CHAPTER 5

THE GOVERNMENT OF THE HONG KONG SPECIAL ADMINISTRATIVE REGION

GENERAL REVENUE ACCOUNT

GOVERNMENT SECRETARIAT

Health and Welfare Bureau
Housing Bureau

GOVERNMENT DEPARTMENTS

Social Welfare Department
Department of Health
Housing Department

PUBLIC BODY

Hospital Authority

Residential services for the elderly

Audit Commission
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RESIDENTIAL SERVICES FOR THE ELDERLY

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RESIDENTIAL SERVICES FOR THE ELDERLY

Summary and key findings

A. **Introduction.** Under the Residential Care Homes (Elderly Persons) Ordinance, the Social Welfare Department (SWD) is responsible for licensing and regulating residential care homes for the elderly (RCHEs), which include care and attention (C&A) homes, self-care hostels and homes for the aged (HFAs). The SWD also provides subvention to some non-governmental organisations (NGOs) and buys places at RCHEs run by private operators, so as to accommodate elderly persons on the SWD's waiting lists for subsidised residential services. In addition, the Housing Authority provides special rental housing for elderly persons under its Housing for Senior Citizens (HSC) programme, and the Hospital Authority provides infirmary places for elderly persons who need long-term hospitalisation. In 2000-01, the total public expenditure incurred in meeting the residential needs of the elderly amounted to $2.5 billion (paras. 1.1 to 1.11).

B. **Provision of subsidised C&A home places.** As at 31 March 2001, the SWD subsidised 10,210 C&A home places at subvented homes, and 4,303 C&A home places at bought-place homes. The provision of these 14,513 places represented 19.3 subsidised C&A home places per 1,000 elderly persons (aged 65 or over). In the past three years, the SWD increased the supply of subsidised C&A home places by 5,302, of which 3,103 places (59%) were provided through the bought-place schemes. However, Audit has noted that the service levels at subvented homes, in terms of minimum area per resident and staff requirements, are higher than those at bought-place homes. As a result, many elderly persons have chosen to wait for 35 months for a subvented place, instead of eleven months for a bought place (paras. 2.1 to 2.22).

C. **Provision of subsidised HFA places.** As at 31 March 2001, the SWD subsidised 7,537 HFA places at subvented homes and an SWD-run home. The Elderly Commission considered that able-bodied elderly persons and those who could take care of themselves should remain in the community. The Government has accepted the Elderly Commission's recommendation to phase out HFAs. However, Audit noted that the SWD was still accepting applications for HFA places, which were placed on the waiting list for HFAs. Audit estimates that the phasing out of these 7,537 HFA places will result in a saving of $365.2 million a year. This sum can be used to subsidise another 5,895 C&A home places (paras. 3.1 to 3.16 and 5.20).

D. **Provision of HSC units.** As at 31 March 2001, the Housing Authority provided 9,383 HSC units to tenants aged 60 or over. Of these HSC units, Audit noted that 657 units (7%) had remained vacant for over six months (of which 174 units had been vacant for over 24 months). Audit estimates that the loss in rental income for these 657 vacant HSC units amounts to $8 million a year. The Housing Authority has stopped the construction of HSC units and, instead, would build self-contained small flats for the elderly (paras. 3.17 to 3.28).

E. **Provision of subsidised infirmary places.** Subsidised infirmary places are provided by the Hospital Authority for elderly persons who need personal and nursing care, and medical and other professional services to support a dignified and quality lifestyle. As at 31 March 2001, the Hospital

Authority provided 1,134 infirmary places. However, there were 5,218 elderly persons on the waiting list, who on average needed to wait for 31 months for admission. Audit noted that the provision of these 1,134 places represented 1.5 infirmary places per 1,000 elderly persons (aged 65 or over), which was well below the Hospital Authority's planning target of five infirmary places per 1,000 elderly persons (paras. 4.3 and 4.6 to 4.20).

F. **Provision of subsidised nursing-home places.** Subsidised nursing homes provide an intermediary type of accommodation between infirmaries and C&A homes. As at 31 March 2001, the SWD subsidised 1,400 nursing-home places managed by NGOs, and there were 4,729 elderly persons on the waiting list for nursing-home places. The cost of a nursing-home place for caring of an elderly person in need of infirmary service was $18,625 per month, whereas that of an infirmary place was $30,000 per month. Audit notes that elderly persons in advanced countries who do not require intensive medical treatment are normally taken care of at nursing homes in the welfare setting instead of infirmaries in the hospital setting. Audit estimates that, if the resources spent on funding the 1,134 infirmary places are used instead to provide the same number of nursing-home places to accommodate elderly persons who do not require intensive medical treatment, $154.8 million can be saved each year. This sum can be used to subsidise another 693 nursing-home places (paras. 4.2, 4.4, 4.5 and 4.10 to 4.20).

G. **Cost-effectiveness of arrangements for providing residential services for the elderly.** In July 2001, the SWD invited tenders for the operation of a C&A home on government premises. The cost of a C&A home place under the tender was $5,163 a month. This cost is much lower than the cost of $8,918 for operating a C&A home place by a subvented NGO. Furthermore, Audit notes that elderly persons in advanced countries are normally given the freedom to choose the residential homes run by government agencies or private operators. Governments in these countries pay subsidies directly to the elderly persons (instead of the service providers) to subsidise their costs of living at these residential homes. Audit estimates that, if the Government adopts more cost-effective arrangements for providing the existing 10,210 subvented C&A home places (such as obtaining the services by open tenders, reducing the operating costs of subvented homes or paying subsidies directly to the elderly), an annual saving of $460.1 million can be achieved. This saving can be used to subsidise another 7,426 C&A home places (paras. 5.11 to 5.15 and 5.20 to 5.24).

H. **Financial resources for providing residential services for the elderly.** In 2000-01, the Government paid $2,418 million subsidy for the provision of residential services for the elderly through the SWD and the Hospital Authority. Due to the ageing population, Audit estimates that the public resources for providing elderly services will increase to $2,632 million in 2009 and $3,734 million in 2019. As at 31 March 2001, elderly persons on average needed to wait for 35 months for a subvented C&A home place, 31 months for a subsidised infirmary place, and 13 months for a subsidised nursing-home place. Under the existing arrangements, elderly persons applying for subsidised residential places are not required to undergo an assessment of their maximum assets and income. Audit notes that elderly persons in advanced countries are normally required to make contributions to cover part or all of the costs of residential places according to their income and assets, which is commonly known as a means-test system. Audit also notes that the Elderly Commission has stated that the Government and subvented organisations should first take care of needy elderly persons who lack the means. Audit estimates that, if some form of means testing is introduced for subsidised residential services for the elderly, the Government can achieve a potential saving of $269 million each year. This sum can be used to subsidise another 175 nursing-home places and 3,711 C&A home places (paras. 5.1 to 5.10 and 5.16 to 5.24).

I. **Licensing and monitoring of RCHEs.** The SWD has established four inspectorate teams to conduct periodic inspections of RCHEs, namely Social Work, Health, Building Safety and Fire Safety Inspectorate Teams. In a sample examination conducted by Audit, Audit noted that the four inspectorate teams sometimes had not complied with the SWD's required frequencies of inspections. Audit also noted that the present system of maintaining some 2,800 paper files for recording and follow-up actions on the 699 RCHEs was not an efficient and effective system for the SWD to monitor the performance of RCHEs (paras. 6.1 to 6.32).

J. **Monitoring of subsidised residential services for the elderly.** In late 1998, the SWD introduced a Service Performance Monitoring System for monitoring the performance of NGOs receiving government subventions. Audit considers that the SWD should make improvements to the System by adopting a risk-based approach to determining the frequency of assessments, and implementing a computerised system for the assessments. Audit also considers that the SWD should introduce self-assessments and external assessments for services provided by residential homes under the SWD's bought-place schemes (paras. 7.1 to 7.14).

K. **Healthcare services of RCHEs.** In December 2001, with the assistance of consultants and the SWD, Audit paid visits to 20 randomly selected RCHEs. At interviews with 16 health workers (who had completed an approved course of healthcare training) and 80 care workers working at these RCHEs, Audit noted that many of these health workers and care workers had inadequate knowledge of how to deal with an elderly resident in ten commonly encountered healthcare and emergency situations at an RCHE. At these RCHEs, Audit noted that improvement could be made to their healthcare facilities such as the installation of call-bell systems, and provision of hospital beds and geriatric chairs. Audit considers that, with the current staffing of only two Nursing Officers, the Health Inspectorate Team of the SWD cannot effectively monitor the performance of the 699 RCHEs to ensure that they provide satisfactory healthcare services to the elderly (paras. 8.1, 8.2, 8.5 to 8.18, 8.32, 8.34 and 8.35).

L. **Training provided by Visiting Health Teams of Department of Health.** The Department of Health has established 18 Visiting Health Teams (VHTs) which provide health education programmes to elderly persons and carers at 729 residential institutions for the elderly. Audit noted that there were variations in the number of visits by the VHTs to these institutions for providing health education programmes. In 2000, of the 729 residential institutions, 22 were not visited by the VHTs, but 38 were visited by the VHTs for more than 20 times. Audit considers that the variations in the number of such visits were due to the fact that utilisation of the VHT services was voluntary (paras. 8.3, 8.4, 8.20 to 8.26 and 8.33 to 8.35).

M. **Audit recommendations.** Audit has made the following major recommendations that the Director of Social Welfare should:

Provision of subsidised C&A home places

(a) take action to provide as far as possible a uniform level of service for all places at government subsidised C&A homes in terms of minimum area per resident, qualification and number of staff, and physical facilities (para. 2.20(b));

Provision of subsidised HFA places

(b) formulate an action plan with target dates to phase out existing HFAs (para. 3.14(d));

Licensing and monitoring of RCHEs

(c) adopt a risk-based approach to determining the frequencies of inspections of RCHEs so that more inspections are conducted at high-risk RCHEs (para. 6.29(c));

(d) implement a computerised inspection system for the planning, recording and monitoring of inspections carried out by the inspectorate teams (para. 6.29(d));

Monitoring of subsidised residential services for the elderly

(e) adopt a risk-based approach to determining the frequencies of assessments by the SWD so that more inspections are conducted at those subvented and bought-place residential homes which have not been able to meet the Service Quality Standards (para. 7.13(a));

Healthcare services of RCHEs

(f) request the SWD's inspectorate teams to conduct inspections of the services and facilities which were found to have been inadequately provided at some RCHEs (para. 8.32(b)); and

(g) 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 at a C&A home (para. 8.32(c)).

N. Audit has made the following major recommendations that the Secretary for Health and Welfare should:

Provision of subsidised nursing-home and infirmary places

(a) conduct a comprehensive review to decide whether infirmary care should be provided in the welfare setting instead of in the hospital setting (para. 4.16(a) and (b)); and

Government's financing of subsidised residential services for the elderly

(b) conduct a comprehensive review on the arrangements for providing subsidised residential services to 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 tendering exercise (para. 5.22(a));

(ii) the cost-effectiveness of different options of providing residential services to the elderly. The options include, where practicable, obtaining the services by open tender, reducing the operating costs of subvented RCHEs, and paying subsidies directly to the elderly (para. 5.22(b)); and

(iii) the desirability of introducing a means-test system so that those who can afford to pay would make some contributions towards the provision of residential services (para. 5.22(d)).

O. Audit has made the following major recommendations that the Director of Housing, in consultation with the Housing Authority, should:

Provision of subsidised HSC places

(a) formulate a strategy for the provision of self-contained small flats for self-reliant elderly persons (para. 3.26(a)); and

(b) consider allocating the HSC units, which have been vacant for a long time, to other suitable applicants on the Housing Authority's waiting list, so as to make full use of these flats (para. 3.26(c)).

P. Audit has also made the following major recommendations that the Director of Social Welfare, in collaboration with the Director of Health, should:

Healthcare services of RCHEs

(a) provide more training to health workers and care workers working at RCHEs (para. 8.33(a));

(b) seek the support of the VHTs of the Department of Health for strengthening the healthcare-service inspections of RCHEs, such as by secondment of staff and provision of professional advice (para. 8.33(b)); and

(c) seek clarification as to whether the SWD is empowered under the Ordinance to authorise the VHTs to provide appropriate training courses to the staff of RCHEs (para. 8.33(c)).

Q. **Response from the Administration.** The Administration has generally accepted the audit recommendations (paras. 2.21, 2.22, 3.15, 3.16, 3.27, 3.28, 4.18, 4.19, 5.23, 5.24, 8.34 and 8.35).

PART 1: INTRODUCTION

Background

Government policies on residential services for the elderly

1.1 In 1991, the Government promulgated a White Paper on "Social Welfare into the 1990s and Beyond". The White Paper stated that residential services were provided for those elderly who, for health or other reasons, were unable to look after themselves, and who had no relatives or friends to provide them with assistance when required.

1.2 In the 1997 Policy Address, the Government designated "Care for the elderly" as one of the Government's main Strategic Policy Objectives. The aim is to provide the elderly with a sense of security, a sense of belonging, and a feeling of health and worthiness. In July 1997, the Elderly Commission (Note 1) was established. The main task of the Commission is to advise the Government on the policies and services for the elderly.

Roles of the Social Welfare Department

1.3 In June 1996, the Residential Care Homes (Elderly Persons) Ordinance (hereinafter referred to as "the Ordinance" — Cap. 459) came into full effect. The Ordinance empowers the Director of Social Welfare to monitor and regulate homes established for residential care of persons who have attained the age of 60 or over. Under the Ordinance, care and attention homes, self-care hostels and homes for the aged are required to apply for licences from the Social Welfare Department (SWD) for the provision of residential care home for the elderly (RCHE) services.

Major service providers

1.4 Public sector organisations which provide residential services to the elderly are:

(a) the SWD which:

(i) provides subvention to RCHEs run by some non-governmental organisations (NGOs);

Note 1: *There are 20 non-official and ex-officio members in the Elderly Commission. Non-official members include academics, social workers, medical and nursing professionals and community leaders in social services. Ex-officio members include representatives of the Health and Welfare Bureau, Housing Bureau, Education and Manpower Bureau, Housing Department, Department of Health, Social Welfare Department and Hospital Authority.*

(ii) buys places at RCHEs run by private operators to accommodate elderly persons on the SWD's waiting lists for the services; and

(iii) has provided 1,400 subsidised places at six nursing homes since 1998. These are elderly homes with medical and nursing facilities (see para. 4.2 below);

(b) the Hospital Authority which provides infirmary places for elderly persons who need long-term hospitalisation; and

(c) the Housing Authority which provides special public rental housing for elderly persons under its Housing for Senior Citizens (HSC) scheme to people in need of public housing assistance.

Types of residential services for the elderly

1.5 In general, residential services for the elderly are provided in the following six types of accommodation (figures in brackets are the estimated amounts of public expenditure in 2000-01):

- care and attention (C&A) home ($1,419.4 million);
- self-care hostel ($7.6 million);
- home for the aged (HFA — $365.2 million);
- nursing home ($217.2 million);
- infirmary ($408.2 million); and
- housing unit for senior citizens ($62 million).

The admission criteria for subsidised places in the above types of accommodation are shown in Appendix A. The application procedures for subsidised residential places provided by the Hospital Authority and the SWD are shown in Appendix B. Residents at these subsidised homes and HSC units are required to pay fees. The number of subsidised and non-subsidised residential places provided for the elderly as at 31 March 2001 is shown in Table 1 below.

