中華人民共和國香港特別行政區政府總部衞生福利局
Health and Welfare Bureau
Government Secretariat, Government of the Hong Kong Special Administrative Region,
The People's Republic of China

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24 May 2002

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Clerk to Public Accounts Committee
LegCo Secretariat
(Attn : Miss Sandy Chu)
Legislative Council Building
8 Jackson Road
Central

Dear Miss Chu,

The Director of Audit's Report on the results of value for money audits (Report No. 38)

Chapter 5: Residential services for the elderly

I refer to your letters of 7 and 15 May and append below the information as requested.

Statistics on Central Infirmary Waiting List

2. Annex I contains statistics on applicants on the central infirmary waiting list (CIWL) from 1996/97 to 2001/2002, and infirmary places provided during the same period. To present a fuller picture, I also enclose at Annex II a breakdown of the applicants by their place of residence at the time of application from 1998/99 onwards.

3. I would like to highlight that the majority of applicants on the CIWL are already receiving some form of public services, as reflected from the breakdown of their place of residence:

(a) About 70% of the applicants are living in care homes (20% in subvented care homes and 50% in private/self-financing care homes). In addition, the Hospital Authority's Community Geriatric Assessment Teams (CGATs) provide outreaching geriatric care to all subvented care homes and the majority of the private care homes. Infirmary Units are set up and Infirmary Care Supplement is provided to enable a number of subvented care and attention homes to take care of elders assessed to be in need of infirmary care;

(b) About 10% of the applicants are 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 are available and provided mainly by the welfare sector as required. These include Community Nurses and enhanced home and community care services, which is a package of centre and home-based services tailor-made to meet the individual care needs of frail elders.

4. You may wish to note that the total number of infirmary beds increased from 1,915 in 1996/97 to 2,851 in 2001/02. 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 is to lessen the pressure on acute beds, the costs of which are much higher than infirmary beds. The majority of post-acute patients are elders, for example, stroke patients who immediately become severely disabled and who require urgent post-acute infirmary care. On the other hand, the majority of CIWL applicants are already receiving some form of care through different channels as described in paragraph 3 above.

5. As you will see from Annex I, the number of active applicants on CIWL has 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 is 39 months.

Planning Ratio for Infirmary Places

6. The planning ratio of five infirmary beds per 1,000 elders aged 65 or above was adopted by the Medical Development Advisory Committee of the previous 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.

7. Since then, there have been significant developments in the provision of medial and care services for frail elders. The Hospital Authority, which was established in 1991, conducted regular three to five yearly reviews of the requirement for different types of hospital beds, including infirmary beds, on a territory-wide basis. In conducting such reviews, the Hospital Authority took 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 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 is on schedule in meeting this target. Two years ago, the Hospital Authority reached an agreement with the Administration on moving away from a facility-based funding mechanism to a population-based funding mechanism. Emphasis has been put on post-discharge care and community-based services to support patients to remain in the community.

8. In light of the developments in the planning mechanism for provision of hospital beds and the changing needs for infirmary beds, the Administration regards that the original planning ratio is no longer appropriate. With experiences gained in practising 'continuum of care' in both community and residential care services for frail elders, the Administration would in due course review the role of the Hospital Authority in the provision of infirmary care.

Financial Implications of Transferring Infirmary Care from Hospital to Non-hospital Setting

9. Under the Hospital Authority, infirm patients are actively treated to facilitate their recovery to a stage requiring less intensive care. Existing infirmary beds admit patients for the following two purposes:

(a) long term care for applicants of CIWL; and

(b) extended care for infirm patients transferred from acute hospitals.

10. The transfer of infirmary care from hospital to non-hospital setting is a complex issue which requires further study. For example, not all infirm patients can be transferred from the hospital to a nursing home setting. The Administration will need to examine in detail the various aspects, which include target groups, costings, and the level of care and support services required.

11. Therefore, at this point I can only provide for reference purpose only some rough estimated costs for each type of beds as listed in paragraph 9 :

	Per month
(a)	$19,124
(b)	$37,826

Note: The estimated costs include administrative overhead (e.g. administrative and maintenance costs for buildings, utilities and equipment) and other non-transferrable costs (e.g. professional and administrative staff) which amount to approximately 26%.

