than infirmary beds. The majority of post-acute patients were elderly persons, for example, stroke patients who immediately became severely disabled and who required urgent post-acute infirmary care. On the other hand, the majority of CIWL applicants were already receiving some form of care through different channels as described in preceding inset; and

- the number of active applicants on the CIWL had reduced from 5,690 in 1998-99 to 4,973 in 2001-02. The average waiting time for CIWL applicants admitted in the year 2001-02 was 39 months.

39. The **Secretary for Health and Welfare** also said that the majority of elderly persons who needed infirmary care were relatively frail. The number of elderly persons who passed away while waiting for infirmary places had dropped from about 3,500 persons in 1998-99 to about 2,000 persons in 1999-2000. The situation had not worsened.

40. The Committee was surprised at the Secretary for Health and Welfare's statement in his letter of 24 May 2002 that "the Administration regards that the original planning ratio (for infirmary places) is no longer appropriate". It wondered whether the Administration had consulted the MDAC, the Hospital Authority, the Elderly Commission or the LegCo regarding its decision to abolish the original planning ratio.

41. The **Secretary for Health and Welfare** responded in his letter of 12 June 2002, in ***Appendix 20***, that:

- the total number of infirmary beds in 2001-02 was 2,851. This represented a ratio of 3.8 infirmary beds per 1,000 elderly persons aged 65 or above. The total number of infirmary beds would be increased by 100 to 2,951 by March 2003, and the ratio would correspondingly be increased to 3.9 infirmary beds per 1,000 elderly persons. The Administration was on schedule in meeting the policy pledge set in 1997-98 in providing 1,000 infirmary beds by 2002-03; and

- the Administration had not abolished the planning ratio, but considered that this target which had been set over 20 years ago was no longer appropriate and should be reviewed in light of the developments in the provision of medical and care services for frail elderly persons since its adoption in 1981. The Administration further considered that in addition to the planning ratio, the review should cover the changing needs for infirmary beds and the role of the Hospital Authority in the provision of such beds. Given that this was a complex subject, the Administration would require some time to work out proposals. When it had definite proposals on specific areas, it would consult relevant parties, including the Elderly Commission and the relevant LegCo Panels.

Residential services for the elderly

42. The Committee noted from Table 5 of the Audit Report that the estimated monthly subsidy for an infirmary place was as high as $30,000. In contrast, the cost of a nursing-home place for caring of an elderly person in need of infirmary service would amount to $18,625, as revealed in paragraph 4.14 of the Audit Report. According to paragraph 4.20, the Chief Executive of the Hospital Authority had said that if the elderly persons on the waiting list for infirmary places were transferred to nursing homes, the Hospital Authority still required beds for managing post-acute infirm patients and those who were presently accommodated in a setting not appropriate for infirm patients. Hence, the Hospital Authority could not provide savings by transferring these patients to the welfare sector. The Committee invited the Chief Executive, Hospital Authority to elaborate on this point.

43. The **Chief Executive, Hospital Authority** explained that:

- the estimated monthly subsidy of $30,000 for an infirmary place was the average subsidy for infirmary beds for both applicants on the CIWL and post-acute infirm patients. The cost of the 1,134 infirmary beds for CIWL applicants was lower; and

- the Hospital Authority would have no objection to the policy option of taking the provision of infirmary care for CIWL applicants out of the hospital setting. However, it should be noted that many elderly persons were currently residing in private residential homes. The Hospital Authority required additional resources to provide outreach services. Moreover, when some stroke patients at private elderly homes could not be taken care of with the most appropriate care, they would need to receive further medical care at the hospital. If resources for the provision of infirmary beds for CIWL applicants were to be taken from the Hospital Authority, there was a need to conduct a cost analysis.

44. The Committee enquired about the estimated monthly subsidy for each type of infirmary bed. In his letter of 25 May 2002, in ***Appendix 21***, the **Chief Executive, Hospital Authority** stated that existing infirmary beds admitted patients for long-term care for applicants on the CIWL and for extended care for infirm patients transferred from acute hospitals. The estimated costs for the two type of beds were $19,124 and $37,826 per month respectively.

Residential services for the elderly

45. The Committee noted from paragraph 4.19(c) of the Audit Report the Director of Social Welfare's statement that an arrangement to transfer the infirmary function to the social welfare setting must be accompanied by a corresponding budget transfer. The Committee invited the Director to elaborate on her view. The **Director of Social Welfare** said in her letter of 23 May 2002 that:

- due to the shortage of infirmary places in hospitals, some transfer of cost in looking after these infirm elderly persons, though not directly from the Hospital Authority to the SWD, had already taken place in the form of the SWD on its own finding extra funding to pay for home operators looking after these elderly persons in the welfare setting in the form of cash-limited infirmary supplements; and

- given the overall fiscal stringency, she could foresee major difficulties for the SWD to secure further additional resources on its own to take care of infirm elderly persons in the welfare setting. She had therefore expressed the view that any delineation of respective responsibilities in long-term care should be accompanied by the corresponding budget transfers from the Hospital Authority to the SWD, otherwise the SWD would be faced with the consequence of the provision of care to other elderly persons currently in the welfare setting being adversely affected, such as lengthened waiting times for nursing-home places.

46. In response to the Committee's concern over the allocation of resources between the Hospital Authority and the SWD regarding the provision of infirmary care, the **Secretary for Health and Welfare** said that the Administration was planning to provide one type of residential care home which could cater for the different levels of care needs of the elderly. It needed to analyse with the Hospital Authority and identify the group of infirm elderly persons who could be accommodated in non-hospital setting for receiving infirmary care service. The allocation of resources depended on the assessment of care needs of the elderly persons. He agreed that there was a need to discuss with the Hospital Authority and the SWD the problem of allocation of resources between them regarding the provision of infirmary care.

Government's financing of subsidised residential services for the elderly

47. The Committee noted from paragraphs 5.8 and 5.10 of the Audit Report that Audit had conducted a research on the arrangements for providing residential services for the elderly in four advanced countries. Audit found that in general, elderly persons needed to make contributions to cover part of the costs of the residential services. The size of the

contribution varied according to the persons' income and assets, based on a means-test system. On the other hand, the Committee noted from the submission dated 3 May 2002 from the Hong Kong Council of Social Service, in ***Appendix 22***, that according to the General Household Survey conducted in 2000, the median income of elderly persons was $2,600. It was anticipated that not many of the elderly persons could afford to pay more. It would be very costly to set up the administration system to conduct the assessment and would end up with very few elderly persons making contributions for the service.

48. Against this background and in view of the Director of Social Welfare's support for the introduction of some form of means test as stated in paragraph 5.24(e) of the Audit Report, the Committee asked:

- when the Administration had accepted the principle of introducing some form of means test in respect of the provision of RCHEs; and

- whether a consultation exercise had been conducted in this regard.