Table 1

Residential places provided for the elderly as at 31 March 2001

Type of residential place	Number of hostels/ homes/infirmaries/ public housing estates	Number of places		Percentage of total
(A) **Subsidised places**				
C&A home			14,513	20.6%
— by NGOs	87 homes (Note 1)	10,210		
— by private operators under BPS and EBPS (see para. 2.7)	96 homes	4,303		
Self-care hostel			260	0.4%
— by SWD	1 hostel (Note 2)	69		
— by NGOs	6 hostels (Note 1)	191		
HFA			7,537	10.7%
— by SWD	1 home (Note 2)	88		
— by NGOs	76 homes (Note 1)	7,449		
Nursing home				
— by NGOs	6 homes		1,400	2.0%
Infirmary				
— by Hospital Authority	13 infirmaries		1,134	1.6%
			24,844	35.3%
HSC unit				
— by Housing Authority	49 estates		9,383	13.4%
	Total subsidised places		**34,227**	**48.7%**
(B) **Non-subsidised C&A home places**			35,993	51.3%
— by private organisations	520 homes	34,354		
— by non-profit-making organisations	30 homes	1,639		
	Total		**70,220**	**100.0%**

Source: SWD's, Hospital Authority's and Housing Authority's records

Note 1: Some NGOs provided more than one type of residential service (e.g. C&A home, self-care hostel or HFA) at the same premises.

Note 2: The SWD ran an RCHE which provided 69 self-care places and 88 HFA places.

Audit review

1.6 Due to the ageing population in Hong Kong, the number of elderly persons who are in need of subsidised residential services is increasing. In 2000-01:

(a) the Government paid $2,418 million to finance 24,844 subsidised residential places comprising places at C&A homes, self-care hostels, HFAs, nursing homes and infirmaries (see Table 5 in para. 5.2 below for details);

(b) the Housing Authority provided 9,383 HSC units at a cost of $62 million (see para. 3.18 below); and

(c) the total public expenditure incurred in meeting the residential needs of the elderly was estimated at $2,480 million (i.e. $2,418 million + $62 million).

1.7 There had been public concerns about the quality of healthcare and residential services provided at some RCHEs run by private operators. In 1994, the Ordinance was enacted to empower the SWD to monitor and regulate the provision of services by self-care hostels, HFAs and C&A homes.

1.8 Against the above background, Audit has recently conducted an examination to review:

(a) the provision of subsidised C&A home places (PART 2);

(b) the provision of subsidised self-care, HFA and HSC places (PART 3);

(c) the provision of subsidised nursing-home and infirmary places (PART 4);

(d) the Government's financing of subsidised residential services for the elderly (PART 5);

(e) the SWD's licensing and monitoring of RCHEs (PART 6);

(f) the SWD's monitoring of subsidised residential services for the elderly (PART 7); and

(g) the healthcare services of RCHEs (PART 8).

1.9 The objectives of the audit review are to examine the economy, efficiency and effectiveness of the Government's planning, provision and monitoring of residential services for the elderly. Audit has found that there are a number of areas where improvements can be made. Arising from the audit findings, Audit has estimated that there is a potential saving of $1.2 billion a year, which can be used to subsidise an additional 868 nursing-home places and 17,032 C&A home places (see para. 5.20 below). Audit has made a number of recommendations to address the issues.

General response from the Administration

1.10 The **Director of Social Welfare** has said that:

(a) Audit's review into the economy, efficiency and effectiveness in the provision of subsidised residential services for the elderly is most timely. Hong Kong is facing the challenge of an ageing population. At present, slightly over 10% of the population are 65 or over. By 2021, it is projected that 15.7% of the population will be 65 or over;

(b) an anticipatory and visionary approach is needed if the Government wishes to sustain its efforts in looking after the elderly who are in need of Government support in a quality manner. Faced with the reality of fiscal constraints, a sustainable policy and strategy to take care of the residential and care needs of the elderly calls for more attention on value for money, requires cross-sector collaboration, and should be underpinned by financial arrangements that target government subsidies to those most in need. She is pleased that this wide range of inter-related issues has been addressed in this Audit Report;

(c) some of Audit's recommendations have taken account of the SWD's recent initiatives on improving value for money in the provision of residential care services for the elderly, such as the introduction of competitive bidding for the operation of purpose-built residential care homes for the elderly referred to in paragraphs 5.11 to 5.12 of this report; and

(d) the SWD is mindful of the complexities involved in introducing changes into the current system of providing residential services for the elderly, particularly in the light of the current economic difficulties and concerns about rising unemployment. In implementing any new strategy and revised arrangements, the SWD considers it important to have adequate consultation with stakeholders with a view to reaching a consensus for action. The SWD would have to be realistic in the pace of transformation, taking account of the legitimate concerns of service providers and their staff, as well as service users and the community at large.

1.11 The **Secretary for Health and Welfare** has said that:

(a) most of the elderly in Hong Kong are healthy. The Health and Welfare Bureau (HWB) has started and will continue to promote the concept of healthy ageing in the community and among different sectors, focusing on the physical and psychological well-being of older persons and persons who will soon become old;

(b) some elderly persons are having chronic illnesses and disabilities who are in need of some form of assistance in the provision of care and support services on a long-term basis. To meet the needs of a growing ageing population, the HWB has a priority to provide quality long-term care services in a comprehensive, client-centred and integrated manner;

(c) to meet the elderly's preference to age at home and to enable them to remain as members of the community for as long as possible, the HWB will continue to put emphasis on home and community care in the coming years. This will offer a viable alternative to institutional care for frail elderly persons. The HWB will expand its enhanced home and community care services and re-engineer existing services to benefit more frail elderly persons. The HWB will also continue to build integrated facilities in the community to provide one-stop services and will provide support required by families to look after their frail elderly persons at home; and

(d) for those elderly persons whose care needs cannot be taken care of at home, the HWB will provide appropriate residential care to meet their varying needs. The HWB will continue to develop a sustainable and quality residential care system with participation from NGOs and the private sector.

PART 2: PROVISION OF SUBSIDISED C&A HOME PLACES

2.1 This PART examines the provision of C&A home places for the elderly subsidised by the SWD.

C&A home places subsidised by SWD

2.2 A C&A home is an establishment providing residential care, supervision and guidance for persons who have attained the age of 60. These elderly persons are generally weak in health and are suffering from a functional disability to the extent that they require personal care and attention in the course of daily living activities, but they do not require a high degree of professional medical or nursing care. As at 31 March 2001, there were 87 subvented C&A homes which provided 10,210 places. In addition, there were 520 private homes and 30 non-profit-making homes which together provided 40,296 places (the SWD bought 4,303 places at these private homes under the bought-place schemes). Residents of subvented C&A homes or bought-place C&A homes are required to pay fees, ranging from $1,605 to $1,813 a month for a subvented place, and $1,295 to $1,707 a month for a place under the bought-place schemes.

Audit observations on provision of C&A home places by SWD

Report of the Director of Audit of October 1994 on C&A home places

2.3 In Chapter 8 of Report No. 23 of the Director of Audit of October 1994, Audit reviewed the provision of C&A home places by the SWD. The following were the major audit observations:

— in 1994, the provision of 6.8 C&A home places per 1,000 elderly persons aged 60 or over failed to achieve the planning ratio of 11 C&A home places per 1,000 elderly persons aged 60 or over; and

— as at 31 March 1994, there were 11,228 applicants for C&A home places on the SWD's waiting list, and the average waiting time for an applicant to be admitted to a C&A home was 36 months.

2.4 In January 1995, the Public Accounts Committee of the Legislative Council recommended that:

(a) the Administration should make every effort to achieve the planning target on the provision of C&A home places; and

(b) the Secretary for Health and Welfare should assume the overall coordination in the provision of residential services for the elderly.

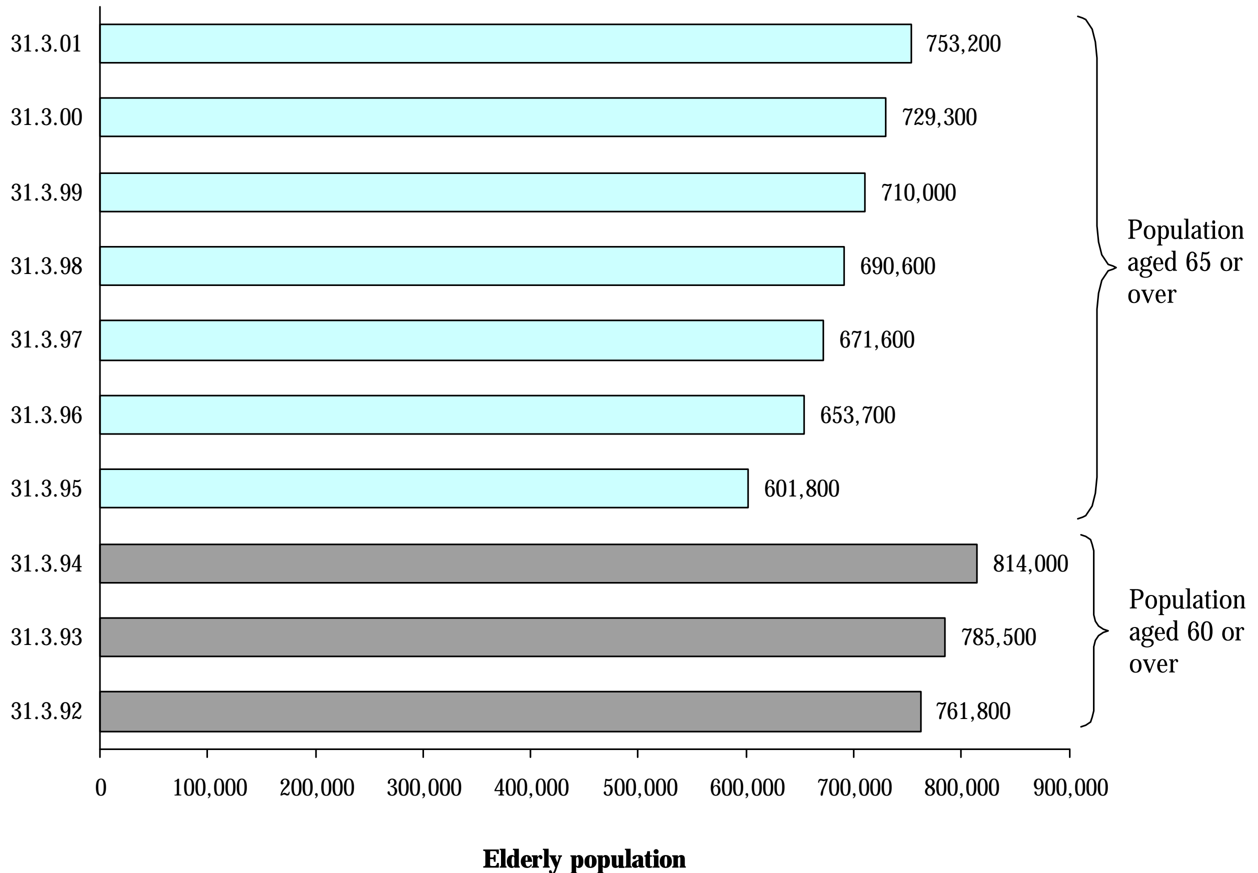
2.5 In response to the Public Accounts Committee's recommendations, in May 1995, the Administration stated in the Government Minute that the HWB had established an Elderly Services Division to coordinate and oversee the overall policy on care for elderly persons. The present audit review covers the examination of the provision of C&A home places, and the implementation of the Public Accounts Committee's recommendations.

Achievement of the planning target on provision of C&A home places

2.6 In November 1993, the Government appointed a Working Group on Care for the Elderly (chaired by the Secretary for Health and Welfare) to conduct a general review of services for elderly persons and to formulate proposals on the objectives and future development of such services. In August 1994, the Working Group submitted a report on "Care for the Elderly". **Among others, the Working Group recommended that the planning ratio for C&A home places should be revised, from 11 places per 1,000 persons aged 60 or over, to 17 places per 1,000 persons aged 65 or over.** In early 1995, the SWD accepted and implemented the revised planning ratio. Figure 1 below shows the elderly population in Hong Kong from 1992 to 2001.

Figure 1

Elderly population from 1992 to 2001 (Note)



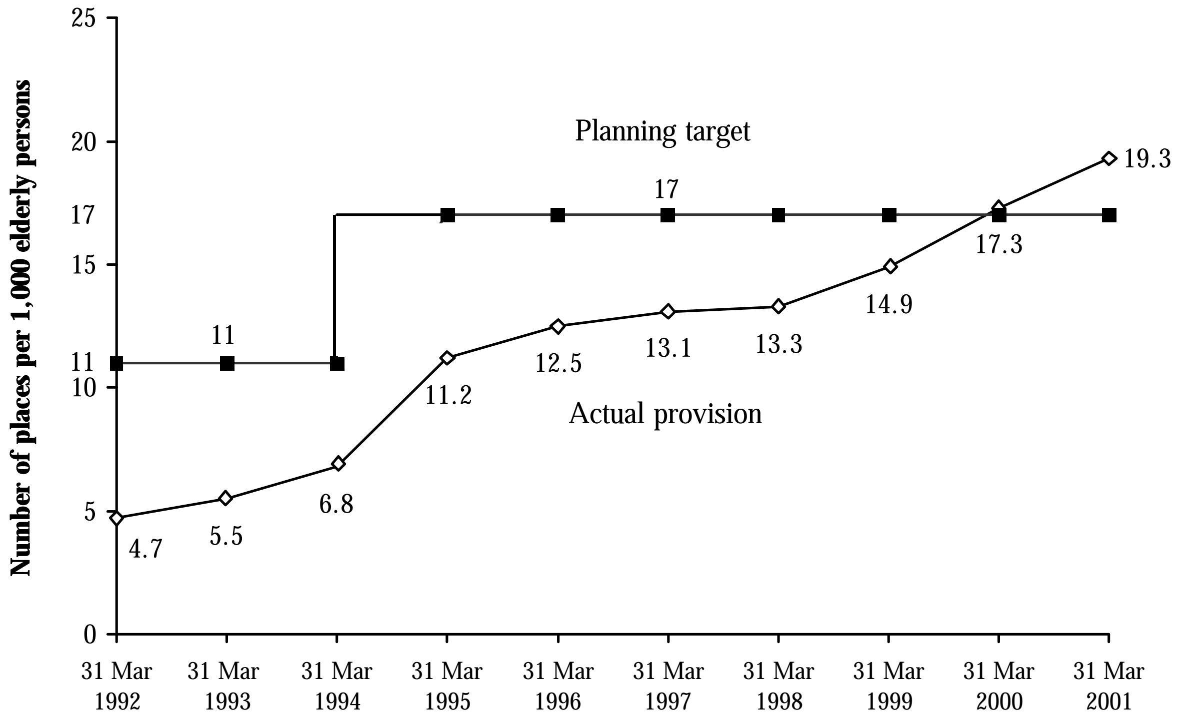
Source: *Census and Statistics Department's records*

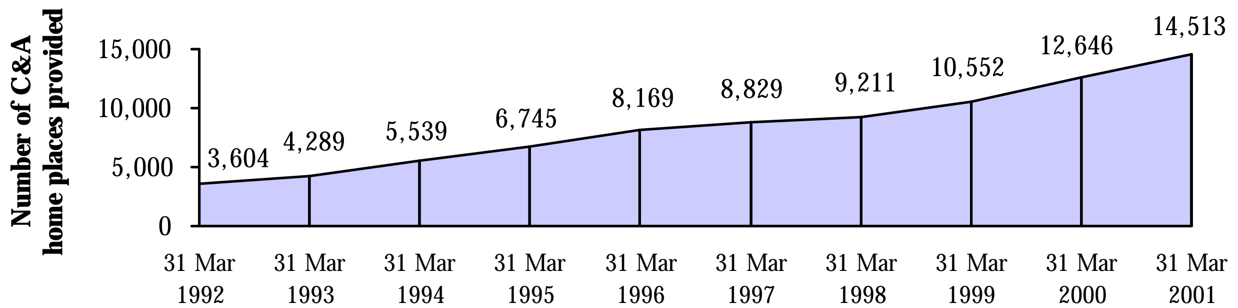
Note: *Before 1995, the planning ratio was based on the population aged 60 or over. Since 1995, the planning ratio has been revised and based on the population aged 65 or over.*

2.7 The planning target and actual provision of C&A home places subsidised by the SWD (including places under the Bought Place Scheme (BPS) and Enhanced Bought Place Scheme (EBPS) — see paras. 2.10 to 2.12 below) from 1992 to 2001 are shown in Figure 2 below.

