HONG KONG FAMILY WELFARE SOCIETY

Comments on the Study of the Needs of Elderly People in Hong Kong for Residential Care and Community Support Service - Executive Summary

2.38	We agree to the development of accurate assessment tools, not "stringent assessment tools". "Stringent" implies that in filtering out inoppropriate applicants there could be a high possibility of screening out some marginal needy elderlies. The use of the word "accurate" is more neutral and more appropriate.
3.25	The phenomenon of more people with higher grades of impairment being in private homes than in subvented care, cannot imply that a private sector is crucial. More frail elderly living in private elderly home than in subvented home is due to a number of reasons. First most of them prefer to live in the community, if they can, as long as possible. Second they would not apply for an elderly hostel until they are really frail and not capable, and they need to wait for quite a long period for admission. Third some are admitted to private hostel because the family may not have the emotional or physical ability to care, or the community can no longer support their frailty. Private homes may not have the same staffing requirements as NGO subvented homes. Accordingly we cannot say that the private sector is crucial for elderly served and it is justified to spend public money to increase bought placements in such profit making homes. The government input of resources to cater the residential needs of elderlies is far from adequate. This creates the market for private residential units, not because of their excellence. The government should build more subvented homes instead of paying for the profit of private homes through a bought placement scheme. There are hidden issues underlying the phenomenon that residents in subvented homes are healthier than those in private homes. Their admission may be due to a lack of carer, housing problem, family problem, spouse relationship problem etc. Their care may have more health promotion, and avoid deterioration of health, unlike private home. The reasons of admission have not been examined in the report. If the above-mentioned are some of the problems. the report then fails to look at these needs and fails to suggest proper service to handle their needs. If so, can we claim that most family members are willing to take care of their elderlies? The report also overlooks the housing and social problems of those who have no informal carers but are in better health. Concluding the above, we think the report does not have a thorough view of the needs of the elderly and their families, and its conclusions are based on biased and misunderstood data.
3.43	It is inappropriate to conclude the need for expansion of means testing

	from the statement given by elderly respondents that they have “more than enough” funds to make ends meet. There is no scientific measurement of what is”more than enough” and what is “make ends meet”. Some elderlies may simply refer to financial ability to buy a lunch box with poor nutrition as ‘enough funds’ to make ends meet. Without more detailed questions and analysis, the conclusion made by the report in regard to the expansion of means testing is superficial and is not convincing.
3.55	The report has a correct observation that there are difficulties in coordinating work between HA and SWD for hospitalization and timely discharge of frail elderly people. However the phenomenon cannot be explained solely by “lack of coordination”. District joint committee insolving social welfare and Health can improve co-ordination. Inadequate coordination may be one factor, but the ultimate factor is the lack of adequate resources to facilitate the coordination. For instance, the standard caseload of a home help team is 70. It is now 110 cases per team in most of our home help teams. Besides the waiting list for the service is thirty per team. Under such circumstances, how can services be arranged for the needy? It is a matter of inadequate resources.
3.58 3.59	We agree that an integrated package of Day Care Centre and Home Help Service is beneficial to clients requiring community care. Our agency which has 21 teams of home help services observes that the resources of a day care centre and the home help teams can be coordinated for a more efficient use of resources on the one hand and to, improve the quality of rehabilitative service on the other. A care plan can be worked out between the workers of Day Care Centre and the Home Help team. For instance, the medical staffing in a Day Care Centre might agree to help to monitor the health development of a client living at home; while our home help services (escorting, meal delivery, etc.) can match with the daily schedule of Day Care Centre smoothly and provide more flexibility to the frail elderlies. It is known that some clients refuse to enter Day Care Centre as centre members because they have to stay in the centre for the whole day and they are not provided with a bed for rest in the afternoon. With home help escort service, elderly members’ health can be maintained and monitored through a more efficient deployment of resources.
3.65	We agree that there is a lack of medical domiciliary care. Notwithstanding the presence of community nurses, they are dependent on hospital specialists to provide them with advice and support with respect to patients who they are visiting. We agree that input of medical staff in domiciliary care is a very positive