49. The **Secretary for Health and Welfare** informed the Committee at the public hearing and in his letter of 24 May 2002 that:

- in formulating a system, the Administration needed to take into account elderly persons' comparatively long duration of stay in nursing homes. Elderly residents would be required to pay $6,000 or even $7,000 to $8,000 a month to ensure cost recovery by the Government. Without a pension or insurance scheme, most of the elderly persons would have difficulty paying more. As proposed in the Harvard Report, there should be an insurance scheme in the long run, which enabled members of the public to spend a portion of the premium on long-term care services when they reached old age;

- the Administration had not yet formulated any proposal in introducing means-testing for the provision of residential care services. However, in the context of developing a quality and sustainable long-term care system, the Administration was examining options that helped it target resources at elderly persons with genuine needs. These included the implementation of the standardised care need assessment mechanism since November 2000. The Administration was also exploring the option of setting up a new subsidy arrangement which allowed elderly persons more freedom in choosing care homes, flexibility to contribute more to their own care costs, and a quick access to such service. As this was a complex matter, the Administration would require more time to work out the details and implications, including

the factor of affordability. It would be a severe financial burden on elderly persons and their families if they had to pay for a high proportion of the residential care cost, particularly for a higher level of care, on a long-term basis; and

- in parallel and to create an environment to enable a subsidy scheme to succeed, the Administration had taken some steps to improve the quality of residential care services. These included enhancing training of staff in care homes; dissemination of information on care homes to the public; progressive promulgation of application of subvented service standards in the private sector; commissioning a consultancy study on the establishment of an accreditation system for care homes in Hong Kong with the objective of raising the quality of service; and selecting operators through open tendering to provide additional and quality subsidised and non-subsidised places in all new care home premises supplied by the Government.

50. The **Director of Social Welfare** supplemented that:

- she had responded in the Audit Report that Audit's recommendation on the introduction of some form of means test was worthy of support. The rationale was that according to the basic principle of a social welfare system, resources should be targeted at the elderly persons with genuine needs. Given increasing fiscal constraints, the recommendation of allocating the limited number of RCHE places to those most in need was worthy of support; and

- means-testing did not mean that the elderly persons would either receive or not receive the services. At present, some form of means test had been adopted in welfare services for the elderly. In the case of home care and enhanced home care services, there were three levels of charges for meals delivered to elderly persons. The elderly persons are required to take a means test. If they were on the Comprehensive Social Security Allowance (CSSA), they would pay $12.6 for a meal. If they were in a better financial position, with their income in excess of the CSSA by less than 150%, they would pay $15.4 for a meal. If the elderly persons' income was in excess of the CSSA by 150% or more, they would pay $18.6 for a meal.

Residential services for the elderly

Monitoring of healthcare services of RCHEs

51. As stated in paragraph 8.5 of the Audit Report, during the visits to 20 randomly selected RCHEs, Audit had conducted interviews with carers and residents at the RCHEs and made observations on the facilities and services provided. Figure 9 revealed that 69% and 44% of health workers could not provide satisfactory answers to questions respectively on the provision of care to an elderly person who was on oral medication and on the knowledge on normal blood pressure. According to paragraph 8.28, there were no provisions under the Residential Care Homes (Elderly Persons) Ordinance, the Residential Care Homes (Elderly Persons) Regulation, or Code of Practice specifying the minimum qualifications of a person to be employed as a care worker or ancillary worker at an RCHE. The Committee noted from paragraph 8.29 that under the existing arrangements, there was no assurance that, between 6 pm and 7 am each day, there were staff working at a C&A home who had received proper and recognised healthcare training. As 15 of the 20 RCHEs visited by Audit were private RCHEs, the Committee asked the Director of Social Welfare to comment on the standards of healthcare services provided at private RCHEs.

52. The **Director of Social Welfare** explained that:

- at present, private homes were only required, under the Residential Care Homes (Elderly Persons) Ordinance, to apply for licences from the SWD. The more than 500 private homes had all been granted licences. She admitted that in view of the varying standards in healthcare services at private homes, the SWD needed to step up monitoring on them. However, provision of a higher level of services would entail an increase in the operating cost of these homes. Some elderly residents in private homes were supported by middle-income families. These families might not be able to afford increased fees for places at the private homes; and

- whenever the Administration discussed the option of tightening control on private homes through legislative amendments, the impact on the commercial operators should be considered. Even under such restriction, the SWD was providing incentives to the private homes for improving their service quality. Firstly, the Government bought places directly from private RCHEs with a view to ensuring a higher level of services. Secondly, staff in private and subvented homes were invited to attend training courses, most of which were subsidised by the SWD. Actually, 684 training places would be provided for health workers in 2002-03, and by 2005, the SWD would provide a total of 2,160 multi-skilled training places for care workers.

Residential services for the elderly

53. Regarding the periodic inspections of RCHEs by the SWD's Health Inspectorate Team (HIT), the Committee noted from paragraph 8.16 of the Audit Report that as at 31 March 2001, the HIT had two Nursing Officers who were responsible for inspecting all RCHEs. As pointed out by Audit in paragraph 8.17, with only two Nursing Officers, the HIT could not be expected to effectively monitor the RCHEs. The Committee considered that although the 18 Visiting Health Teams (VHTs) of the Department of Health (DH) conducted periodic visits to RCHEs to provide health education programmes, they were not playing the monitoring role. The Committee asked whether the SWD would take any measures to improve the situation.

54. The **Director of Social Welfare** replied that there was inadequate nursing manpower in the HIT. She welcomed Audit's suggestion for the Department of Health to provide professional support or advice to the HIT. She would discuss with the Director of Health for cooperation in this regard.

55. In the light of the above reply, the Committee invited the Director of Health to give her comments on Audit's recommendation. **Dr Margaret CHAN FUNG Fu-chun, Director of Health**, said that:

- there was one VHT for each district. In principle, the DH was willing to complement the SWD's efforts. However, as the SWD was responsible for licensing RCHEs, its monitoring function was different from the DH's function;

- concerning the work of the VHTs, the DH would send professional medical teams to RCHEs to provide services. Although the utilisation of the VHT services was voluntary, 97% of the RCHEs were willing to accept the services. The VHTs provided practical training and made suggestions on the spot, having regard to the environment and needs of the RCHE and the training needs of its workers, to improve the services provided at the RCHE. In the light of its VHTs' work experience, the DH would regularly provide feedback to the nursing officers of the HIT. The DH would reflect to the SWD the problems in the RCHEs without informing the SWD of the names of the RCHEs concerned; and

- the DH would also assist RCHEs in drafting their Code of Practice and require them to strengthen services that needed improvement. The VHTs would pay more visits to bigger institutions. If individual institutions were keen about healthcare education, the VHTs would pay more visits to them. She would discuss with the Director of Social Welfare measures to improve the service standard of RCHEs.

56. In response to the Committee's enquiry about voluntary utilisation of the VHT services, the **Director of Health** said that if RCHEs were to be required to receive healthcare education, the Administration would need to consider introducing relevant legislative amendments. As 97% of the institutions had accepted such services, she preferred persuading the remaining 3% to receive training.