Figure 2

Provision of subsidised C&A home places from 1992 to 2001 (Note)





Source: *SWD's and Census and Statistics Department's records*

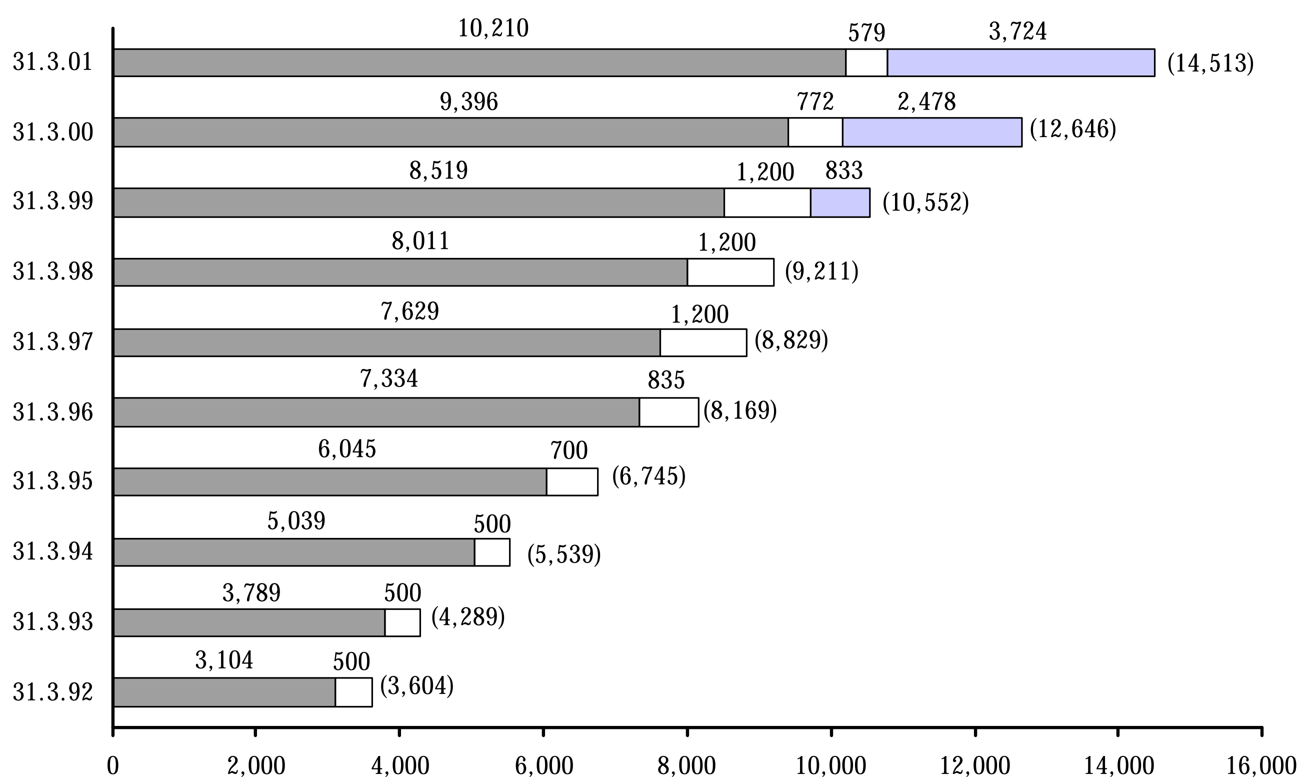
Note: *Before 1995, the planning ratio was based on the population aged 60 or over. Since 1995, the planning ratio has been revised and based on the population aged 65 or over.*

SWD increased the provision of C&A home places in recent years

2.8 As shown in Figure 2 above, since March 2000, the SWD has been able to achieve the planning target on the provision of subsidised C&A home places because the SWD increased the number of subsidised C&A home places provided through subventions to NGOs and through the BPS and EBPS. Figure 3 below shows the number of such subsidised C&A home places from 1992 to 2001.

Figure 3

Number of subsidised C&A home places provided under Government subvention, BPS and EBPS from 1992 to 2001 (Note)



Source: SWD's records

Note: The BPS and EBPS were introduced in October 1989 and July 1998 respectively.

2.9 Between April 1998 and March 2001, the SWD had increased the supply of subvented C&A home places by 2,199 (i.e. 10,210 – 8,011). During the same period, through the BPS and EBPS, the SWD had also increased the supply of subsidised C&A home places by 3,103 (579 + 3,724 – 1,200), so as to achieve the target ratio of 17 subsidised C&A home places per 1,000 elderly persons aged 65 or over. In 2000-01, the SWD spent a total of **$1,419.4 million on C&A home places** (i.e. $1,092.6 million for 10,210 subvented places and $326.8 million for 4,303 bought places).

Provision of C&A home places
for the elderly through BPS and EBPS

2.10 ***BPS.*** In October 1989, the SWD introduced the BPS to buy 500 places from private RCHEs to accommodate applicants on the SWD's waiting list for C&A home places. The BPS was funded by the Lotteries Fund. Since October 1993, the BPS has been funded by the SWD's subventions. Under the BPS, the SWD signs service contracts with individual operators of private RCHEs, specifying the number of places to be bought and the fee for each place. The contracts lay down the service requirements for staff and area per resident. Each contract, normally covering a period of six months, may be renewed subject to satisfactory delivery of the services. There are three types of places under the BPS, namely Type A1 (no longer provided as from 2000-01), Type A2 (a minimum area of 8 square metres per resident) and Type B (a minimum area of 7 square metres per resident — see Table 2 in para. 2.14 below).

2.11 The BPS has two main objectives, namely:

— increasing the provision of subsidised C&A home places in order to reduce the waiting time of the elderly on the SWD's waiting list for the services; and

— raising the service standards of private RCHEs because operators under the BPS need to meet service standards higher than those required under the Ordinance (e.g. the minimum area per resident under the Ordinance is 6.5 square metres, whereas that under the BPS ranges from 7 to 8 square metres).

The SWD has set a target to replace all BPS places by EBPS places by 2003.

2.12 ***EBPS.*** In July 1998, the SWD introduced the EBPS. Under the EBPS, RCHEs are required to provide a higher level of services in terms of the minimum area per resident (from 8 to 9.5 square metres) and staff requirements (see Table 2 in para. 2.14 below). There is an additional requirement that, from early 2000, 30% of care workers of the EBPS homes need to have received personal-care-worker training, and this percentage has been raised to 50% from early 2002. There are two types of places under the EBPS, namely Type EA1 (a minimum area of 9.5 square metres per resident) and Type EA2 (a minimum area of 8 square metres per resident).

Service level disparities between subvented C&A home places and C&A home places under bought-place schemes

2.13 Subject to resources, subsidised C&A home places obtained through the BPS and EBPS provide a means for the SWD to increase the supply of subsidised C&A home places. However, Audit noted that there were significant disparities in the service levels and waiting time for admission between subvented C&A home places and C&A home places under the BPS and EBPS (see paras. 2.14 to 2.19 below).

2.14 ***Service levels of subvented C&A home places and C&A home places under bought-place schemes.*** The service levels are mainly expressed in terms of minimum area per resident and minimum staff requirements as prescribed by the SWD in the service agreements with subvented bodies (for subvented places) and private operators (for bought places). Table 2 below shows the minimum area per resident and the minimum number of staff required in respect of different types of subvented places and bought places.

Table 2

Minimum area per resident and staff requirements for different types of subsidised C&A home places

Type of C&A home places	Minimum area per resident	Minimum number of staff for a 40-place C&A home (see Appendix C)
	(m^2 = square metre)	
Subvented places of NGOs	10.5 m^2	**21.75**
Places bought under BPS		
— Type A2	8 m^2	11
— Type B	7 m^2	11
Places bought under EBPS		
— Type EA1	9.5 m^2	21
— Type EA2	8 m^2	19

Source: SWD's records

2.15 The minimum staff requirements are shown in Appendix C. Although the minimum number of staff at a subvented C&A home and that at an EBPS home are about the same, a subvented home has many more professional staff. For example, at a 40-place subvented C&A home, there is one Senior Social Work Assistant, one Welfare Worker, one Registered Nurse and three Enrolled Nurses. However, there is only one Home Manager and two Registered Nurses/Enrolled Nurses at a Type EA1 EBPS home.

2.16 ***Waiting time for admission to subvented C&A homes and C&A homes under the bought-place schemes.*** Applicants for C&A home places subsidised by the SWD are required to indicate whether they are willing to reside in the C&A homes under the BPS or EBPS. Apparently due to the higher service levels of subvented C&A home places, as at 31 March 2001, only 9% of the applicants on the SWD's waiting list for C&A home places had indicated their willingness to reside in accommodation provided under the BPS or EBPS. Consequently, as at 31 March 2001:

(a) applicants who were willing to reside in accommodation provided under the BPS or EBPS on average needed only to wait for 11 months (Note 2) before admission; and

(b) applicants for places at subvented RCHEs on average needed to wait for 35 months.

The number of applicants on the SWD's waiting list for C&A home places and the average waiting times for admission (broken down into those who were willing and those who were not willing to reside in accommodation provided under the BPS or EBPS) in the past four years are shown in Table 3 below.

Note 2: *The average waiting time was based on the number of months the applicants had been waiting before admission to RCHEs in a financial year (hereinafter referred to as the average waiting time).*

Table 3

Average waiting time for admission to C&A homes

As at 31 March	Subvented C&A homes			BPS or EBPS homes		
	Number of places provided	Number of applicants on waiting list (Note 2)	Average waiting time (Month)	Number of places provided	Number of applicants on waiting list (Note 3)	Average waiting time (Month)
1998 (Note 1)	8,011	16,088	28	1,200	3,190	19
1999	8,519	16,311	29	2,033	1,157	9
2000	9,396	16,087	27	3,250	2,034	13
2001	10,210	16,370	35	4,303	1,578	11

Source: SWD's records

Note 1: The Residential Care Services Delivery System has commenced recording the relevant information since November 1997.

Note 2: These applicants would only accept places at subvented C&A homes.

Note 3: These applicants would also accept places at BPS or EBPS homes.

2.17 **Elderly persons who would only accept places at subvented C&A homes had to wait for about 35 months due to the higher demand for such places.** The fact that more elderly persons would rather choose to reside in subvented C&A homes suggests that the quality of care at these homes is perceived to be relatively better. This is largely due to the provision of better physical facilities and more qualified staff at these homes.

2.18 **Audit considers that there is a need to reduce the disparity in the waiting time for admission to different types of C&A homes. This can be achieved by improving the quality of services of the BPS and EBPS homes so as to enhance elderly persons' willingness to accept places at these homes.**

2.19 **Furthermore, Audit considers that the elderly are very concerned about the waiting time for a place at a C&A home. Therefore, the SWD should provide information to the users and the public as to how long an elderly person has to wait before being admitted to a C&A home.**

Audit recommendations on provision of C&A home places by SWD

2.20 **Audit has *recommended* that the Director of Social Welfare, in conjunction with the Secretary for Health and Welfare, should:**

(a) **take action to reduce the disparity in the waiting time for admission to a subvented C&A home and a BPS or EBPS home;**

(b) **take action to provide as far as possible a uniform level of service for all places at government subsidised C&A homes in terms of:**

(i) **minimum area per resident;**

(ii) **qualification and number of staff; and**

(iii) **physical facilities;**

(c) **inform the applicants for C&A home places the estimated waiting time for a place at 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.**

Response from the Administration

2.21 The **Director of Social Welfare** has said that:

(a) Audit has rightly observed that there is a disparity between subsidised C&A home places provided at subvented C&A homes run by NGOs and those provided through the BPS/EBPS;

(b) the SWD has taken measures to ensure that the level of services provided at EBPS homes is comparable to that at subvented homes, such as requiring EBPS homes to provide a higher level of services, comply with service quality standards, and have at least half of their care workers having received appropriate training;

(c) for C&A homes, the perceived superiority of subvented homes is mainly due to these homes being purpose-built and the users having a higher level of confidence in the home operators. To address the fundamental causes for the disparity, the SWD has begun an approach to increasing the supply of purpose-built RCHE premises, and developing an independent accreditation system to assess and assure the service quality of all homes;

(d) the SWD agrees that it should provide more information to its potential service users. In view of the present disparity in waiting times which could not be readily reduced, the SWD would provide advice to users to enable them and their families to make an informed choice. The SWD has made available on the SWD's homepage information on the facilities, service provision, space provision and staffing of EBPS homes, as well as the average waiting times (updated quarterly) for various types of residential care services; and

(e) in December 2001, the SWD published a Directory of RCHEs to improve public access to the information of the RCHEs. Social workers may check with the SWD about the status of the applications for residential services referred by them.

2.22 The **Secretary for Health and Welfare** has said that, to address the disparity in the service standards at subvented and bought-place homes, the HWB is pursuing and will continue to explore quality assurance and other measures with a view to further raising the standards of private care homes.

PART 3: PROVISION OF SUBSIDISED SELF-CARE, HFA AND HSC PLACES

3.1 This PART examines the provision of self-care and HFA places by the SWD, and HSC places by the Housing Authority.

Self-care hostels subsidised or provided by SWD

3.2 A self-care hostel is an establishment providing residential care, supervision and guidance for people who have attained the age of 60. Elderly persons residing there are capable of taking care of their personal hygiene and performing household duties such as cleaning, cooking, shopping and other domestic tasks. As at 31 March 2001, there were seven self-care hostels (Note 3) which provided a total of 260 places at a cost of **$7.6 million** a year. An elderly person staying at a self-care hostel pays a fee of $502 a month. In 1994, the Working Group on Care for the Elderly (see para. 2.6 above) recommended that the provision of self-care places should be phased out gradually. The Working Group considered that the sheltered housing scheme for able-bodied elderly persons provided by the Housing Authority overlapped considerably with the self-care hostel programme. The SWD has taken action to convert the self-care places into HFA places (Note 4) and C&A home places. The number of self-care places had been reduced from 987 in March 1997 to 260 in March 2001.

HFA places subsidised or provided by SWD

3.3 An HFA (or aged home as referred to in the Ordinance) is an establishment providing residential care, supervision and guidance for persons who have reached the age of 60. These elderly persons are capable of taking care of their personal hygiene but have some difficulties in performing household work such as cleaning, cooking, washing clothes, shopping and other domestic activities. Meal and laundry services, limited personal care and social activities are provided at the HFAs. As at 31 March 2001, there were 77 HFAs providing 7,537 places, of which 76 (providing 7,449 places) were run by NGOs under Government subvention, and one (providing 88 places) was run by the SWD (see Table 1 in para. 1.5 above). An elderly person staying at an HFA pays a fee ranging from $1,429 to $1,506 a month.