	solution, for example to home help teams. With the support of nurses, OTs or PTs, the home care professionals can work together with united community care objectives providing preventive health care support and health-monitoring service with reference to health related home environment.
3.70	It is not realistic to expect volunteers to provide a regular and long term meal delivery and escort service. In our experience, volunteers are enthusiastic in helping, and are particularly helpful in one-shot programmes. Yet not many of them are able to help with long term and regular services to the needy who require stable performance. Many elderly, not regarded as impaired, can be easily confused, upset, depressed by uncertain service, and frequent or even occasional change of provider. Furthermore, it is unfair for volunteers to bear a responsibility that is out of their capability, such as the safety of clients while providing escorting services. It is unlikely that they will do so, knowing the risks. Due to their instability and unpredictable volume of help, it creates severe administrative difficulties in organizing them to provide long term and regular services like meal delivery and escorting service.
3.70	We do not object Home Help service providing more intensive personal care to frail clients, providing that adequate training is provided to existing home helpers in order to equip them with adequate knowledge and skill. Besides para-medical input for the home help team is very important to offer advise/assessment as required in delivering intensive health care. However it is necessary to recognize that not all the existing home-helpers are capable of acquiring skills of health care. Therefore we suggest a home help team should have a composition of different levels of home care workers. Some of them may provide assistance to enhance the daily living of elderlies and some provide more sophisticated health care service.
3.72	We strongly agree that primary medical care should be provided to elderly people living in the community. The CGAT or the new Health Visiting Teams can provide this. Although some very pro-active CGAT facilitate direct referral from Home Help service, it is not a universal practice and some CGATs even reject the referral. Therefore there should be a policy addressing the need of medical care of frail elderlies in the community and establishing a mechanism to fulfill the needs. Establishment of outreaching medical care should be considered, to deliver medical service to the home of elderlies when they cannot access the service through outpatient units on account of their mental confusion, frailty, immobility, etc.
5.2	With a growing demand of social service and the changing age structure, it is impossible for government to assume the principle of‘ensuring growth in public expenditure does not exceed growth in gross domestic product”. The policy assumes a higher priority of budget control over

	service quality, irrespective of the change of age structure and the growing demand for quality social service. In H.K. we start from a low base of service provision. The principle ignores what is a basic level of service standard and what is quality service. As a result, when there is contraction of resources, service standard will definitely be sacrificed because there exists only a very simple linear relationship between GDP and public expenditure. We suggest that the government should re-examine the percentage of public expenditure out of GDP in relation to the change of social structure and the needs of the population.
7.16	Referring to the suggestion that the social centres operate as satellites of a multi-service centre, the report misunderstands the nature of M/E and S/E and how they may complement, rather than duplicate each other. M/E's cannot actually serve very large geographical areas because of issues of accessibility e.g. transport network and frailty of the elderly. However members of S/Es are able to utilise appropriate services of the M/E's as necessary. This is not duplication. There is no rational case made by the consultants for a sole management arrangement of M/Es and S/E's in a satellite system. To improve the services for the elderly in the community and make best use of the greater accessibility and economy of scale of S/E's, the services of the M/Es could be utilised in a different manner to back up the S/E's e.g. outreaching educational services from M/E to a number of S/Es in a district, meals support for S/Es and central programmes organised for S/Es.
7.13 7.14	We agree that the continuum of care model is beneficial to frail elderlies and case management approach is an effective means to actualize this model. Our agency undertook a pilot project for two years, adopting Jack Ruthman's case management practice in Home Help Service, It found that through a comprehensive assessment, home help clients' needs had been comprehensively assessed and suitable service obtained in respect of day care, social aspects, housing aspects, residential aspect and so forth. The research confirmed that most of the Home Help clients have need for multiple service, that Home Help Social Workers can be qualified case managers and the structure of the service allows frequent monitoring of frail elderlies situation. We agree and suggest that Home Help Service should be re-oriented towards providing care, in this continuum, and as an agent practising case management.

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