Overall discussion

57. The Committee understood from the Secretary for Health and Welfare's letter of 24 May 2002 that the Administration had not yet formulated any proposal to introduce means-testing for the provision of residential care services and was working out the details of the proposal for a one-stop service for the provision of subsidised long-term care to elderly persons. It appeared to the Committee that although the Administration had taken some steps to improve the quality of residential care services, it would take a long time to implement the new strategies. In view of the growing demand for residential services for the elderly and the fact that many elderly persons would pass away while waiting for the services, the Committee enquired about the stopgap measures that the Administration would take to deal with the present situation.

58. In his letter of 12 June 2002, the **Secretary for Health and Welfare** informed the Committee that:

- the Administration would continue to accord priority to meeting the care needs of frail elderly persons, including the need for residential services. The waiting list for residential services, comprising about 27,000 applicants, did not totally reflect genuine need. The reasons were as follows:

  (a) the applicants had not yet undergone the standardised care need assessment mechanism; and

  (b) about 50% of the applicants were residing in private or self-financing homes, were in subvented care homes receiving lower levels of care services, or were receiving some form of home and community services;

- the Administration would continue to respond to demands for long-term care services by enhancing value for money and improving services. With the introduction of enhanced home and community care services in April 2001, eligible elderly persons for residential services were given the option to receive the new services in lieu of residential services, or while they were awaiting residential services placement. About 29,000 elderly persons were

now being served by a range of community services, including enhanced home and community care services, representing about 60% increase compared to 1997-98. The Administration intended to re-engineer and upgrade existing community support services, and to further expand enhanced home and community care services to ensure that appropriate care services were provided to frail elderly persons once their care needs were determined by the standardised care need assessment mechanism;

- in parallel, the Administration would continue to provide residential services for those elderly person who required such services through a mixed mode of service provision, with participation from NGOs and the private sector. There were about 26,000 subsidised beds, representing about 62% increase compared to 1997-98. In 2002-03, the Administration would provide an additional 1,600 subsidised beds; and

- the Administration would keep the provision of long-term care services, including residential services, under regular review, taking into account the experience of enhanced home and community care services, and the service needs as determined by the standardised care need assessment mechanism.

Evidence taken at the public hearing on 4 July 2002

Provision of HSC units by the Housing Authority

59. In response to the Committee's enquiries about the latest position of the 887 vacant HSC units, **Mr Marco WU, Deputy Director of Housing**, said that:

- in April 2002, the number of vacant units had reduced to 294. 331 units had been let to elderly persons and 52 units had been let to non-elderly persons. Of the units under offer, 17 units had been offered to elderly persons and 193 units to non-elderly persons; and

- the number of applicants registered on the Waiting List was decreasing. There were currently a total of 84,000 households on the list. The one-person, two-person and three-person applications from elderly persons amounted to 8,016 households, which represented less than 10% of the households on the list.

Residential services for the elderly

60. In view of the large number of elderly applicants for public rental housing, the Committee considered that vacant HSC units should not be allocated to non-elderly applicants. The **Deputy Director of Housing** responded that:

- apart from HSC units, the HD also allocated to elderly applicants self-contained units for one person or two persons. Hence, there were sufficient units for elderly applicants; and

- some HSC units had remained vacant for a long period of time because some elderly applicants might not find the facilities or the locations agreeable. They preferred self-contained units. Priority would certainly be given to elderly applicants in the allocation of HSC units while the HD would also allocate surplus vacant units to non-elderly applicants.

61. The Committee noted from the Director of Housing's reply of 22 May 2002 that the HD would, as far as possible, allocate HSC units according to the elderly applicants' preference, including allocating to applicants those HSC units close to their families. The Director further informed the Committee in his letter of 10 June 2002 that during the vetting interview of the elderly persons before allocation, an elderly applicant's request to be rehoused to specific HSC near his or her relatives in public housing would be recorded in the interview form for follow-up by the allocation team. The Committee asked whether the HD would post notices in public housing estates with vacant HSC units, so that the tenants in these housing estates would encourage their parents who were already on the waiting list for HSC units to apply for these vacant units.

62. The **Deputy Director of Housing** replied that the HD had not adopted the measure, but very much encouraged elderly persons to live in the same public housing estate as their relatives so that the younger generation could take care of them. The HD needed to consider whether this message would encourage elderly persons to live alone.

63. Table 4 of the Audit Report revealed that the percentage of vacant HSC units remained high in the period from 1998 to 2001 except for the year 1999. The Committee wondered why there were so many vacant units, given the large number of applicants on the waiting list of HSC units. It seemed that the vacant units were unpopular units. The Committee considered that as the Housing Authority had continued to build HSC units, the problem of vacant units was prolonged, thus wasting taxpayers' money.

64. The **Deputy Director of Housing** responded that the percentage of vacant units was not high in 1999, but it had been rising in the past two years. The reason was an increased supply of HSC units and self-contained units. The Housing Authority had commissioned a consultant in 2000 to conduct a study on the housing needs of the elderly. In the light of the findings of the consultancy report, the Strategic Planning Committee of the Housing Authority had decided in November 2000 to stop further production of HSC units.

65. As regards the Housing Authority's decision to stop further production of HSC units, the Committee asked:

- when the Housing Authority or the HD was first aware that the HSC was not very popular;

- whether the HD had adopted any measures, before the Housing Authority made the decision, to reduce the planned production of HSC units; and

- about the details of the Housing Authority's discussions on the issue and the justifications for the decision.

66. In his letter of 12 July 2002, in ***Appendix 23***, the **Director of Housing** provided information about the decision process of the Housing Authority leading to stopping further production of HSC units. He stated that:

- having regard to elderly persons' special accommodation needs, the Housing Authority had decided in 1985 that it should build HSC units in public housing estates with warden service so that NGOs could devote their resources to the care of those elderly persons who would require more support services. The arrangement was supported by the SWD;

- it was on this mission that the Housing Authority had assumed the responsibility of providing HSC. HSC units had been all along well received by the public for its provisions, including the built-in emergency alarm system and 24-hour warden service. When members of the Elderly Commission visited some HSC units in February 1998, they were impressed by their cosy and protected environment. There was no sign that HSC was not popular until 1998-99 when the take-up of HSC units began to slacken. As shown in Table 4 of the Audit Report, the vacancy rate was normal as at the end of March 1997 and even in early 1999, i.e. 1.7% and 3.7% respectively, but was relatively higher in 1998, i.e. 7.9%. As the take-up rate

was improved in 1999 with a vacancy rate of 3.7%, the HD needed to closely monitor the vacancy position before making any decision that might impact on other elderly service providers;

- the relatively higher vacancy rate in 1998 was attributable to the increase not only in the provision of hostel type HSC with improved facilities but also the supply of self-contained small flats for the elderly. With a wider choice of housing types available, HSC units, especially those without en suite bathrooms, were becoming less attractive;