Note 3: *Of these seven self-care hostels, one was directly run by the SWD. The other six hostels were run by NGOs under Government subventions.*

Note 4: *In the 2000 Policy Address, the Government pledged to gradually convert the existing HFA places (identified as suitable for upgrading) into places in C&A homes (see para. 3.9 below).*

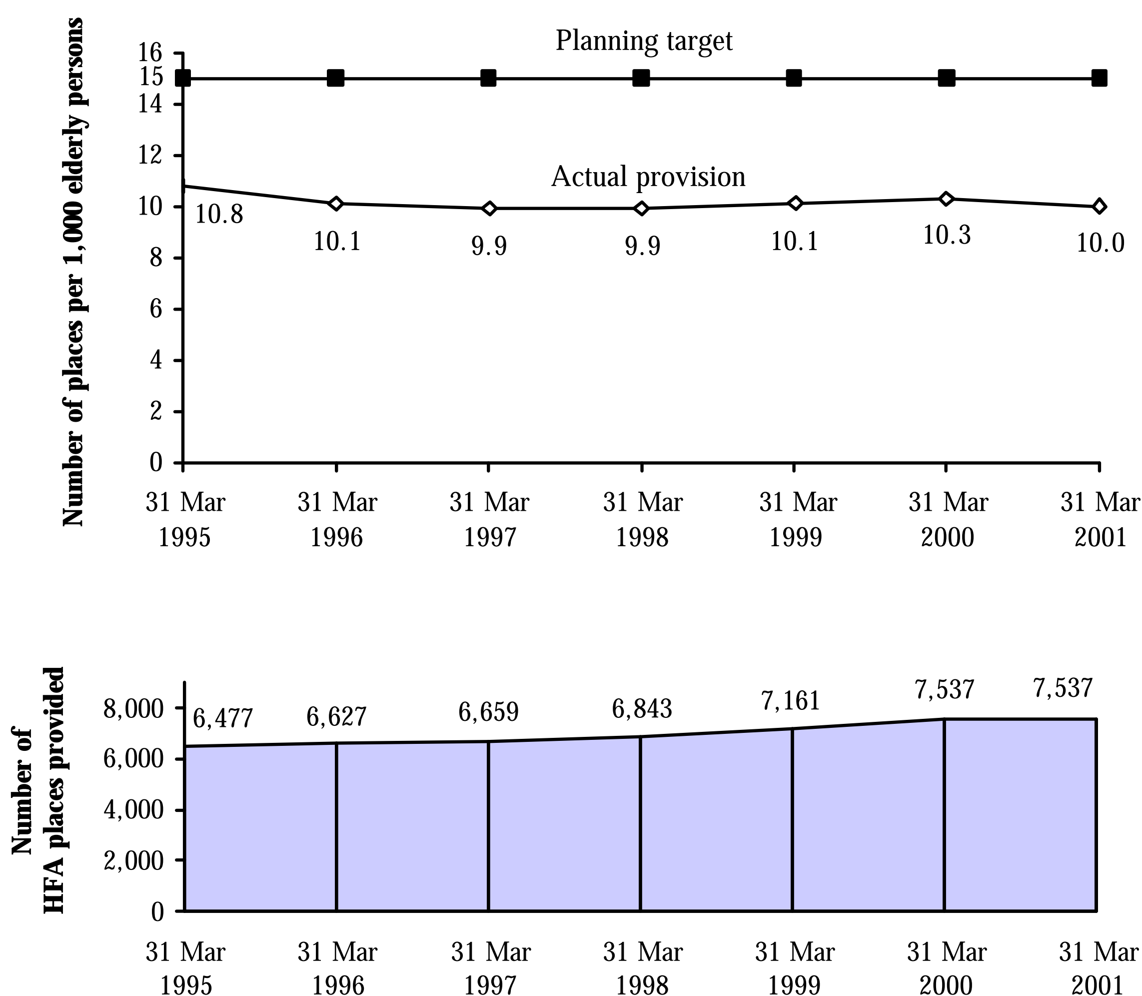
Audit observations on phasing out HFA places

Planning target and provision of HFA places

3.4 In 1995, the SWD adopted the recommendation of the Working Group on Care for the Elderly to revise the planning ratio for HFA places from **10 places per 1,000 persons aged 60 or over, to 15 places per 1,000 persons aged 65 or over.** Figure 4 below shows the planning target and actual provision of HFA places subsidised by the SWD in the past seven years.

Figure 4

Provision of subsidised HFA places from 1995 to 2001



Source: SWD's and Census and Statistics Department's records

3.5 As shown in Figure 4 above, the actual provision of HFA places had been well below the target. Furthermore, there was only a small increase in the provision of HFA places in recent years. Apparently, this was due to the Government's decision to gradually phase out the HFAs, following a comprehensive assessment of services for the elderly between 1997 and 1998 (see paras. 3.6 to 3.9 below).

Elderly Commission's recommendation to phase out HFA places

3.6 In 1997, the Elderly Commission conducted a comprehensive assessment on the long-term demand of the elderly for housing and residential care services and recommended a strategy to meet the long-term needs.

3.7 In the Report of the Elderly Commission published in September 1998, the Commission considered that residential care services should be directed to elderly persons with genuine needs. On this basis, the Commission recommended that:

— in the longer term, HFAs should adopt the same admission criteria as C&A homes; and

— **able-bodied elderly persons and those who could take care of themselves should remain in the community.**

3.8 In implementing the above changes, the Elderly Commission recommended that the revised admission criteria should only be applied to elderly persons who were on the waiting list. Elderly persons who were already living at HFAs should not be affected.

3.9 In the 2000 Policy Address, the Government announced that it would take the initiative to gradually convert the existing HFA places (which were suitable for conversion) into C&A home places. The target was to convert 200 places in 2001-02.

3.10 In May 2000, the SWD examined the provision of HFAs with a view to identifying HFAs suitable for conversion. The SWD conducted a survey and found that, of the 7,836 HFA places (comprising 7,537 HFA places and 299 self-care places), it was only technically feasible to convert 2,977 places (38%) into C&A home places.

3.11 In August 2001, in response to Audit's enquiry about the phasing out of HFAs, the SWD said that:

(a) based on the guiding principle of "Ageing in Place", elderly residents were encouraged to stay at the same residential home when their health conditions deteriorated;

(b) the conversion of HFA places into C&A home places was the measure to turn the concept of "Ageing in Place" into reality;

(c) against the above background, the SWD intended to phase out the HFAs in the long run;

(d) the SWD had taken into consideration the following factors in formulating the phase-out programme:

    (i) feasibility of alteration of the HFAs due to their physical conditions;

    (ii) whether the residents occupying HFA places were eligible for allocation of places at C&A homes; and

    (iii) availability of additional recurrent funding for conversion of HFA places into C&A home places;

(e) the SWD would examine alternative means (such as reprovisioning the HFAs into new premises) to phase out those HFAs that were difficult to convert because of their physical conditions; and

(f) the SWD would enhance the community support services to meet the needs of those elderly persons who might choose to return to the community.

3.12 **However, Audit noted that the SWD was still accepting applications for HFA places. These applications were placed on the waiting list for HFAs. As at 31 March 2001:**

- **there were 6,194 elderly persons on the waiting list; and**

- **the average waiting time for admission to an HFA was 19 months.**

Audit considers that, in order to phase out the HFAs (as recommended by the Elderly Commission), the SWD should formulate a plan for this purpose.

3.13 The HFA phase-out plan should include a timetable for converting the premises of existing HFAs into either C&A homes or premises for other purposes. The existing residents at HFAs should be transferred to C&A homes if they meet the admission criteria. For those HFAs (62%) which are not suitable for conversion, ways should be found to use the premises for other purposes.

Audit recommendations on phasing out HFA places

3.14 **Audit has *recommended* that the Director of Social Welfare should:**

(a) **cease accepting 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) **transfer the existing HFA residents to C&A homes;**

(d) **formulate an action plan with target dates to phase out existing HFAs;**

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

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

Response from the Administration

3.15 The **Director of Social Welfare** has said that:

(a) as a matter of policy objective, welfare facilities for the elderly should concentrate on looking after those frail elderly persons with care needs, whereas the housing needs of the elderly should be met through the housing programme for the elderly. The SWD has adopted various measures to address the existing stock of HFA places under the SWD's purview, such as stopping the building of HFAs, and converting existing HFA places into C&A home places as far as practicable;

(b) the SWD's reasons for not ceasing acceptance of new applications for HFA places, or not closing down some HFAs, are that some potential and incumbent elderly persons might feel aggrieved by such a decision, and some existing staff of the HFA operators might be affected. For example, due to the strong sentiments of the elderly residents against relocation, the SWD has stopped pursuing an initiative to hive off a home run by the SWD providing self-care and HFA places. The HWB has acknowledged that it might be necessary to maintain a residual waiting list for HFA places; and

(c) the SWD would revisit together with the HWB the current measures to phase out HFA places to see whether it could draw up a firm timetable for action. Having regard to the surplus HSC flats of the Housing Authority, the SWD is 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.

3.16 The **Secretary for Health and Welfare** has said that the HWB is pleased to take forward Audit's recommendations on working out a long-term strategy with the SWD and other parties concerned on phasing out all HFA premises, including a timetable to phase out the HFA waiting list and find alternative use of HFA premises that cannot be converted into C&A homes.

HSC provided by Housing Authority

3.17 Since 1987, the Housing Authority has introduced HSC units to provide residential services to tenants aged 60 or over, and who are self-reliant and can live independently. These units are specifically designed for the elderly who are in need of public housing assistance. Under the HSC, each resident is allocated a unit (or shares a unit jointly with other residents). Residents normally share common facilities such as kitchen and washroom with two to three other residents living in nearby units. HSC units are provided with warden service. Elderly persons may be allocated these specially designed units through the Single Elderly Persons Priority Scheme or the Elderly Persons Priority Scheme. The latter scheme provides housing for two or more elderly persons who agree to live together upon allocation.

Audit observations on provision of HSC units by Housing Authority

Provision of HSC units by Housing Authority

3.18 As at 31 March 2001, the Housing Authority provided 9,383 HSC units at a cost of $62 million a year (Note 5), and 7,870 residents were residing in such units. An elderly person staying in an HSC unit pays rents, ranging from $283 to $1,760 a month. Table 4 below shows the provision of HSC units in the past five years.

Table 4

Provision of HSC units by Housing Authority

As at 31 March	Number of HSC units provided	Number of HSC units allocated	Number of vacant HSC units	Percentage of vacant units expressed as a percentage of available units
	(a)	(b)	(c) = (a) - (b)	(d) = (c) ÷ (a) × 100%
1997	4,046	3,977	69	1.7%
1998	5,648	5,204	444	7.9%
1999	7,201	6,933	268	3.7%
2000	8,786	8,059	727	8.3%
2001 (Note)	9,383	8,496	887	9.5%

Source: Housing Authority's records

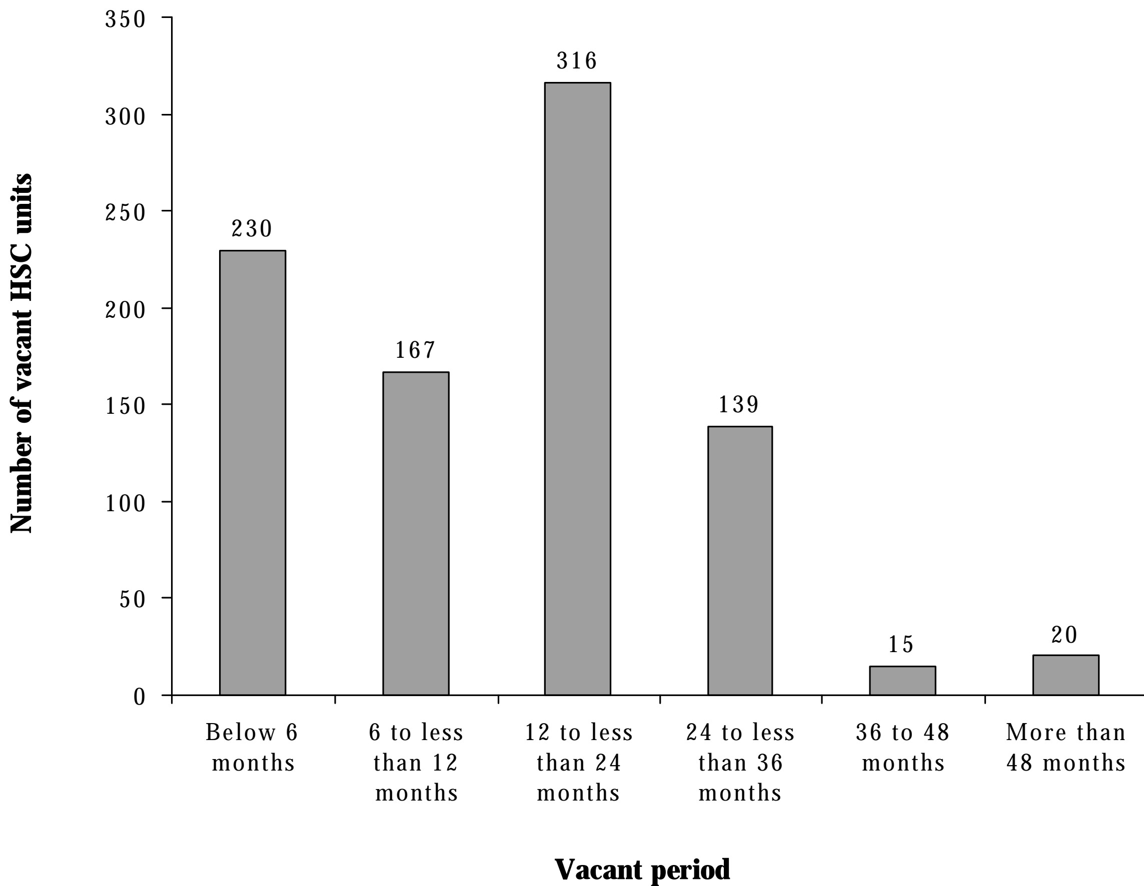
Note: As at 31 December 2001, there were 9,691 HSC units provided, of which 8,905 units were allocated and 786 units (8.1%) remained vacant.

Note 5: *Based on the operating and depreciation cost of an HSC unit amounting to $1,568 a month, and the average monthly rent of $1,020 paid by a resident, the cost is $62 million a year (i.e. [$1,568 – $1,020] × 9,383 × 12).*

3.19 Figure 5 below shows an analysis of the vacant periods of the 887 vacant HSC units as at 31 March 2001.

Figure 5

Analysis of vacant periods of 887 HSC units as at 31 March 2001



Source: Housing Authority's records

3.20 Audit considers that it is undesirable for HSC units to remain vacant for a long time. For the 657 HSC units (167 + 316 + 139 + 15 + 20) which had remained vacant for over six months, Audit estimates that the loss in rental income amounted to $8 million a year (Note 6).