Measures to Improve Quality of Private Care Homes

12. Para 5.23(b) of the captioned report describes the major measures. The Administration has formulated a proposal to grant gross floor area and premium concessions to encourage private developers to incorporate residential care home for the elderly premises in their new private developments. In formulating the proposal, the Administration has taken into account the views of relevant bodies, including the Real Estate Developers Association, the Elderly Commission, the Land and Building Advisory Committee, and the Legislative Council Panels on Welfare Services and Planning, Lands and Works. The Administration is working on the details and will in due course seek amendments to the Building (Planning) Regulations to implement the proposed scheme.

Consideration of Means-testing on Residential Care Services

13. The Administration has 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, we are examining options that help us target resources at elders with genuine needs. These include the implementation of the standardized care need assessment mechanism since November 2000. We are also exploring the option of setting up a new subsidy arrangement which allows the elders more freedom in choosing care homes, flexibility to contribute more to their own care costs, and a quick access to such service. Given that this is a complex matter, the Administration will require more time to work out the details and implications, including the factor of affordability. It would be a severe financial burden on the elders and their families if they have to pay for a high proportion of the residential care cost, particularly for higher level of care, on a long term basis.

14. In parallel and to create an environment to enable a subsidy scheme to succeed, the Administration has taken some steps to improve the quality of residential care services. These include 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 subsidized and non-subsidized places in all new Government supplied care home premises.

One Stop Service for Provision of Subsidised Long Term Care

15. As stated in paragraph 13 above, the Administration has introduced a standardized care need assessment tool since November 2000. The tool has helped to make more precise matching of services to care needs in both the community and residential settings. As a next step, the Administration is considering to establish a single point of entry for all subsidized community and residential care services. The concept is to no longer require elders to queue up for different services. Instead, there will be one central waiting list for all subsidized long term care services, and services for elders will be matched in accordance with their care needs as assessed by the standardized tool. At this stage, the Administration is working out the details of the proposal.

16. I wish to point out that in implementing any major new strategy, the Administration will consult and take into account the views of relevant parties and pay heed to the appropriate pace of introduction.

Yours sincerely,

(Dr E K Yeoh)
Secretary for Health and Welfare

c.c. Chief Executive, Hospital Authority
Director of Social Welfare

Number of Infirmary Places and Number of Applicants on Central Infirmary Waiting List (CIWL) from 1996/97 - 2001/02

		1996/97	1997/98	1998/99	1999/00	2000/01	2001/02
Number of beds as at 31 March (a)	CIWL	728	896	1018	1134	1134	1184
Number of beds as at 31 March(b)	Local Infirmary	1187	1185	1199	1353	1421	1667
Total number of beds (a) + (b)		1915	2081	2217	2487	2555	2851
Number of new admissions for the period ending 31 March	CIWL	393	206	522	388	347	
Number of deaths/discharges for the period ending 31 March*	Local Infirmary	3084	4180	4526	5345	5806	
Number of applicants on CIWL as at 31 March		6248^	7692^	5690 (Active)	5062 (Active)	5218 (Active)	4973 (active)

Remarks:

1. CIWL = Central Infirmary Waiting List
2. Local Infirmary = local infirmary beds are for patients from general and acute wards
3. *Number of deaths/discharges indicates turnover in use of local infirmary beds.
4. Number of CIWL new admissions and number of deaths/discharges for local infirmary beds for the period ending 31 March are not yet available for 2001/02
5. ^ As the death match function was not available in the system before end 1998, these figures include death cases. Hence, the number of CIWL applicants in 1996/97 and 1997/98 appears to be higher
6. Active cases exclude closed cases due to death, self-withdrawal and temporarily not requiring infirmary placement

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Annex II

Breakdown of CIWL Applicants by Place of Residence

Type of Residence	31.Mar.99	31.Mar.00	31.Mar.01	31.Mar.02
Hospital (excluding infirmary)	383	441	504	532
Subvented care and attention home	1149	1003	1049	1114
HFA (ie subvented home for the aged or hostel for the elderly (meal section)	28	30	39	43
Subvented nursing home	3	6	64	74
Private care home	2877	2557	2507	2248
Public housing	250	259	296	301
Private housing	319	369	456	456
Others	681	397	303	205
Total (Active)	**5690**	**5062**	**5218**	**4973**

Note: (a) Statistics on CIWL applicants by type of housing before 1998 are not available.

(b) Elders in the 'Others' category most likely reside in the community.

(c) Active cases exclude closed cases due to death, self-withdrawal and temporarily not requiring infirmary placement

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