- apart from the 7.9% vacant HSC units, the remaining 92.1% of the HSC units that were occupied in 1998, were maintained in good conditions with elderly persons happily living there. They enjoyed very much the common facilities and activities organised for them, e.g. television and other entertainment programmes, reading materials, chess playing and other social as well as healthy-ageing activities. More importantly, they felt secure and safe with the 24-hour warden service provided therein;

- the HD reviewed its housing provision and design regularly, taking into account the demand and changing needs of the elderly. The Housing Authority introduced HSC to provide housing with warden service for able-bodied elderly persons so that the NGOs could devote their resources to accommodate elderly persons with impairments in residential care homes. As reduction in HSC units might impact on other elderly policies and service provisions, the HD considered it necessary to examine the issue together with the provision of other services for the elderly. The HD therefore held a series of consultations with the then Health and Welfare Bureau and its departments and, at the same time, decided to conduct an overall review of its existing provision of and strategies for elderly housing to coordinate the Government's pledge of "ageing in place" and "continuum of care". It was in this context that the HD commissioned a consultancy study;

- the Housing Authority decided to stop further production of HSC units in November 2000, having regard to the elderly persons' preference for self-contained small flats. However, there was a need to maintain the existing HSC units and allow the then ongoing construction programme to continue, so that elderly applicants could have a choice between self-contained small flats and HSC units with warden service;

- according to the findings of the consultancy study, flats with shared facilities were less popular among the elderly tenants. The Strategic Planning Committee of the Housing Authority endorsed on 30 November 2000, among other initiatives, to discontinue further production of HSC with shared facilities but concentrating more on building self-contained small flats, having regard to the elderly persons' preference. Accordingly, the Elderly Commission was also informed of and supportive to this new development in February 2001; and

- the consultancy study on "Provision of Housing and Care Services for the Elderly in Public Housing Estates" was a comprehensive review of the Housing Authority's existing provision of housing and support services for the elderly in public rental housing of which HSC was only one of options. The primary aim was to explore the feasibility of developing an integrated mode of service delivery to achieve the two central themes advocated by the Elderly Commission, i.e. "ageing in place" and "continuum of care". International references were made in the study. The new concept of Universal Design was also studied in depth.

67. The Committee was concerned about the disposal of the last batch of new HSC units. It requested the Director of Housing to provide information on the new units, including their target completion date, number and locations, the timetable for allocation and the actions taken to promote these units.

68. The **Director of Housing** provided the information in the same letter, as follows:

	District	**Estate**	**Number of units**	**Target completion date**
Extended-Urban	Tsuen Wan	Wah Lai	152	)
	Ma On Shan	Chung On	156	)
				) 1 August 2002
Urban	Cheung Sha Wan	Fu Cheong	131	)
	Total		439	

The Director also stated that all these units would be offered to eligible single persons on the Waiting List with priority given to the elderly. The HD anticipated that all 439 units would be offered to elderly persons in the first round of allocation by the end of September 2002. Those units rejected by elderly persons would be offered to non-elderly applicants in October 2002. As regards actions to promote these new units, the HD would take the following publicity measures:

- posting notices in Wah Lai, Chung On, Fu Cheong and neighbouring estates in late July 2002 to publicise that there would be new HSC units available for letting, so that local residents with elderly relatives who would like to live there might call the HD's hotline to indicate their interest;

- asking the elderly applicants during vetting interviews whether they would like to be rehoused to HSC units and note down their preference. Allocation would be made according to their preferred districts, subject to availability of resources;

- arranging group visits for the elderly applicants to see the environment and facilities provided in the new HSC units in three housing estates; and

- showing the video on HSC units to elderly applicants at the time when they attend interviews in the HD's Customer Service Centre.

69. In the light of the above reply, the Committee requested the Director of Housing to provide a report on the following as at 30 November 2002:

- the total number of the HSC units, including the last batch to be completed on 1 August 2002, that were vacant; and

- among the last batch of the 439 new HSC units, the respective numbers of those that had been allocated to elderly and non-elderly applicants, and the number that remained vacant.

70. The **Director of Housing** informed the Committee, vide his reply of 11 December 2002 in ***Appendix 24***, that:

- the total number of vacant HSC units including the last three projects completed in July and August 2002 in Fu Cheong, Wah Lai and Chung On Estates, was 144 units, with a vacancy rate of 1.4%;

- to expedite the letting of HSC units, HD had pooled 862 such units in all districts for flat selection by eligible Waiting List applicants in the last Express Flat Allocation Scheme just completed in October 2002. Out of the 862 flats pooled, 801 units were selected by the applicants; and

- the letting position of the last batch of the 439 new HSC units was as follows:

District		**Estate**	**Number of new units**	**Number of units let to elderly applicants**	**Number of units let to non-elderly applicants**	**Number of units yet to be let**		
						Number of units under offer		***Number of vacant units***
						To elderly applicants	***To non-elderly applicants***	
Urban	**Cheung Sha Wan**	**Fu Cheong**	131	61	2	66	0	2
Extended Urban	**Tsuen Wan**	**Wah Lai**	152	11	15	42	83	1
	Ma On Shan	**Chung On**	156	5	5	1	143	2*
Total			**439**	**77**	**22**	**109**	**226**	**5**

* Two flats were withheld from letting due to improvement works being carried out.

Provision of subsidised nursing-home and infirmary places

71. Referring to the Secretary for Health and Welfare's statement in his letter of 24 May 2002 that the Administration regarded that the original planning ratio for infirmary places was no longer appropriate, the Committee pointed out that the Secretary had neither mentioned this thought in the course of the audit review or at the first public hearing nor informed any LegCo Panels of the thinking. The Committee considered that procedures should have been established for the revision of the planning ratio.

72. The Committee questioned when the Administration came to the view that the original planning ratio for infirmary places was no longer appropriate. **Dr E K YEOH, Secretary for Health, Welfare and Food**, explained that:

- many services provided by the Hospital Authority had undergone changes. The demand of the community had also changed. Issues relating to the planning of infirmaries had been raised in the Audit Report. There were discussions on the current situation at the last public hearing. Although the Administration considered that the planning ratio was no longer appropriate, this did not mean that the Administration had abolished the planning ratio. This actually meant that the circumstances were changing;

- in the past, it was the MDAC of the former Medical and Health Department which advised the Government on the demand for infirmaries. Following the establishment of the Hospital Authority, the MDAC had ceased operation. Under the Hospital Authority Ordinance, the Hospital Authority was required to advise the Government on the territory-wide demand for medical services. Thus the Hospital Authority needed to submit to the Government a proposal on the planning ratio for infirmary places. The Government and the Hospital Authority had agreed that a review must be conducted on the planning ratio. In fact, the Hospital Authority would conduct a review of the demand of infirm patients every three to five years, which covered the territory-wide requirement for infirmary places and services;

- the original planning ratio was no longer appropriate due to rapid development in medical technology and the change in the mode of provision of residential services for the elderly by the SWD. The SWD had strengthened the provision of outreach services. Treatments which must be provided in the hospital setting could now be provided at places other than the hospital; and

- according to the report of the MDAC in 1981, the provision of infirmaries was due to the needs of many post-acute patients for hospitalisation. The aim of providing infirmary beds was to reduce the pressure on acute beds. At that time, there was a shortage of residential services for the elderly provided by the SWD and many patients continued to stay in the hospital. Nowadays, due to the changing needs for infirmary places, the Administration considered that there was a need to conduct a review of the planning ratio.