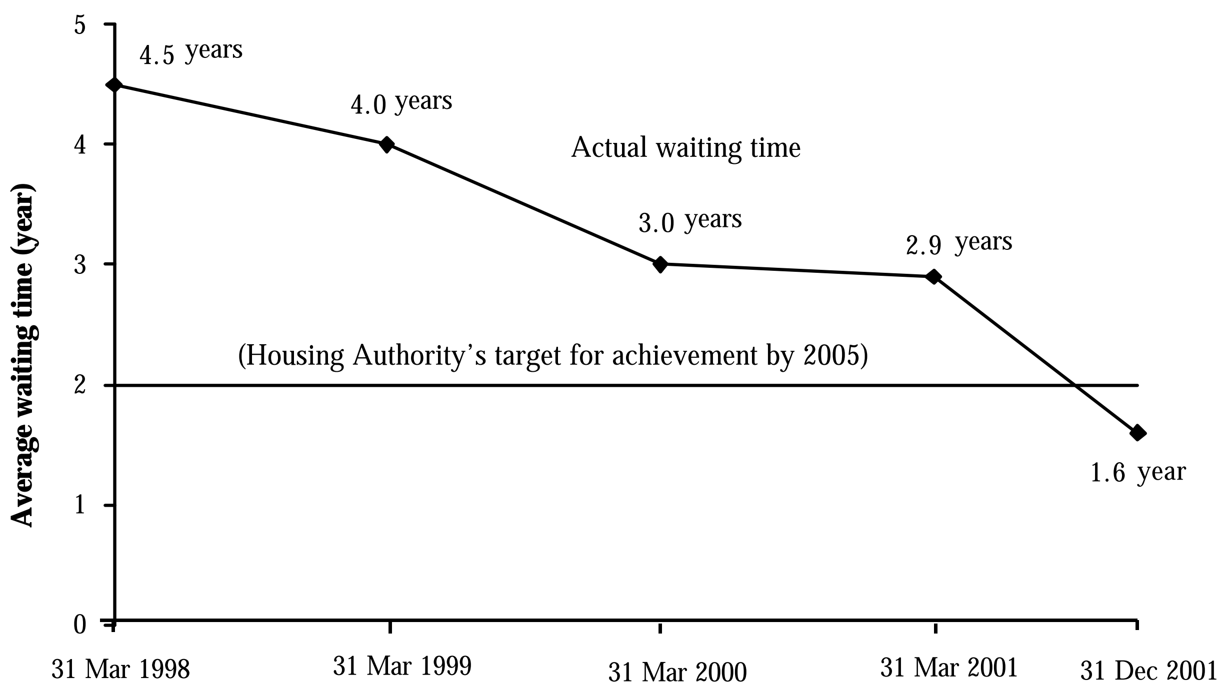
Note 6: *Based on the average rent of an HSC unit of $1,020 a month, the estimated loss in rental income was $8 million a year ($1,020 × 657 × 12).*

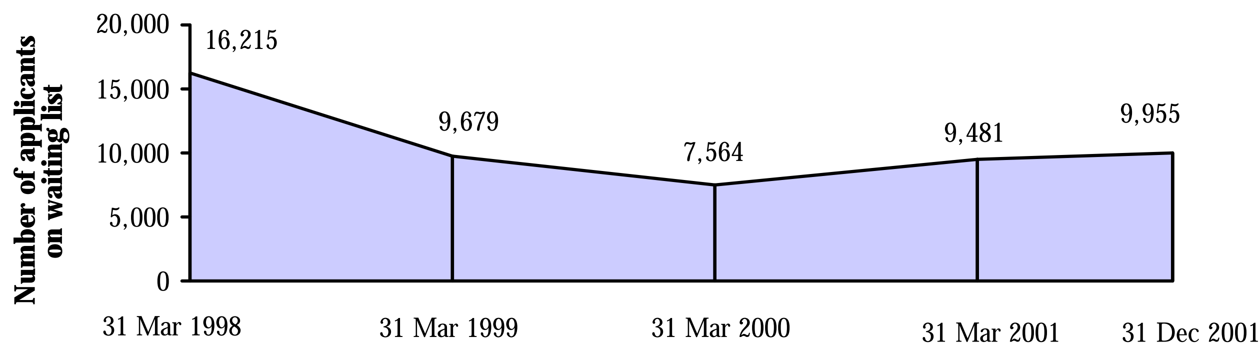
Planning target for HSC units

3.21 The Housing Authority's planning target for HSC units is to reduce the average waiting time to two years by 2005. The average waiting times for single elderly persons applying for HSC units from 1998 to 2001 are shown in Figure 6 below.

Figure 6

Average waiting time for HSC units from 1998 to 2001





Source: Housing Authority's records

3.22 As shown in Figure 6 above, since late 2001, the Housing Department has been able to achieve the waiting time target. However, some HSC units had remained vacant for a long time (see Table 4 in para. 3.18 and Figure 5 in para. 3.19 above). In response to Audit's enquiries, the Housing Department stated that the following factors affected the popularity of and demand for HSC units:

- some elderly persons were unwilling to share the facilities of an HSC unit with others;

- some HSC units were situated in unfavourable locations; and

- some elderly persons were unwilling to take up the premises vacated by former tenants due to previous tragic incidents, such as death or suicide.

Consultancy study on Provision of Housing and Care Services for the Elderly in Public Housing Estates

3.23 In November 2000, the Strategic Planning Committee of the Housing Authority endorsed the findings of a consultancy study on "Provision of Housing and Care Services for the Elderly in Public Housing Estates". The study:

- found that HSC was not very popular among the elderly tenants because of its shared facilities; and

- recommended that self-contained units be built to satisfy the housing needs of single elderly tenants (common lounges, warden service and emergency alarms were to be maintained).

3.24 The Housing Authority has decided to:

- stop further production of HSC units; and

- concentrate on building more self-contained small flats for the elderly having regard to their preferences and the cost-effectiveness of doing so.

3.25 The Housing Authority has taken positive steps to replace HSC units by self-contained small flats for self-reliant elderly persons. **Audit considers that:**

(a) **to adequately plan for the production of the self-contained small flats for self-reliant elderly persons, there is a need for the Housing Authority to formulate a strategy (based on the forecast population in the future) for the provision of these flats, and to determine a suitable planning ratio per 1,000 elderly persons (similar to the planning ratios adopted for the planning of infirmary, C&A home and HFA places).** The Housing Authority could use this planning ratio to plan for the longer-term supply of housing units to meet the needs of the elderly. As the HWB is responsible for the overall provision of services and facilities for the elderly, it should, in collaboration with the Housing Bureau and the Housing Authority, develop this planning ratio; and

(b) **in view of the fact that 657 (167 + 316 + 139 + 15 + 20) HSC units (7% of 9,383) had been vacant for over six months (see Figure 5 above), the Housing Authority should take action to allocate these vacant HSC units to other applicants on the Housing Authority's waiting list for public rental housing. This will improve the utilisation of these vacant flats.**

Audit recommendations on provision of HSC units by Housing Authority

3.26 **Audit has *recommended* that the Director of Housing, in consultation with the Housing Authority, should:**

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

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

(c) **consider allocating the HSC units, which have been vacant for a long time, to other suitable applicants on the Housing Authority's waiting list, so as to make full use of these flats.**

Response from the Administration

3.27 The **Director of Housing** has said that:

(a) he agrees with Audit's observations and recommendations on the provision of HSC units by the Housing Authority;

(b) the consultancy study on "Provision of Housing and Care Services for the Elderly in Public Housing Estates" undertaken in 2000 was initiated by the Housing Authority. The recommendations of the study were endorsed by the Housing Authority in formulating strategies for the provision of housing and care services in meeting the needs of the elderly. The strategies followed largely the two central themes of the Government on the provision of elderly housing services, namely "Ageing in Place", and "Continuum of Care";

(c) in November 2001, the Rental Housing Committee of the Housing Authority endorsed the letting of HSC units to non-elderly applicants on the Waiting List and other rehousing categories in order to make fullest use of housing resources; and

(d) regarding the planning ratio for the provision of small flats for self-reliant elderly persons, the Housing Authority acts on the advice of the Housing Bureau, based on the housing demand model worked out in consultation with the Planning Department.

3.28 The **Secretary for Housing** supports in principle Audit's recommendation concerning the formulation of a suitable ratio for the provision of self-contained small flats for self-reliant elderly persons.

PART 4: PROVISION OF SUBSIDISED NURSING-HOME AND INFIRMARY PLACES

4.1 This PART examines the provision of nursing-home places subsidised by the SWD and infirmary places provided by the Hospital Authority.

Nursing-home places subsidised by SWD

4.2 In the 1993 Policy Address, the Government announced that a network of elderly nursing homes with medical and nursing facilities would be developed. A nursing home provides non-hospital-based residential nursing care facilities designed specially to cater for elderly persons who, because of their health conditions, could not be adequately cared for at C&A homes. However, these elderly persons do not require the intensive medical and nursing care provided in infirmary hospitals. Nursing homes provide an intermediary type of accommodation between infirmaries and C&A homes. An elderly person staying at a nursing home pays a fee of $1,994 a month. Since 1998, 1,400 subvented nursing-home places have been provided by six NGOs to accommodate elderly persons referred by the SWD. The subvention was $217 million for 2000-01.

Infirmary places provided by Hospital Authority

4.3 Infirmary care is provided in the Hospital Authority's hospitals and is intended to provide care to elderly and disabled persons whose health conditions have reached the stage that active medical treatment is unlikely to benefit them further. The infirmary care service of these hospitals provides personal and nursing care, and medical and other professional services to support a dignified and quality lifestyle for elderly persons. Persons applying for infirmary places need to be assessed by the Hospital Authority to ascertain their healthcare needs. Qualified applicants are placed on the Central Infirmary Waiting List and are allocated places when bed vacancies become available. As at 31 March 2001, there were 13 institutions under the Hospital Authority which provided 1,134 infirmary beds at a cost of **$408 million** a year (Note 7). A person staying in an infirmary bed pays a hospital fee of $68 a day.

Note 7: *In addition to the provision of infirmary places for applicants on the Hospital Authority's waiting list, as at 31 March 2001, the Hospital Authority also provided 1,421 infirmary places for patients transferred from acute hospitals. These patients would be discharged when their health conditions improved.*

Audit observations on provision of subsidised nursing-home and infirmary places

Planning target for nursing-home places

4.4 **Audit notes that the Government has not determined a planning ratio for the provision of nursing-home places. As at 31 March 2001:**

- **the ratio of provision of nursing-home places per 1,000 elderly persons aged 65 or over was 1.9 (Note 8); and**

- **there were 4,729 elderly persons on the waiting list for nursing-home places.**

4.5 **Audit notes that, although the average waiting time for admission to nursing homes was only 13 months (as at 31 March 2001), this is expected to increase considerably in the near future (see para. 5.17 below). As an elderly person and his family are concerned about the waiting time for a nursing-home place, the SWD should also inform them about the average waiting time for a place to facilitate their planning for such places.**

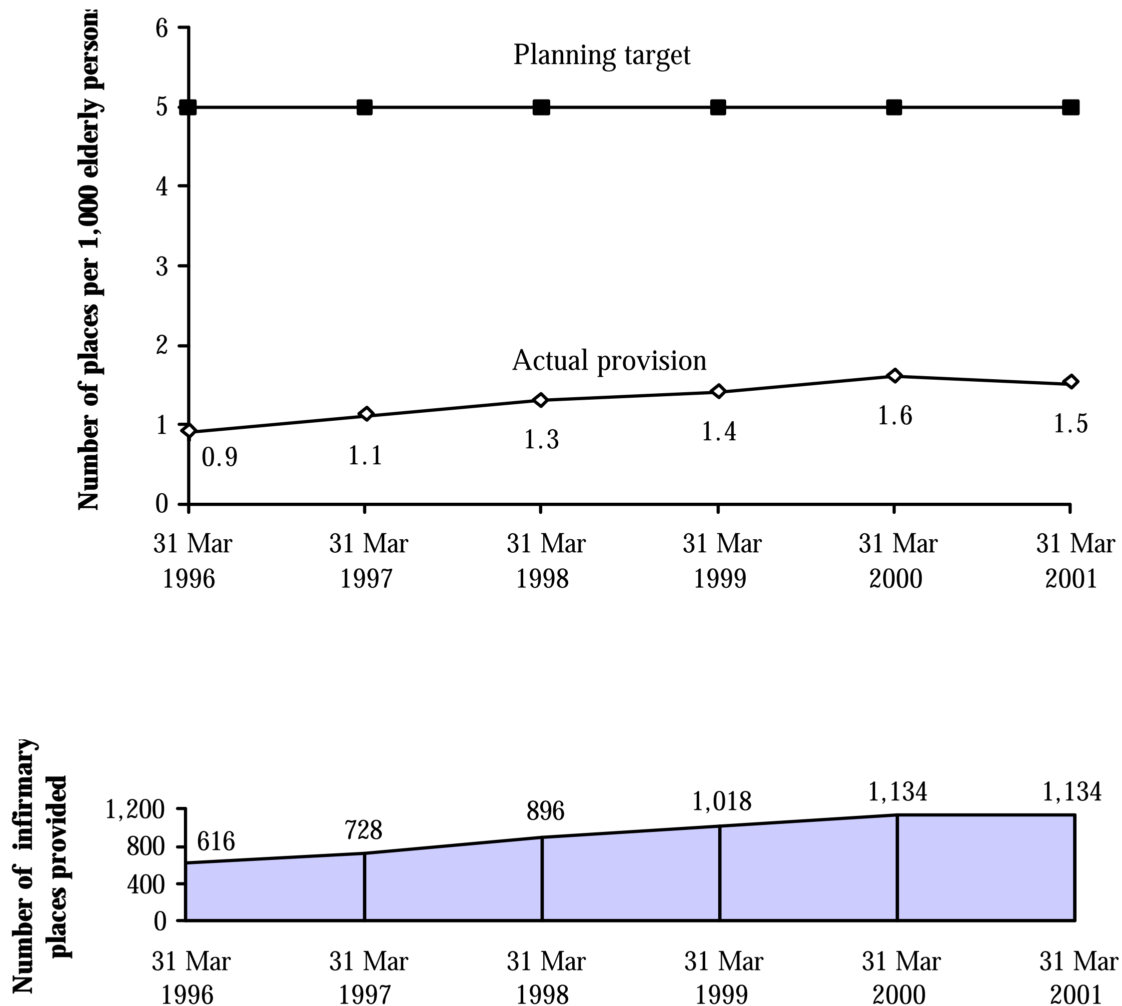
Planning target for infirmary places of the Hospital Authority

4.6 For many years, the planning target for infirmary places adopted by the Hospital Authority was five places per 1,000 population aged 65 or over. Figure 7 below shows the planning target and actual provision of infirmary places by the Hospital Authority in the past six years.

Note 8: *On the basis that there were 1,400 nursing-home places (see Table 1 in para. 1.5 above) and 753,200 elderly persons as at 31 March 2001 (see Figure 1 in para. 2.6 above), the ratio was 1.9 [1,400 ÷ (753,200 ÷ 1,000)].*

Figure 7

Provision of infirmary places from 1996 to 2001



Source: Hospital Authority's and Census and Statistics Department's records

4.7 Audit notes that the actual provision of infirmary places had consistently been well below the planning target in the past few years. In response to Audit's enquiry, in May 2001, the Hospital Authority said that the provision of infirmary places was adjusted annually according to the Government's financial allocation to the Hospital Authority in respect of new bed services.

4.8 As at 31 March 2001, there were 5,218 elderly persons (Note 9) on the waiting list for infirmary places. The changes in the number of elderly persons on the waiting list during 2000-01 were as follows:

	Number of elderly persons on the waiting list for infirmary places
As at 1.4.2000	5,086
Add: New applicants in 2000-01	2,671
	7,757
Less: applicants who:	
• were allocated places	(347)
• withdrew their applications	(546)
• passed away while waiting (Note 10)	(1,646)
As at 31.3.2001	**5,218**

On average, the 347 elderly persons who were allocated places had waited for 31 months before admission (Note 11).

Note 9: *The places of residence of these 5,218 elderly persons as at 31 March 2001 were:*

Place of residence	***Elderly persons***	
	(Number)	***(Percentage)***
Hospitals (excluding infirmaries)	*504*	*9.7%*
Subvented C&A homes	*1,049*	*20.1%*
HFA	*39*	*0.8%*
Subvented nursing homes	*64*	*1.2%*
Private RCHEs	*2,507*	*48.0%*
Public housing flats	*296*	*5.7%*
Private housing	*456*	*8.7%*
Others	*303*	*5.8%*
	5,218	*100.0%*

Source: Hospital Authority's records

Note 10: *The numbers of elderly persons who passed away while waiting for infirmary places were: 1,641 persons in 1997-98; 3,499 persons in 1998-99; and 2,006 persons in 1999-2000.*

Note 11: *The average waiting times were: 44 months in March 1998; 46 months in March 1999; and 36 months in March 2000.*

Unclear policy on infirmary services

4.9 **It can be seen from Figure 7 in paragraph 4.6 above that the actual provision of infirmary places (i.e. 1.5 places per 1,000 elderly persons aged 65 or over as at 31 March 2001) by the Hospital Authority was significantly below its target planning ratio of five places per 1,000 elderly persons aged 65 or over.** In May 2001, in response to Audit's enquiry, the Hospital Authority said that:

(a) under the policy objective of "Ageing in Place", it was expected that C&A homes and nursing homes would play a greater role in caring for infirm elderly persons in the welfare setting;

(b) there had been discussions between the HWB and the Hospital Authority to consider the policy option of taking the provision of infirmary care out from the hospital setting except for the post-acute care patients suffering from severe disabilities;

(c) there were also discussions on how to encourage the private sector to play a more active role in the provision of infirmary care in the community;

(d) it was likely that the planning target for medical infirmaries in public hospitals would be changed in the future; and

(e) given the uncertainty of the policy, the Hospital Authority had not revised the planning target until the policy direction was clear.

Need for review of provision of infirmary care services

4.10 In the light of the significant shortage of 70% of infirmary places (Note 12), and a long waiting time of 31 months for the places, Audit considers that HWB should expedite action to conduct a review to decide the future role to be played by infirmaries and nursing homes and the number of places to be provided to meet the needs of the elderly.

Note 12: *The shortage of 2,632 places (70%) was calculated as follows:*

target provision (753,200 ÷ 1,000 × 5)	*3,766*
less actual provision	*(1,134)*
	2,632

4.11 Audit has noted that the nursing homes provide an intermediary type of service between infirmaries and C&A homes. The costs borne by the Government for a place at an infirmary and a nursing home are:

— $30,000 per month for an infirmary place provided by the Hospital Authority; and

— $12,930 per month for a nursing-home place provided by a subvented NGO.

4.12 Having regard to the significant shortage of infirmary places and the significant amount of resources spent on providing the 1,134 infirmary places ($408 million a year — see Table 5 in para. 5.2 below), it seems that if such resources are diverted to providing nursing-home places, more elderly persons will likely benefit. In this connection, Audit's research has found that, in four advanced countries (Australia, Canada, U.K. and U.S.A.), elderly persons who do not require intensive medical treatment are normally taken care of at nursing homes outside the hospital setting (i.e. they do not reside in infirmaries).

4.13 In March 2002, in response to Audit's observations on the provision of infirmary care services, the Hospital Authority said that:

(a) the planning ratio for infirmary beds was traditionally set at five places per 1,000 population aged 65 or over. However, with the varying degrees of medical stability and developing support services for infirm persons, the demand of these elderly persons for hospitalisation had changed;

(b) the SWD had paid Infirmary Care Supplement (see para. 4.14 below) to meet the nursing-care needs of elderly persons waiting for infirmary places. In overseas countries, there was usually only one category of residential care service for the elderly, which was generally called nursing home. The planning of this service was conducted in an integrated and holistic manner instead of fragmented into different components; and

(c) infirmary care and nursing-home care were different levels of care. If an infirm patient was transferred from a hospital setting to a nursing-home setting, additional medical, nursing and personal care support would be required to provide patients with the appropriate level of care.

4.14 The SWD has advised Audit that an Infirmary Care Supplement of $5,695 a month would be paid to a nursing home for maintaining a frail elderly person residing there, and who has been assessed by a Community Geriatric Assessment Team to be in need of infirmary care service. Therefore, the cost of a nursing-home place for caring of an elderly person in need of infirmary service would amount to $18,625 a month ($12,930 + $5,695). On this basis, Audit estimates that, if the resources spent on funding the 1,134 infirmary places of the Hospital Authority are used instead to provide the same number of nursing-home places in the welfare setting to accommodate elderly persons who do not require intensive medical attention, $154.8 million [($30,000 − $18,625) × 1,134 × 12] can be saved a year. Such savings can be used to provide another 693 nursing-home places ($154.8 million ÷ 12 ÷ $18,625) to meet the needs of those elderly persons on the waiting list, who at present have to wait for about 31 months for an infirmary place.

4.15 Audit notes that the HWB was considering the option of taking the provision of infirmary care out of the hospital setting, except for the post-acute care patients suffering from severe disabilities. If this is implemented, it would be appropriate for nursing homes to take on an expanded role in caring for elderly persons in the welfare setting. There is a cost advantage in doing so. **Audit considers that the HWB should, taking into account the different services, and their costs, provided by infirmaries and nursing homes, conduct a comprehensive review of the roles and provision of these two services.**

Audit recommendations on provision of subsidised nursing-home and infirmary places

4.16 **Audit has *recommended* that the Secretary for Health and Welfare should:**

(a) **having regard to the service needs of the elderly and the financial implications, conduct a comprehensive review of the roles of infirmary and nursing-home places in the provision of welfare services to the elderly; and**

(b) **in conducting the review, decide whether infirmary care should be provided in the welfare setting instead of in the hospital setting.**

4.17 **Audit has also *recommended* that the Director of Social Welfare should:**

(a) **inform the applicants for nursing-home places of the estimated waiting times for a place when they submit their applications; and**

(b) **periodically inform the applicants of the updated estimated waiting times.**

Response from the Administration

4.18 The **Secretary for Health and Welfare** has said that:

(a) to enable the elderly to age in a familiar environment, the HWB is progressively introducing the "continuum of care" concept to both home, community and residential care services. Regarding residential care services, the HWB is planning to provide one type of residential care home which can cater for the different levels of care needs of the elderly. This will help remove the need for the elderly to move from one institution to another upon deterioration of their health;

(b) in the longer term and in the context of developing the "continuum of care" concept, the HWB will explore an optimal model of long-term care, including the most appropriate setting for providing infirmary services; and

(c) after implementing the enhanced home and community care services, and the "continuum of care" concept, the present planning ratio for C&A places should be re-examined in the future.

4.19 The **Director of Social Welfare** has said that:

(a) not only for cost consideration but also to fully reflect the concept of "continuum of care", the SWD agrees that the respective roles of the Hospital Authority and the SWD in providing long-term care for frail elderly persons should be revisited. The Secretary for Health and Welfare, noting the potential for cross-sector collaboration, has held meetings with the Director of Health, the Chief Executive of the Hospital Authority and herself to consider the interfacing issues on the provision of residential services for the elderly;

(b) with the benefit of hindsight and increasing emphasis on continuum of care, separate nursing-home facilities are not preferred. Therefore, the SWD is not pursuing further nursing-home developments. In line with the "continuum of care" concept, the SWD will invite tenders for the operation of new RCHEs with built-in facilities which would enable these homes to take care of the elderly when their health conditions deteriorate;

(c) given the current fiscal constraints, an arrangement to transfer the infirmary function to the social welfare setting must be accompanied by a corresponding budget transfer; and

(d) the SWD has made available on the SWD's homepage the average waiting times (updated quarterly) for various types of residential care services.

Response from Hospital Authority

4.20 The **Chief Executive, Hospital Authority** has said that:

(a) if the elderly persons on the waiting list for infirmary places are transferred to nursing homes, the Hospital Authority still requires beds for managing post-acute infirm patients and those who are presently accommodated in a setting not appropriate for infirm care; and

(b) for example, there are on average 12,000 new stroke patients admitted to public hospitals each year. About ten percent of these patients would result in severe disability requiring care up to the infirmary level. These critical patients are now accommodated at private elderly homes because they cannot be taken care of with the most appropriate care. These patients should be provided with short periods of further medical care until an appropriate setting is prepared for the transfer from hospitals. Hence, the Hospital Authority could not provide savings by transferring these patients to the welfare sector.

PART 5: GOVERNMENT's FINANCING OF SUBSIDISED RESIDENTIAL SERVICES FOR THE ELDERLY

5.1 This PART examines the Government's financing of subsidised residential services for the elderly. This PART also reports Audit's research on recent developments in advanced countries on the provision of similar services.

Government subsidies for providing residential services for the elderly

5.2 Table 5 below shows the estimated Government recurrent subsidies for providing residential services for the elderly (Note 13).

Note 13: *The costs of subsidised housing provided by the HSC of the Housing Authority are not included in Table 5 below because such costs are borne by the Housing Authority, instead of directly by the Government.*

Table 5

Estimated government subsidies for providing residential services for the elderly

Type of subsidised residential place	Number of subsidised places as at 31 March 2001	Estimated subsidy for a place each month	Estimated subsidy each year (Note)
	(a)	(b)	(c)= (a)´(b)´12
		($)	($ million)
C&A home			
— by NGOs	10,210	8,918	1,092.6
— by private operators under BPS and EBPS	4,303	6,328	326.8
Self-care hostel			
— by SWD	69	3,538	2.9
— by NGOs	191	2,070	4.7
HFA			
— by SWD	88	5,969	6.3
— by NGOs	7,449	4,015	358.9
Nursing home	1,400	12,930	217.2
Infirmary	1,134	30,000	408.2
Total	**24,844**		**2,417.6**
			Say $2,418 million

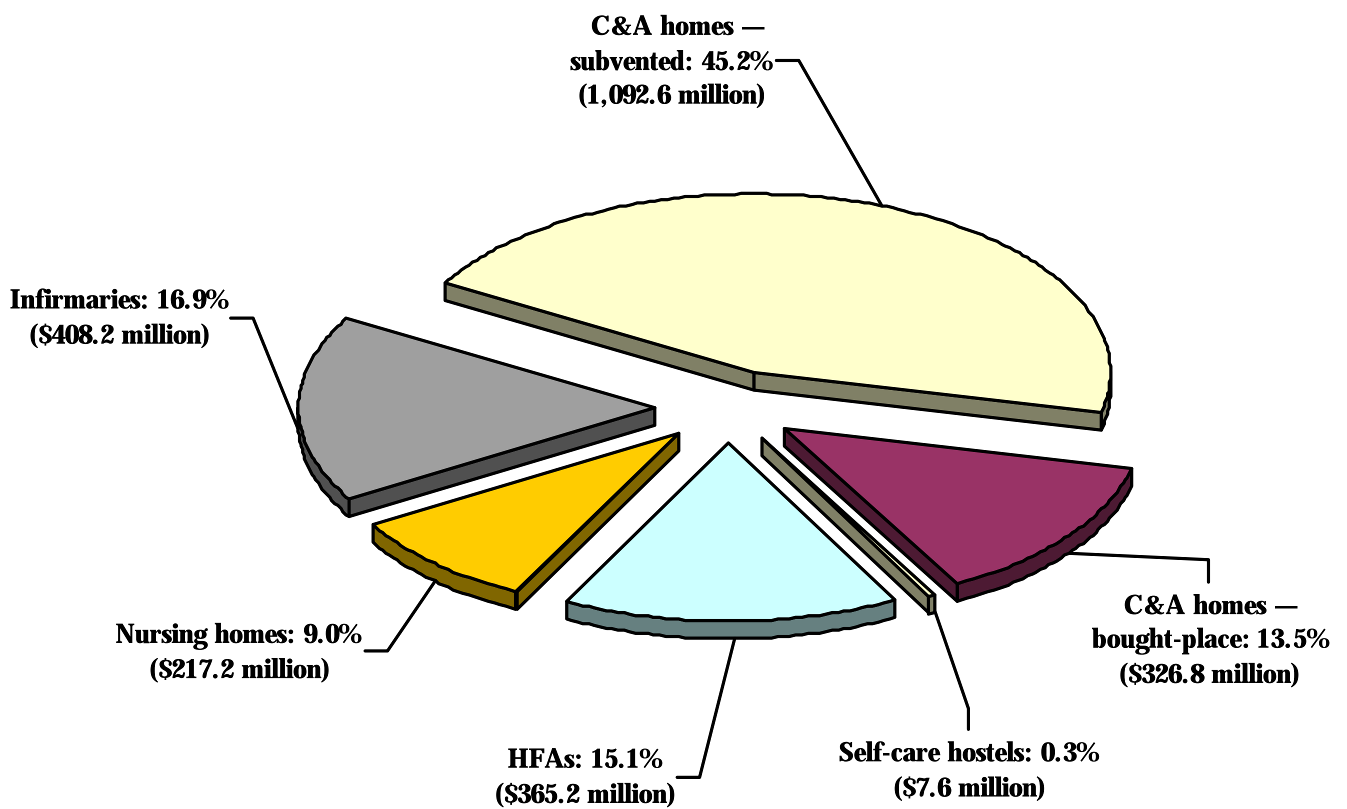
Source: SWD's and Hospital Authority's records

Note: In addition to the direct Government subsidies for subsidised residential places for the elderly, in 2000-01, the SWD paid CSSA allowance of $1,397 million to 19,852 elderly persons staying in private and self-financing RCHEs (see para. 5.6 below).

5.3 Figure 8 below shows the distribution of $2,418 million Government resources in the provision of subsidised residential services for the elderly in 2000-01.

Figure 8

Distribution of public expenditure of $2,417.6 million incurred in providing subsidised residential services for the elderly in 2000-01



Source: SWD's and Hospital Authority's records

Audit observations on Government's financing of subsidised residential services for the elderly

Public resources for subsidised residential services for the elderly

5.4 As shown in Table 5 above, in 2000-01, a total of $2,418 million subsidy was paid by the SWD and the Hospital Authority for the provision of subsidised residential services for the elderly.

5.5 Under the existing arrangements, elderly persons applying for subsidised places of the SWD and the Hospital Authority have to be assessed by the SWD and the Hospital Authority respectively before admission (see Appendix B). An elderly person will only be admitted to a subsidised home of the SWD or an infirmary of the Hospital Authority if his health conditions meet the admission criteria. In addition, the SWD sometimes takes into account the social and living conditions of the applicant when assessing his application for a subsidised residential place. At present, there are no requirements to take into consideration the assets and income of an elderly person applying for a subsidised place of the SWD or the Hospital Authority, i.e. no means test is carried out on the applicants. However, in the case of the HSC places provided by the Housing Authority, an applicant needs to meet the Authority's requirements on his maximum income and value of assets (Note 14).

Comprehensive Social Security Assistance for elderly persons residing in non-subsidised residential homes for the elderly

5.6 As at 31 March 2001, there were 26,905 elderly persons staying at private RCHEs and self-financing RCHEs. Of these 26,905 elderly persons, 19,852 (74%) were in receipt of some form of benefits provided under the Comprehensive Social Security Assistance (CSSA) Scheme. In 2000-01, a total of $1,397 million was paid to these 19,852 elderly persons under the CSSA Scheme, averaging $5,864 per elderly person each month.

Forecast public resources required under existing arrangements

5.7 According to the estimates of the Census and Statistics Department, there will be an increase in the population at the age of 65 or over in the coming two decades. Based on the estimated annual funding of $2,418 million from the Government for the provision of subsidised residential services for the elderly in 2000-01, **Audit projects that the public resources required will increase to $2,632 million in 2009, and $3,734 million in 2019.** (For the sake of simplicity, other factors which may affect the projection, such as changes in policies and general health conditions of the elderly in the future, are not taken into account.) Details of the population forecasts and resource estimates are shown in Table 6 below.