73. The Committee further enquired whether:

- the planning ratio had ever been reviewed in the past two decades; and

- the Hospital Authority had commenced the review.

74. The **Chief Executive, Hospital Authority** informed the Committee that:

- the planning ratio had not been reviewed since its adoption in 1981. The setting of the ratio involved discussions among several relevant sectors and reaching a consensus with the Government. The numbers of acute beds and infirmary beds should also be covered in the review; and

- the Hospital Authority had not commenced the review of the provision of infirmary places. It was aware of the changing circumstances of the welfare sector and the change in the mode of service provision. It considered that now was the appropriate time to conduct the review.

75. As the Chief Executive, Hospital Authority considered that now was the appropriate time to review the planning ratio, the Committee asked the Secretary for Health, Welfare and Food about the timetable and the direction of the review.

76. The **Secretary for Health, Welfare and Food** advised that:

- during the time of the Medical and Health Department, the ratio was set on the basis of a rough estimate of the number of the patients in the hospitals who needed to receive long-term care. According to the analysis at that time, 85% of such places were allocated to elderly persons. It was therefore considered reasonable to express the ratio in terms of the number of beds required for the elderly population;

- as far as the direction of the review was concerned, the Administration would review the planning of infirmaries within one year. The review would cover the services at C&A homes, nursing homes and infirmaries; and

- the first part of the exercise was to review the provision of housing services for the elderly in the next few months. The second part was to implement a central registration system within one year. The third part was to review the provision of infirmary care within one year. However, it might not be

possible, as the first step, to transfer the infirmary care function to the SWD. The Administration needed to rationalise and re-engineer many services in respect of the implementation of the "continuum of care" concept and to enhance care services.

77. In paragraph 4.20(b) of the Audit Report, the Chief Executive, Hospital Authority said that there were on average 12,000 new stroke patients admitted to public hospitals each year. About 10% of these patients would result in severe disability requiring care up to the infirmary level. As at 31 March 2001, the actual provision of infirmary places reached only 1.5 places per 1,000 elderly persons aged 65 or over, as shown in Figure 7 of the Audit Report. The average waiting time in the past few years was three to four years. Many applicants passed away while waiting for the places. In view of the growing demand for residential services for the elderly and the significant shortage of infirmary places, the Committee asked the Secretary for Health, Welfare and Food to elaborate on the direction of the review.

78. The **Secretary for Health, Welfare and Food** said that:

- coordination would be required between the provision of infirmary care and the implementation of the "continuum of care" concept. The delineation of respective responsibilities in long-term care would not be too clear. The Administration needed to establish some yardsticks for determining the delineation. However, under certain circumstances, elderly residents at RCHEs would require hospitalisation. The Administration would reduce, as far as possible, the need for referral of the residents to the hospital; and

- most of the applicants on the CIWL were receiving other services. As they were relatively frail, their remaining life span on average was mostly about one and a half years to two and a half years.

79. In view of the complexity of the issues involved on the subject of residential services for the elderly, the Committee wondered whether the Secretary for Health, Welfare and Food would be able to accomplish the various tasks within one year. The **Secretary for Health, Welfare and Food** was confident that the tasks could be completed within one year. He further stated in his letter of 16 July 2002, in ***Appendix 25***, that the Administration had set a work plan for the next 12 months, as follows:

- the Administration would formulate and implement a plan to phase out self-care hostels and HFAs, and to better meet the needs of these elderly persons by matching them promptly to appropriate services, such as community care and support services and housing assistance. The plan had been endorsed by the Elderly Commission and would start later in 2002;

- the Administration would implement a central registration system for subsidised long-term care services, i.e. both community and residential care services currently provided under the social welfare system. This would obviate the need for elderly persons to wait-list on different queues, sometimes managed by different agencies, for different services. Appropriate services would be assigned to elderly persons in accordance with the care needs as assessed by the standardised care need assessment tool which the Administration introduced in November 2000. It would complete this task within one year;

- to better address the needs of both healthy and frail elderly persons, as well as carers and the community at large, the Administration planned to rationalise and re-engineer a wide spectrum of existing community care and support services in light of the outcome of a consultancy study on the provision of community care and support services conducted in 2000. These included home help teams, home care and meal teams, social centres and multi-service centres. According to the proposed work plan, rationalisation would start to take place from March 2003;

- to achieve continuum of care in residential care, all contract homes put out for open tendering would include such a requirement. The Administration also planned to provide additional places, in new contract homes, for elderly persons whose health conditions necessitated their admission to nursing homes to help reduce waiting time for nursing homes. The Administration had invited tenders for three homes on 12 July 2002 and each of these would contain a portion of subsidised places for such elderly persons; and

- as regards the provision of infirmary beds, the Administration would conduct a review covering the basis of planning, the changing needs for infirmary beds, and the role of the Hospital Authority in the provision of such beds. It would also examine the feasibility of providing infirmary care in a non-hospital setting to achieve cost-effectiveness and continuum of care for the elderly in the long-term care system.

Residential services for the elderly

80. Noting the Secretary for Health, Welfare and Food's undertaking to implement a work plan by July 2003, the Committee asked whether the Administration could put forward some indicators on the provision of residential services for the elderly. The **Secretary for Health, Welfare and Food** agreed that policy indicators must be established. He hoped that the indicators would be established upon the implementation of a central registration system for subsidised long-term care services.

81. The Committee further asked:

- whether there were any existing indicators or yardsticks for measuring the performance in the provision of residential services for the elderly and the Administration's current performance as measured by these indicators or yardsticks; and

- what the Administration's thinking was on the types of indicators that were likely to be adopted a year later.

82. The **Secretary for Health, Welfare and Food** stated in his letter of 16 July 2002 that:

- the Administration considered that the planning ratio of five infirmary beds per 1,000 population aged 65 or above which was set over 20 years ago was no longer appropriate and that it should review the planning basis for the provision of infirmary beds;

- there had been significant developments in the provision of medical and care services for frail elderly persons. The Hospital Authority, which was established in 1991, conducted reviews at three to five-year intervals on the requirement of different types of hospital beds, including infirmary beds, on a territory-wide basis. In this context, the Administration set a target in 1997-98 to provide an additional 1,000 infirmary beds in the next five years. It was on schedule in meeting this target. By March 2003, the ratio of infirmary beds would be increased to four per 1,000 elderly persons; and

- as for indicators for the provision of residential services for the elderly, the Administration set out every year its initiatives and targets for the coming year in the Policy Address booklet on "Care for Elders". In addition to residential services, the 2001 Policy Address booklet covered other services for the elderly, such as financial support, housing, community care and support, active and healthy ageing and support for vulnerable elderly persons.