Note 14: *As at 31 December 2001, the requirements on maximum income and value of assets of a single elderly person applying for an HSC unit were $6,200 per month and $210,000 respectively.*

Table 6

Forecast population and estimated public resources required for the provision of subsidised residential services for the elderly

Year	Total population (a)	Population aged 65 or over (b)	Estimated public resources required (c) (Note) ($ million)
2002	6.95 million	0.79 million	2,418
2009	7.46 million	0.86 million	2,632
2019	8.28 million	1.22 million	3,734

Source: Census and Statistics Department's records and Audit's estimates

Note: (c) = [$2,418 million ÷ 0.79 million people] × population in Column (b).

Developments in advanced countries on arrangements for providing subsidised residential services for the elderly

5.8 Audit conducted a research on the arrangements for providing residential services for the elderly in four advanced countries, namely Australia, Canada, the U.K. and the U.S.A. Audit found that the arrangements in these four countries are broadly similar.

5.9 ***Selection of residential services.*** In these four countries, an eligible elderly person may select an appropriate residential service provided by a private operator, non-profit-making institution or government agency. Depending on the value of assets and income of the elderly person, the government pays a subsidy directly to him to meet the whole or part of the fee of the residential service.

5.10 ***Assessments of applicants.*** The elderly persons in these four countries need to go through health assessments to determine the appropriate type of residential service for them. In general, elderly persons need to make contributions to cover part of the costs of the residential services. The size of the contribution varies according to the persons' income and assets, which is based on a means-test system. Audit notes that, in general, these four countries have established

different forms of retirement protection schemes or long-term care insurance schemes, which help the elderly persons contribute towards the costs of residential care.

Recent scheme of SWD on providing C&A services by open tender

5.11 In July 2001, the SWD launched a scheme to invite tenders for the operation of a C&A home on government premises. The successful tenderer (Organisation A) was granted a five-year contract to run a C&A home to accommodate 120 elderly persons on the SWD's waiting list. The SWD pays $7 million a year for 115 subsidised places (plus another five places which would be paid on a unit-cost basis) to Organisation A for the provision of the services. Under the scheme, on average the monthly fee (i.e. cost to the Government) paid to Organisation A for a place at this C&A home is $5,072. If the SWD's administration cost of $91 for a place a month is included, the monthly recurrent cost for a C&A home place obtained by this tender exercise will amount to $5,163. On this basis, the cost of a C&A home place operated by Organisation A is 42% lower than the monthly cost of $8,918 (see Table 5 in para. 5.2 above) for a place at a subvented C&A home.

5.12 **Audit notes that the new scheme on the provision of C&A services by open tender provides the SWD with an alternative means of obtaining services from service providers at a much lower cost, while maintaining a reasonable service level. In order that cost-effective C&A services are provided to eligible elderly persons on the SWD's waiting list, Audit considers that the SWD should adopt open-tender procedures for the provision of subsidised C&A services as far as possible in the future.**

Need to review arrangements for providing subsidised residential services for the elderly

5.13 ***Government's role in providing residential services for the elderly.*** The Government provided funding for the operation of 24,844 residential places for the elderly (see Table 5 in para. 5.2 above). This is 40.8% of the total 60,837 publicly and privately-funded places (24,844 subsidised places plus 35,993 non-subsidised C&A home places — see Table 1 in para. 1.5 above). The SWD also plays the role of the regulator of residential services for the elderly provided by the private sector and NGOs (Note 15). With an increasing ageing population, the demand for residential services will increase. The Government may find it difficult to meet, through the SWD and the Hospital Authority, the increasing demand cost-effectively. In advanced countries, government departments or agencies normally do not provide funding directly to the residential service providers. Elderly persons in these countries are generally given the freedom to choose the residential homes themselves. These governments pay subsidies directly to the elderly

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Note 15: *Under the Ordinance, the SWD is responsible for monitoring and regulating services provided in RCHEs, namely self-care hostels, HFAs and C&A homes (see para. 1.3 above).*

persons (instead of service providers) to subsidise their costs of living at the residential homes. Audit considers that, provided that an appropriate regulatory mechanism is in place, open competition can help the Government obtain services more cost-effectively. The present practice of the Government of providing funding directly to service providers in Hong Kong may have to be reviewed. Audit considers that the HWB should conduct a review of the Government's role in the provision of residential services for the elderly.

5.14 ***Private-sector involvement.*** **The recently introduced scheme (mentioned in para. 5.11 above) indicates that a substantial amount of resources can be saved if the C&A services are obtained by open competition. This provides opportunities for both NGOs and private operators to provide cost-effective services. In this connection, Audit notes that the Financial Secretary stated in the 2001-02 Budget Speech in March 2001 that the Government had:**

> *"increased private sector participation in the delivery of public services, through* ***outsourcing*** *to enhance efficiency and quality" (Audit emphasis).*

The Financial Secretary further stated (in para. 106) that *"Enhancing public sector productivity is our pledge to the community"*. The major targets would include, among other things, exploring further private-sector involvement in the delivery of public services.

5.15 The recently introduced initiative to invite open tenders for the management of a newly established C&A home has shown that the SWD can make the provision of the services more cost-effective (see para. 5.11 above). The open-tender arrangement indicates that the cost for operating a place at a rent-free C&A home is about $5,163 a month. **This is far below the current cost of $8,918 for operating a place at a subvented C&A home. The figure of $5,163 may be taken as a benchmark cost for operating a place at a C&A home.** Audit notes that open-tender arrangements would be used for future C&A homes housed in government-owned premises. Audit considers that, where possible, similar arrangements should also be introduced for existing C&A homes so as to ensure that residential services are obtained at lower costs. Alternatively, the SWD should consider reducing the operating costs of existing subvented homes having regard to the benchmark cost. The savings obtained can be used to finance additional C&A home places which will reduce the current long waiting times (see Table 7 below).

5.16 ***Introducing means test for providing residential services for the elderly.*** As shown in PARTS 2, 3 and 4 above, there was a significant shortage of subsidised residential places for the elderly, and the waiting time for admission was long. (Although there was no shortage of C&A home places based on the planning target, applicants had to wait for a long time for admission.) Table 7 below summarises the provision of subsidised residential places for the elderly and the waiting times for such places as at 31 March 2001.

Table 7

Provision of subsidised residential places for the elderly and average waiting times as at 31 March 2001

Type of subsidised residential place	Number of places provided		Number of elderly persons on waiting list		Average waiting time (Month)
C&A home		14,513		17,948	–
— by NGOs	10,210		16,370		35
— by private operators under BPS and EBPS	4,303		1,578		11
Nursing home		1,400		4,729	13
Infirmary		1,134		5,218	31
Total		**17,047**		**27,895**	

Source: Hospital Authority's and SWD's records

5.17 **The long waiting times for subsidised residential services for the elderly are undesirable because of their old age.** As the provision of **nursing-home places** only commenced in 1998, the waiting time for admission was relatively short at the beginning. However, the average waiting time for nursing-home places had increased from 13 months in March 2001 to 16 months in December 2001. Given the large number of applicants (4,729 as at 31 March 2001) on the waiting list vis-à-vis the 1,400 places available, it is likely that the waiting time situation will worsen in the near future.

5.18 **Audit considers that, in order to meet the shortage of residential services and shorten the waiting times for the services, more resources are required. These resources can be obtained through some form of a means-test system (as that used in advanced countries such as Australia, Canada, the U.K. and the U.S.A.).** In this connection, Audit notes that about 79% and 53% of elderly persons residing in subvented homes and homes under the bought-place schemes respectively were recipients of CSSA (see paras. 7.3 and 7.5 in PART 7 below). **On this**

basis, it is possible that there is still a significant percentage of elderly persons residing in subsidised homes who have assets and income above the levels which would qualify them for CSSA. A means-test system will identify those people who can afford to pay and will help reduce resources required for providing the services. This will in turn enable the Government to use its resources to provide subsidy to those elderly genuinely in need.

5.19 Audit notes that, in the Elderly Commission's report issued in September 1998 (see para. 3.7 above), the Elderly Commission stated that:

(a) **the Government and subvented organisations should first take care of needy elderly persons who lacked the means, while self-financing and private organisations should provide services of better quality to give choices to those who could afford;**

(b) resources should be used on elderly persons with genuine needs, and the urgency of the needs should be considered in the provision of services; and

(c) those who could afford should share some of the fees.

Savings in public resources and provision of more subsidised residential places for the elderly

5.20 Audit estimates that considerable financial savings can be achieved by implementing the measures stated in PARTS 3, 4 and 5 of this Audit Report relating to the financial arrangements for the provision of subsidised residential services for the elderly. While the realisation of the financial savings is subject to a number of constraints and may not be achievable in the short term, Audit believes that if the Government draws up an action plan with target dates for implementing these measures, potential savings of up to $1.2 billion a year can be achieved in the longer term. An estimate of the financial savings and the additional residential places which can be provided are shown in Table 8 below. It is estimated that the financial savings can be used to provide another 868 nursing-home places and 17,032 C&A home places. The additional residential places would help significantly reduce the waiting time for such subsidised residential services (see Table 7 in para. 5.16 above).

Table 8

Estimated savings and provision of more subsidised residential places (see Appendix D for detailed calculation)

Cost-saving measure mentioned in this Audit Report	Estimated saving each year	Estimated additional residential place provided by using the saving	
		Nursing home	**C&A home**
	($ million)		
(a) Phasing out 7,537 HFA places (see paras. 3.14(d) and 5.21(b)(i))	365.2	–	5,895
(b) Transferring 1,134 long-term care places from hospital setting to welfare setting (see paras. 4.13 and 4.14)	154.8	693	–
(c) Providing 10,210 subvented C&A home places based on the benchmark cost (see paras. 5.15 and 5.21(a))	460.1	–	7,426
(d) Introducing means test for 23,531 subsidised C&A home places, 4,303 bought places and 2,093 nursing-home places (see paras. 5.18 and 5.21(b)(ii))	269.0	175	3,711
Total	**1,249.1**	**868**	**17,032**
	Say $1.2 billion		

Source: SWD's and Hospital Authority's records and Audit's estimates

5.21 In response to Audit's estimated savings stated in Table 8 above, in March 2002:

(a) the SWD said that the bulk of the potential cost savings estimated by Audit would only be achievable by "starting with a clean sheet" in providing the services concerned. This was because the existing service providers had inherited an old mode of subvention system and a rigid staffing structure. These staffing obligations had to be recognised and respected, and some of these obligations had been committed contractually (Note 16); and

(b) the HWB said that:

(i) the conversion of HFA places into C&A home places was an established policy which the HWB was implementing by phases. Moreover, some form of housing assistance might need to be given to the existing and potential HFA residents in the future (Note 17). Furthermore, only 38% of the 7,537 HFA places were convertible to C&A home places (Note 18); and

(ii) it would be a severe financial burden on the elderly and their families if they had to pay for a high proportion of the residential care costs, particularly for a higher level of care, on a long-term basis.

Audit recommendations on Government's financing of subsidised residential services for the elderly

5.22 **Audit has *recommended* that the Secretary for Health and Welfare should take action to conduct a comprehensive review on 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:**

(a) **the significant difference between the cost of subvented homes and the cost obtained by the SWD through the recent tendering exercise;**

Note 16: *Audit believes the Government needs to draw up an action plan with target dates for implementing the cost-effective measures (see para. 5.20 above).*

Note 17: *The estimated saving of $365.2 million (by phasing out the HFA places) can be used to finance different services (housing or care needs) for the elderly. For the sake of simplicity and as an illustration, Audit has shown that the savings can be used to provide additional C&A home places.*

Note 18: *Audit has recommended that, for those HFA premises which are not suitable for conversion to C&A homes, the SWD should find alternative uses for the premises (see para. 3.14(f) above).*

(b) **the cost-effectiveness of different options of providing residential services to the elderly. These options include:**

(i) **where practicable, obtaining the services presently provided by the RCHEs of subvented NGOs by open tender;**

(ii) **reducing the operating costs of subvented RCHEs having regard to the lower cost obtained by the SWD through the recent tendering exercise; and**

(iii) **adopting an arrangement whereby the Government pays subsidies directly to the elderly for them to choose their residential service;**

(c) **the practices of providing similar welfare services to the elderly in advanced countries, and the demand on public resources due to an increasing need for elderly services in Hong Kong;**

(d) **the desirability of introducing a means-test system so that those who can afford to pay would make some contributions towards the provision of such services. The savings arising from such contributions can be used to make available, for example, additional residential places to the elderly; and**

(e) **the Elderly Commission's suggestion that the Government and the 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 more choices to those who can afford them.**

Response from the Administration

5.23 The **Secretary for Health and Welfare** has said that:

(a) in the context of developing a quality and sustainable long-term care system, the HWB is exploring various options, including the setting up of a new subsidy arrangement for the residential care programme which allows the elderly more freedom in choosing care homes and gives them a quick access to such service; and

(b) to prepare for the change, the HWB is pursuing a number of initiatives to improve the supply of quality private residential care homes. These include the development of an accreditation system for these homes, provision of residential services in all new Government purpose-built premises through open tenders, and the development of a scheme to encourage private developers to provide purpose-built care-home premises in their new developments.

5.24 The **Director of Social Welfare** has said that:

(a) the SWD is pleased that Audit has agreed that the SWD's initiative to invite open tenders from both NGOs and the private sector for the operation of a C&A home on Government purpose-built premises is a cost-effective way to provide the service;

(b) following the success of the first tender exercise for the RCHE in the Sai Ying Pun Community Complex, in March 2002, the SWD invited tenders for the second home located at Homantin. Another four homes are scheduled for open tenders in the first quarter of 2002-03. The SWD will adopt open-tender arrangements for the provision of subsidised C&A services at all new purpose-built homes in the future;

(c) through vigorous monitoring, the SWD will ensure quality services are provided at homes where the operators are selected by open tenders. For example, operators of these homes need to set up a users' council to collect feedback and identify room for service improvement. The SWD plans to invite lay assessors to assist in the monitoring of these homes;

(d) Audit has rightly pointed out that, with an increasing ageing population, the demand for residential care services will increase. Despite the implementation of these cost-effective measures to provide subsidised services, there is still a need for these services, which are financed by taxpayers, to be targeted at those most in need of Government support;

(e) Audit's recommendation on introduction of some form of means test is worthy of support. This arrangement has been adopted in other welfare programmes such as CSSA, child-care-centre fee assistance, and home-help/home-care services; and

(f) the SWD agrees that users' choice should always be respected in the allocation of services. The current arrangement of the SWD to match the choices of the elderly with the available residential places is not the most cost-effective way. The SWD believes that Audit's proposed scheme whereby the Government pays subsidies to eligible elderly persons for them to choose their preferred home for admission has merits. To prepare for such an arrangement, there is a need to increase quality assurance and transparency in the operations of the homes through some form of accreditation scheme. With the support of the SWD, an NGO has recently received a grant from the Lotteries Fund for developing an accreditation scheme for RCHEs over the next two years.

Audit observations on payment of CSSA allowance to elderly persons staying in infirmaries

CSSA recipients staying in infirmaries

5.25 According to the SWD's rules, a CSSA recipient who is admitted to a medical institution of the Hospital Authority over a period of time will normally have his CSSA allowance adjusted to a lower rate. At times, SWD officers exercise their discretion to adjust the CSSA allowances under special circumstances, such as when a recipient is required to continue paying fees to an RCHE for a certain period.