Residential services for the elderly

83. In view of the information provided by the Secretary for Health, Welfare and Food, the Committee invited the Director of Audit's comments on the following:

- the ratio of four infirmary beds per 1,000 elderly persons by March 2003; and

- if only the infirmary beds designated for CIWL applicants were taken into account, by March 2003, what the ratio of infirmary beds per 1,000 elderly persons would be.

84. The **Director of Audit** advised the Committee in his letter of 5 August 2002, in ***Appendix 26***, that

- in his letter of 24 May 2002, the Secretary for Health, Welfare and Food had informed the Committee that the planning ratio of five infirmary beds per 1,000 elderly persons aged 65 or over was adopted by the MDAC of the former Medical and Health Department in 1981. Audit subsequently requested the Health, Welfare and Food Bureau for a copy of the related MDAC paper, which had not been made available to Audit during the audit review. According to the MDAC Paper No. 15-1980/81, the planning ratio was set in 1981 in the context of the hospitalised patients. On this basis, the estimated ratio of four infirmary beds per 1,000 elderly persons by March 2003 would appear to be acceptable. However, it should be noted that applicants on the CIWL would need to wait for about 39 months before being admitted to infirmaries; and

- if only the infirmary beds designated for the CIWL were taken into account, by March 2003, the ratio of infirmary beds per 1,000 elderly persons aged 65 or over would be 1.5.

85. The Committee understood from the Director of Social Welfare's reply of 23 May 2002 that the Director could foresee major difficulties for the SWD to secure further additional resources on its own to take care of infirm elderly persons in the welfare setting. The Committee enquired about the difficulties and the shortfall in the funding required.

86. The **Director of Social Welfare** informed that the Committee that:

- the Administration had completed a study at the end of 2001 on frailty of the elderly residents at the subsidised C&A homes. About 1,400 elderly residents were assessed by the Hospital Authority's geriatric outreach team as requiring infirmary level care;

- the Government had since 1986 adopted an interim and stopgap measure to ensure that it would enhance care services for elderly persons whose frailty was quite serious but who could not be accommodated in the hospital setting. Since then, some C&A homes gradually set up infirmary units, each of which offered 20 places. The annual subsidy for a place at the C&A home was more than $49,000, which included an additional subsidy of more than $4,000 for an elderly person in need of infirmary care service;

- in 1994, the Government had appointed a working group to reconsider the situation. The working group subsequently proposed to set up six nursing homes providing a total of 1,400 places. Hence, the Government decided that C&A homes would stop setting up infirmary units. Instead, the SWD would pay an Infirmary Care Supplement of $5,695 a month to a nursing home for maintaining a frail elderly person residing there, and who was in need of infirmary care service; and

- in 1995-96, the SWD was able to grant the Infirmary Care Supplement to each elderly person in C&A homes who had been assessed as requiring infirmary level care. However, as more and more elderly persons living in C&A homes were similarly assessed and the SWD could not secure additional resources, it was allocating the Infirmary Care Supplement on a pro-rata basis to the homes concerned. For 2002-03, there was a shortfall of about $22 million of Infirmary Care Supplement for maintaining 360 frail elderly persons.

87. In view of inadequate funding for Infirmary Care Supplement provided by the SWD, the Committee enquired whether, before the completion of the review of the provision of infirmary care, the Administration would consider allocating additional funding to the SWD to make up for all or part of the shortfall.

88. In his letter of 24 October 2002, in ***Appendix 27***, the **Secretary for Health, Welfare and Food** replied that:

- the Infirmary Care Supplement had been introduced as a top-up provision in subvented C&A homes to take care of elderly persons assessed to require infirmary care. The Infirmary Care Supplement enabled these elderly persons to remain in the same home while receiving more intensive care. As more and more elderly persons living in C&A homes were assessed to require infirmary level care and the total number of such elderly person often exceeded the number of supplements available, the practice adopted in recent

years was to allocate the Infirmary Care Supplement on a pro-rata basis to the homes concerned. However, given the funding available at $29.75 million, which was equivalent to about 476 supplements, i.e. $62,508 per case per year at current prices to top up the Government's subvention to C & A homes, the Infirmary Care Supplement funding was allocated on a pro-rata basis to 56 subvented C&A homes with elderly persons at infirmary care level. These elderly persons might continue to wait-list at the CIWL for admission to infirmary beds under the Hospital Authority; and

- no additional funding had been earmarked in the 2002-03 financial year for Infirmary Care Supplement. Given fiscal constraints, the Administration did not envisage additional funding for the supplement in the coming financial year. The Administration would conduct a comprehensive review of the provision of infirmary care in the next 12 months with a view to better addressing the needs of elderly persons assessed to require infirmary level care in the current economic environment. In the meantime, the SWD would review the existing arrangements for allocation of Infirmary Care Supplement to ensure that subsidised residential care homes looking after frail elderly persons would have an equitable share of the resources available.

Recent developments

89. It was stated in the Secretary for Health, Welfare and Food's letter of 24 May 2002 that although the Administration had not yet formulated any proposal for introducing a means-test system, it was examining options to help it target resources at elderly persons with genuine needs, e.g. the option of setting up a new subsidy arrangement. The Committee enquired about progress made by the Administration in this regard.

90. The **Secretary for Health, Welfare and Food** informed the Committee in his letter of 20 January 2003, in ***Appendix 28***, that the Administration was at an early stage of its deliberation on various options that helped to target resources at elderly persons with genuine needs, including the option of developing a fee assistance scheme to allow elderly persons to have more choices and flexibility in using residential care services. After the Administration had formulated proposals, it would consult the relevant parties, including the LegCo.

91. The Committee also enquired:

- about progress made by the Administration in implementing the work plan; and

- whether the Health, Welfare and Food Bureau had commenced discussions with the Hospital Authority and the SWD about the problem of allocation of resources between them regarding the provision of infirmary care.

92. In the same letter, the **Secretary for Health, Welfare and Food** stated that:

- since the first public hearing, the SWD had taken action to draw up a detailed plan to phase out self-care hostels and HFAs and was now putting it in place. Since 1 January 2003, the SWD had ceased to put elderly persons approaching its offices for such services on a waiting list for admission to self-care hostels and HFAs. Instead, caseworkers were required to assess their needs and refer them for appropriate services immediately. To facilitate service referral, the SWD had published a guidebook providing comprehensive information on the range of financial, housing, community care and support services available to elderly persons. For the about 5,600 elderly persons currently on the waiting list of the self-care hostels and HFAs, caseworkers would review all the cases over the next six months with a view to ascertaining the genuine welfare needs of the applicants and offering them promptly community care and support services and housing assistance as appropriate. The SWD would shortly write to all these elderly persons on the waiting list providing them with a copy of the above-mentioned guidebook for reference;

- the SWD was upgrading its computer system to facilitate the implementation of a centralised registration system of both residential and community services. The Administration aimed to put the new system in place in the latter half of 2003;

- the re-engineering exercise consisted of the revamping of centre-based services and the upgrading of home-based services. Existing social centres for the elderly and multi-service centres for the elderly would be upgraded to neighbourhood elderly centres and district elderly community centres respectively to provide expanded functions to elderly persons and the community. Existing home help teams would also be upgraded to integrated home care services teams to provide enhanced personal and nursing care services to frail elderly persons. The Administration had achieved satisfactory results in the re-engineering exercise. The revamped centre-based and upgraded home-based services would commence in phases within 2003-04;

- for the three contract RCHEs which the Administration invited tenders in July 2002 providing over 280 subsidised places in total, about half of these places were designated for elderly persons whose health conditions necessitated their admission to nursing homes. The Administration would continue to pursue the concept of "continuum of care" in RCHE premises supplied by the Government which would be put out for tender in future; and

- the transfer of infirmary care from hospital to non-hospital setting was a complex issue which required detailed study. Not all infirm patients could be transferred from the hospital to a non-hospital setting. In the context of the review, the Health, Welfare and Food Bureau was examining with the Hospital Authority, the SWD and the DH the criteria to identify elderly persons who needed to be taken care of in the hospital setting. In the meantime, the SWD had taken steps to extend the allocation of Infirmary Care Supplement to frail elderly persons receiving subsidised service in private RCHEs under the Enhanced Bought Place Scheme. The revised system ensured more equitable distribution of the limited resources and would also enable the Administration to gain a better idea of the total number of elderly persons requiring infirmary care. This information would be useful in its further deliberation of the issue.

93. **Conclusions and recommendations** The Committee:

Provision of subsidised care and attention (C&A) home places

- expresses concern that:

  (a) there are significant disparities in the service levels in terms of minimum area per resident and staff requirements between subvented C&A home places and C&A home places under the bought-place schemes; and

  (b) as at May 2002, the waiting time for admission to subvented residential care homes for the elderly (RCHEs) was 34 months, whereas that for home places provided under the bought-place schemes was 10 months only;

- acknowledges that the Social Welfare Department (SWD):

  (a) has embarked on a major programme to secure purpose-built RCHE premises from various sources; and

(b) has commissioned the Hong Kong Association of Gerontology to undertake a two-year project to develop and establish an accreditation system for RCHEs in Hong Kong so as to ensure the delivery of quality care and continuous improvement;

- urges the Director of Social Welfare to:

(a) take further action to reduce the disparity in the waiting time for admission to a subvented C&A home and a bought-place home;

(b) take further action to ensure that the level of services provided in bought-place homes is comparable to that in subvented homes;

(c) inform the applicants for C&A home places of the estimated waiting time for a place in different types of C&A homes when they submit their applications; and

(d) periodically inform the applicants of the current estimated waiting time so as to enable them to make an informed choice of the type of C&A home;

Phasing out of subsidised home for the aged (HFA) places

- expresses serious concern that, despite the Government's acceptance of the Elderly Commission's recommendations in September 1998 to phase out HFA places, the SWD was still accepting applications for HFA places and placing them on the waiting list for the service;

- acknowledges that:

(a) the SWD has stopped building HFAs and is taking action to convert existing HFA places into C&A home places as far as practicable;

(b) since 1 January 2003, the SWD has ceased to accept applications for self-care hostels and HFAs; and

(c) all the cases (about 5,600 elderly persons) on the waiting list of self-care hostels and HFAs will be reviewed over the next six months with a view to ascertaining the genuine welfare needs of the aplicants and offering them promptly community care and support services and housing assistance as appropriate;

- urges the Director of Social Welfare to:

  (a) ensure that there are sufficient complementary services, such as home help service, to meet the needs of potential applicants for care, upon ceasing acceptance of new applications for HFA places;

  (b) transfer applicants on the waiting list for HFA places to the waiting list for C&A home places if they meet the admission criteria;

  (c) expedite the conversion of the premises of those HFAs which have been identified as suitable for upgrading to C&A homes; and

  (d) find alternative uses for the premises of those HFAs which are not suitable for conversion to C&A homes;

Provision of Housing for Senior Citizens (HSC) units by the Housing Authority

- expresses serious concern that:

  (a) as at 31 March 2001, of the 9,383 HSC units provided by the Housing Authority to elderly persons, 887 units were vacant, resulting in wastage of housing resources;

  (b) as at 30 April 2002, 294 of the 887 units were still vacant, and 439 new HSC units were completed in July and August 2002; and

  (c) as at 30 November 2002, among the 439 new HSC units, 22 were let to and 226 units were under offer to non-elderly applicants;

- notes that the Housing Authority:

  (a) had decided in November 2000 to stop further production of HSC units having regard to the elderly's preference for self-contained small units, and concentrate on building more self-contained small flats for the elderly; and

  (b) endorsed in November 2001 the letting of HSC units to non-elderly applicants on the Waiting List and other rehousing categories;

- acknowledges that:

  (a) the Director of Housing has taken measures to promote the last batch of new HSC units, including posting notices in the housing estates and neighbouring estates concerned to publicise the units, allocating the units according to the elderly applicants' preferred districts and arranging group visits by such applicants to the new HSCs; and

  (b) as at 30 November 2002, the total number of vacant HSC units was 144;

- urges the Housing Authority to:

  (a) formulate a strategy for the provision of self-contained small flats for self-reliant elderly persons; and

  (b) determine, in collaboration with the Secretary for Health, Welfare and Food and the Secretary for Housing, Planning and Lands, a suitable planning ratio for the provision of small flats for self-reliant elderly persons;

Provision of subsidised nursing-home and infirmary places

- expresses dismay that:

  (a) as at 31 March 2001, there were 5,218 elderly persons on the waiting list for infirmary places, who on average needed to wait for 31 months;

  (b) as at 31 March 2001, the provision of 1,134 infirmary places by the Hospital Authority for Central Infirmary Waiting List applicants was well below the demand for such places;

  (c) even if 338 additional infirmary beds will be made available for Central Infirmary Waiting List applicants by March 2003, there will still be a significant shortfall in the supply of such beds;

  (d) without going through proper consultation and a proper policy revision process, the Administration regards that the planning ratio of five infirmary places per 1,000 elderly persons is no longer appropriate;

  (e) the provision of 1,400 nursing-home places by non-governmental organisations under Government subvention only represented 1.9 nursing-home places per 1,000 elderly persons aged 65 or over; and

(f) as at 31 March 2001, there were 4,729 elderly persons on the waiting list for nursing-home places;

- expresses deep regret and sadness that more than 7,000 elderly persons passed away in the years 1997-98 to 1999-2000 while waiting for infirmary places;

- notes that:

  (a) some of the applicants on the Central Infirmary Waiting List are already receiving some form of home and community services;

  (b) the Secretary for Health, Welfare and Food has undertaken to implement, by July 2003, a work plan which will include:

    (i) implementing a central registration system for subsidised long-term care services;

    (ii) rationalising and re-engineering a wide spectrum of existing community care and support services;

    (iii) providing additional places, in new contract RCHEs, for elderly persons whose health conditions necessitate their admission to nursing homes; and

    (iv) conducting a review covering the basis of planning, the changing needs for infirmary beds and the role of the Hospital Authority in the provision of such beds;

  (c) the Director of Social Welfare considers that any delineation of respective responsibilities in long-term care should be accompanied by the corresponding budget transfers from the Hospital Authority to the SWD; and

  (d) the Secretary for Health, Welfare and Food considers that there is a need to discuss with the Hospital Authority and the SWD the problem of allocation of resources between them regarding the provision of infirmary care;

- acknowledges that the Administration has made progress, as follows, in implementing the work plan as at January 2003:

(a) the SWD is upgrading its computer system to facilitate the implementation of a centralised registration system of both residential and community services;

(b) the revamped centre-based and upgraded home-based services will commence in phases within 2003-04;

(c) for the contract RCHEs which the Government invited tenders in July 2002 providing over 280 subsidised places, about half of these places are designated for elderly persons whose health conditions necessitate their admission to nursing homes; and

(d) the Health, Welfare and Food Bureau is examining with the Hospital Authority, the SWD and the DH the criteria to identify elderly persons who need to be taken care of in the hospital setting;

- urges the Administration to:

(a) decide, in conducting the review, whether infirmary care should be provided in the welfare setting instead of in the hospital setting;

(b) allocate additional funding to the SWD to make up for all or part of the shortfall of about $22 million of Infirmary Care Supplement for maintaining 360 frail elderly persons; and

(c) conduct proper consultation, including that with the Legislative Council (LegCo), regarding the long-term policy on care for the elderly;

- acknowledges that the SWD:

(a) is not pursuing further nursing-home developments;

(b) will invite tenders for operating new RCHEs with built-in facilities for taking care of the elderly when their health conditions deteriorate; and

(c) has made available on its homepage the average waiting times for various types of residential care services and is updating the information on a quarterly basis;

Residential services for the elderly

Government's financing of subsidised residential services for the elderly

- expresses concern that the monthly cost of $8,918 for a place at a subvented C&A home is 42% higher than the monthly cost of $5,163 for a place under the SWD's tender exercise conducted in July 2001;

- acknowledges that:

  (a) the SWD will adopt open-tender arrangements for the provision of subsidised C&A home services at all new purpose-built homes in the future; and

  (b) the Elderly Commission has suggested that the Government and subvented organisations should first take care of needy elderly persons who lack the means, while self-financing and private organisations should provide services of better quality to give choices to those who can afford;

- notes that:

  (a) although the Administration has not yet formulated any proposal for introducing a means-test system, it is examining options to help it target resources at elderly persons with genuine needs, including the option of developing a fee assistance scheme; and

  (b) the Administration will consult the parties concerned, including the LegCo, after it has formulated proposals;

- urges the Secretary for Health, Welfare and Food to:

  (a) expeditiously conduct a comprehensive review of the arrangements for providing subsidised residential services for the elderly with a view to increasing the number of subsidised residential places to meet the increasing needs of the elderly. The review should take into account:

    (i) the significant difference between the cost of subvented homes and the cost obtained by the SWD through the recent open tender exercises;

    (ii) the cost-effectiveness of different options for providing residential services to the elderly, which include obtaining the services by open tenders, reducing the operating costs of subvented homes, and paying subsidies directly to the elderly;

(iii) the practices in advanced countries in providing similar welfare services to the elderly;

(iv) the demand on public resources due to an increasing need for elderly services in Hong Kong; and

(v) the Elderly Commission's suggestion; and

(b) conduct proper consultation, including that with the LegCo, in the review;

Licensing and monitoring of RCHEs

- expresses concern that:

(a) the inspectorate teams of the SWD sometimes did not use standard inspection reports in inspecting RCHEs;

(b) the inspectorate teams of the SWD sometimes did not comply with the SWD's required frequencies of inspections of RCHEs; and

(c) the SWD's manual system for monitoring the performance of RCHEs is not efficient and effective;

Monitoring of healthcare services of RCHEs

- expresses serious concern that:

(a) many health workers and care workers working at RCHEs have inadequate knowledge of how to deal with some commonly encountered healthcare and emergency situations;

(b) some RCHEs were not equipped with adequate healthcare facilities;

(c) the two Nursing Officers of the SWD cannot effectively monitor the 671 RCHEs providing 58,146 places;

(d) under the existing requirements, there is no assurance that, between 6:00 pm and 7:00 am each day, a C&A home is staffed with those who have received proper and recognised healthcare training; and

(e) some RCHEs do not accept the offer of the Visiting Health Teams (VHTs) of the DH to conduct healthcare education programmes for them;

- urges the Director of Social Welfare to:

(a) take action to amend the Residential Care Homes (Elderly Persons) Regulation so that at all times at least one staff member who has received recognised training in healthcare is on duty in a C&A home;

(b) in collaboration with the DH, provide more training to health workers and care workers in RCHEs;

(c) seek the support of the VHTs of the DH for strengthening the healthcare-service inspections of RCHEs, such as by secondment of staff and provision of professional advice; and

(d) seek clarification as to whether the SWD is empowered under the Residential Care Homes (Elderly Persons) Ordinance to authorise the VHTs to provide appropriate training courses to the staff of RCHEs; and

Follow-up actions

- wishes to be kept informed of:

(a) the progress of the supply of purpose-built RCHE premises;

(b) the progress made in developing the accreditation system for RCHEs;

(c) further actions taken to reduce the disparity in the waiting time for admission to a subvented C&A home and a bought-place home and to ensure that the level of services provided at bought-place homes is comparable to that at subvented homes;

(d) the actions taken to inform the applicants for C&A home places of the estimated waiting time for a place in different types of C&A homes when they submit their applications and to periodically update them on the current estimated waiting time;

(e) the progress made in phasing out subsidised HFA places;

(f) further actions taken by the Director of Housing to improve the utilisation of vacant HSC units;

(g) the progress made in implementing a strategy and determining a suitable planning ratio for the provision of self-contained small flats for self-reliant elderly persons;

(h) further progress made in implementing the work plan on the provision of subsidised long-term care services and the actions taken to address the problem of allocation of resources between the Hospital Authority and the SWD regarding the provision of infirmary care;

(i) the progress made in implementing the recommendations on periodic inspections by the inspectorate teams of the SWD as mentioned in paragraph 6.29 of the Audit Report and those on the monitoring of subsidised residential services for the elderly by the SWD as mentioned in paragraph 7.13 of the Audit Report; and

(j) the progress made in implementing the recommendations on the monitoring of healthcare services of RCHEs as mentioned in paragraphs 8.32 (c) and 8.33 of the Audit Report.