Audit's data-matching exercise

5.26 In August 2001, Audit conducted a data-matching exercise (Note 19). The data of the elderly persons staying in the Hospital Authority's infirmaries and data of CSSA recipients were compared. Audit found that six CSSA recipients who had been admitted to the Hospital Authority's infirmaries had not promptly reported their hospitalisation to the SWD. The total overpayment of CSSA allowances in these six cases amounted to $407,686. Of the six cases:

(a) the SWD had been aware of four cases before the SWD was notified of Audit's observations in December 2001. (In these cases, between eight to 34 months after the admission of the CSSA recipients to the hospitals, their family members reported the hospitalisation to the SWD); and

(b) two cases were discovered by Audit through the data-matching exercise.

5.27 Regarding the recovery actions on the overpayments of $407,686:

(a) in two cases, the overpayments totalling $165,058 had been refunded to the SWD;

(b) in one case, the SWD would recover the overpayment of $18,216 by 12 installments by deductions from subsequent CSSA payments; and

(c) in three cases, the SWD was in the process of determining the recovery actions on the overpayments totalling $224,412.

Details of the six overpayment cases are shown in Appendix E.

5.28 In December 2001, Audit informed the SWD of the observations shown in Appendix E. In response, the SWD said that:

(a) in the administration of the CSSA scheme, the SWD would have to rely on the recipients (or their family members) to report changes in their circumstances, including hospitalisation;

(b) SWD staff would remind the CSSA recipients to report changes promptly during the processing of new and review cases;

(c) the six cases identified at Appendix E were cases of late reporting or no reporting;

Note 19: *The personal data used were those as at 31 March 2001.*

(d) in order to guard against failure to report the admission of CSSA recipients to hospitals, the SWD had obtained the Privacy Commissioner's approval to carry out data-matching exercises by comparing the data of CSSA recipients and the data of the Hospital Authority's patients;

(e) the first SWD data-matching exercise was conducted in August 2001; and

(f) the SWD's Special Investigation Team would check to ascertain whether overpayment was involved in individual cases.

5.29 Audit considers that the SWD should periodically remind the CSSA recipients that they should report their hospitalisation to the SWD on a timely basis. **This will enable the SWD to make timely adjustments to the payments of CSSA allowances, including payments to the elderly.**

Audit recommendations on payment of CSSA allowance to elderly persons staying in infirmaries

5.30 **Audit has *recommended* that the Director of Social Welfare should:**

(a) **expedite action to recover overpayments of CSSA allowances from CSSA recipients who had been admitted to the Hospital Authority's medical institutions; and**

(b) **periodically remind the CSSA recipients that they should report to the SWD, within a prescribed time limit, their hospitalisation in medical institutions of the Hospital Authority.**

Response from the Administration

5.31 The **Director of Social Welfare** has said that:

(a) as a general practice, the SWD will ensure early recovery action in all overpayment cases to safeguard loss of public money; and

(b) the SWD has established a practice to remind all CSSA applicants and recipients to report changes upon their admission to a Government or subvented institution, or a medical institution of the Hospital Authority. CSSA recipients are required to sign an undertaking to report such changes. The SWD will continue efforts to prevent CSSA recipients from not reporting the above changes.

PART 6: SWD's LICENSING AND MONITORING OF RCHEs

6.1 This PART examines the inspections carried out by the inspectorate teams of the SWD. The purpose of the inspections is to ensure that RCHEs comply with the licensing requirements under the Ordinance.

Licensing requirements under the Ordinance

The Ordinance

6.2 The Ordinance, which came into full operation in June 1996, requires RCHEs (i.e. self-care hostels, HFAs and C&A homes, see para. 1.3 above) to operate under licences or certificates of exemption issued by the SWD. Under section 2 of the Ordinance, a residential care home is defined as "any premises at which more than five persons who have attained the age of 60 years are habitually received for the purposes of care while resident therein". The Ordinance provides a licensing system administered by the SWD for the control and monitoring of RCHEs. The purpose of the Ordinance is to ensure that elderly residents at these homes receive services of acceptable standards that are of benefit to them physically, emotionally and socially. As at December 2001, of the 699 RCHEs, 698 RCHEs had been granted licences by the SWD. The SWD was reviewing the remaining RCHE which was operating under a certificate of exemption.

Residential Care Homes (Elderly Persons) Regulation

6.3 The Residential Care Homes (Elderly Persons) Regulation (hereinafter referred to as the Regulation) was made under section 23 of the Ordinance. The Regulation provides for, among other things:

(a) definitions of different types of residential care homes;

(b) requirements for registration of health workers;

(c) duties of operators of RCHEs;

(d) duties of home managers;

(e) requirements for locations and designs of RCHEs;

(f) requirements for precautions against fire and other risks; and

(g) offences, penalties and fees.

6.4 Schedule 1 of the Regulation has prescribed the minimum staffing requirements for each type of RCHE (see Appendix F). Schedule 2 of the Regulation has stated that the minimum area for each resident at an RCHE is 6.5 square metres.

Code of Practice under the Ordinance

6.5 The Director of Social Welfare has issued a Code of Practice under section 22(1) of the Ordinance which sets out the principles, procedures, guidelines and standards for the operation, keeping, management and controls of RCHEs.

6.6 The Director of Social Welfare may refuse to issue a licence to an applicant if it appears to her that the premises to be used for an RCHE do not comply with any requirements related to design, structure, fire precautions, health, sanitation or safety set out in the Code of Practice.

Monitoring of RCHEs

6.7 Section 17 of the Ordinance empowers the Director of Social Welfare to appoint officers of the SWD and the Buildings Department, registered medical practitioners and registered nurses as inspectors of RCHEs. These inspectors and officers of the Fire Services Department may at all reasonable times enter and inspect RCHEs.

6.8 Under section 19 of the Ordinance, the Director of Social Welfare may give directions to an RCHE to ensure that:

(a) the home is operated and managed satisfactorily;

(b) the welfare of the residents is promoted in a proper manner;

(c) adequate apparatus and equipment required as safeguards against fire or other hazard likely to endanger the lives or health of residents are provided at the home; and

(d) the provisions of the Ordinance are complied with.

6.9 The Director of Social Welfare may order cessation of the use of premises as an RCHE if:

— it appears to her that there is a risk of danger to persons in residence at the home; or

— the requirements of a direction given by the Director are not complied with within a specified period.

Work of SWD's Licensing Office of Residential Care Homes for the Elderly

6.10 The Licensing Office of Residential Care Homes for the Elderly (hereinafter referred to as "the Licensing Office") of the SWD is responsible for monitoring and licensing of RCHEs (i.e. self-care hostels, HFAs and C&A homes — Note 20). The Licensing Office is headed by a Senior Social Work Officer who is assisted by three Social Work Officers. In order to ensure that RCHEs comply with the requirements laid down in the Ordinance, the Regulation and Code of Practice, the SWD has formed four inspectorate teams in the Licensing Office which carry out periodic inspections of RCHEs, namely:

- Social Work Inspectorate Team (SWIT);

- Health Inspectorate Team (HIT);

- Building Safety Inspectorate Team (BSIT); and

- Fire Safety Inspectorate Team (FSIT).

Note 20: *The Department of Health is responsible for monitoring and licensing nursing homes, and the Hospital Authority is responsible for running and monitoring infirmaries.*

SWIT

6.11 The SWIT is staffed by two Assistant Social Work Officers, four Chief Social Work Assistants and ten Senior Social Work Assistants. The SWIT's inspections mainly review the RCHEs' general management, compliance with the staffing and minimum area requirements, furniture and equipment, general healthcare services, nutrition and diet, cleanliness and sanitation of RCHEs, and the provision of social care to residents.

HIT

6.12 The HIT has a staff establishment of two Nursing Officers. Each Nursing Officer individually inspects RCHEs to see whether they comply with the licensing requirements for health and care services, nutrition and diet for residents, and cleanliness and sanitation of the premises.

BSIT

6.13 There are two Building Surveyors and one Survey Officer in the BSIT who are seconded from the Buildings Department. The Building Surveyors examine building plans and inspect RCHEs to see whether they comply with the licensing requirements for building safety, including the design of premises, structural safety, means of escape, fire resisting construction, etc. The Survey Officer assists the Building Surveyors in conducting site inspections of RCHEs, and retrieving approved building plans from the Buildings Department for verification.

FSIT

6.14 The Fire Services Department has seconded two Senior Station Officers to work in the FSIT. These two officers inspect RCHEs to see whether satisfactory fire precautionary measures and fire service installations are in place.

Inspections of RCHEs

6.15 Each of the above four inspectorate teams carries out inspections independently. Normally one officer of a team carries out an inspection. Prior notices are not given to the RCHEs before the inspections. Routine inspections are carried out according to predetermined frequencies (see Table 9 in para. 6.18 below). Officers of the SWIT are responsible for coordinating the inspections of all teams. Based on the inspection results of the four inspectorate teams, they send advisory and warning letters to the RCHE operators. Since mid-2000, senior officers of the SWD and Fire Services Department have conducted random visits to RCHEs to ensure that the SWIT, HIT and FSIT have satisfactorily conducted their inspections. In order to ensure a uniform standard of inspection for the BSIT, since October 2001, the SWD has introduced a system of randomly swapping building inspections on a monthly basis for the two Building Surveyors.

Audit observations on periodic inspections by inspectorate teams

6.16 In order to ensure compliance with the requirements laid down in the Ordinance, the Regulation and the Code of Practice, the four inspectorate teams conduct periodic inspections of RCHEs. When RCHEs apply for new licences or renewal of licences, each of the four inspectorate teams normally conducts inspections before the issue or renewal of the licences.

Use of standard inspection reports by the inspectorate teams

6.17 The SWD has designed standard inspection reports for completion by the SWIT, HIT and FSIT during inspections of RCHEs (for both routine inspections and inspections relating to issue or renewal of licences). These standard inspection reports list out the areas requiring special attention. The inspectorate teams are required to submit the inspection results/findings in respect of each inspection area in the reports. Audit noted that the inspectors of the BSIT only used a standard inspection checklist during inspections for new licence applications. For inspections relating to licence renewals, the inspectors of the BSIT documented their observations and comments in individual files of the RCHEs concerned and forwarded the files to the responsible SWD officers for consideration and necessary action. **Audit considers that, similar to the inspection reports of the other inspectorate teams, a standard report for licence renewal should be designed for the BSIT.**

Frequency of inspections

6.18 The SWD has laid down guidelines on the frequency of inspections of an RCHE by the four inspectorate teams, as shown in Table 9 below.

Table 9

SWD's required frequencies of periodic inspection of a licensed RCHE

Type of RCHE	**Frequency of inspections by**			
	SWIT	**HIT**	**BSIT**	**FSIT**
Private RCHE	Half-yearly	Half-yearly	Yearly	Yearly
Private RCHE under BPS or EBPS	Quarterly	Half-yearly	Yearly	Yearly
Subvented RCHE	Yearly	Yearly	Yearly	Yearly

Source: SWD's records

6.19 ***Audit examination.*** Audit randomly selected ten RCHEs to examine the use of standard inspection reports in the routine inspections by the SWIT, HIT and FSIT between 1 April 1999 and 31 March 2001. Audit noted that the SWIT and FSIT sometimes did not use the standard inspection reports (they documented their observations and comments in individual files of the RCHEs). **Regarding inspections carried out at the ten RCHEs during this two-year period, Audit found that:**

(a) **of the total 13 routine inspections (Note 21) carried out, the SWIT did not use the standard inspection report in four inspections (31%); and**

(b) **the FSIT did not use the standard inspection report in the two routine inspections (Note 22).**

6.20 **Audit considers that the use of standard inspection reports during inspections has the following benefits:**

— **it helps ensure that all areas requiring special attention are covered during the inspections;**

— **it serves as a record of inspections for follow-up actions; and**

— **it facilitates senior officers of the SWD, Fire Services Department and Buildings Department to verify that the inspections have been properly conducted by the inspectorate teams.**

6.21 **In order to ensure that the resources of the inspectorate teams are effectively utilised in monitoring the performance of RCHEs, Audit considers that the SWD should adopt a risk-based approach to determining the frequencies of inspections of RCHEs. Under this approach, RCHEs can be classified into the following categories:**

Note 21: *After an inspectorate team has carried out an inspection relating to the issue or renewal of a licence (or certificate of exemption) of an RCHE, the time of the next routine inspection of that RCHE can be adjusted according to the SWD's approved frequency of inspection (see Table 9 in para. 6.18 above). The SWIT conducted another 40 inspections relating to issue or renewal of licences, which were not covered in the audit examination.*

Note 22: *The FSIT conducted 22 other inspections relating to issue or renewal of licences during the period. These inspections were not covered in the audit examination.*

(a) **low risk (i.e. those RCHEs which always comply with the requirements);**

(b) **medium risk (i.e. those RCHEs which sometimes do not comply with the requirements); and**

(c) **high risk (i.e. those RCHEs which often do not comply with the requirements).**

The frequencies of inspections can be adjusted according to the assessed risks.

6.22 ***Audit examination.*** Audit randomly selected ten RCHEs and compared the number of routine inspections carried out by the four inspectorate teams in the two years ending 31 March 2001 with the SWD's required frequencies of inspections in Table 9 in paragraph 6.18 above (Note 23). Audit noted that the four inspectorate teams sometimes had not complied with the required frequencies of inspections. The cases of non-compliance are summarised in Table 10 below.

Table 10

Inspections of ten RCHEs not carried out on time between 1 April 1999 and 31 March 2001 (see Appendix G for details)

	SWIT	**HIT**	**BSIT**	**FSIT**
Number of inspections not carried out on time	9	10	3	1
Average delay	4 months	5 months	5 months	5 months

Source: SWD's records

Note 23: *The SWD did not maintain a central system on inspections carried out. The records of the inspections were recorded in individual inspection files of the RCHEs concerned.*

6.23 **It can be seen from Table 10 above that the four inspectorate teams did not always comply with the SWD's required frequencies of inspections. Audit considers that there is a need for the SWD to introduce measures to ensure that periodic inspections are conducted timely and properly by the four inspectorate teams.**

6.24 ***Mechanism for ensuring timely inspections.*** As at 31 December 2001, each of the four inspectorate teams maintained its own inspection file for each of the 699 RCHEs (thus a total of 2,796 inspection files were maintained). Regarding the FSIT and BSIT inspections, after examining the inspection reports submitted by inspectors, the responsible Senior Social Work Officer of the Licensing Office would mark on the individual inspection files to remind the general registry of the Licensing Office to bring up the files before the next inspections (according to the required frequencies). Officers in the general registry would bring up the inspection files to the responsible Senior Social Work Officer who would instruct the inspectorate teams to conduct the inspections.

6.25 Regarding the SWIT and HIT inspections, instead of relying on the bring-up system of the general registry, each inspector of the SWIT and HIT maintained his own register for planning and controlling the inspections according to the required frequencies. The registers used by different inspectors were designed by themselves and were of different format.

6.26 ***Need for a computerised system.*** **Audit considers that the present system of maintaining some 2,800 paper files for recording the inspection results and follow-up actions on the 699 RCHEs is not an efficient and effective way for the SWD to monitor the performance of RCHEs.** The manual bring-up system on these 2,800 paper files may at times lead to delays. In reviewing the performance of an RCHE, SWD officers need to locate four files (SWIT, HIT, BSIT and FSIT) for review. This process is time-consuming and requires substantial administrative efforts.

6.27 **Audit considers that a more efficient and effective way is for the SWD to introduce a computerised inspection system. This system can provide a useful tool for the supervisors and senior management in their review of the performance of the inspectorate teams and RCHEs.** The system should be designed to generate exception reports on RCHEs which have not satisfactorily complied with the requirements of the SWD. To facilitate the input of inspection results of the inspectorate teams, consideration can be given to acquiring hand-held computers for use by the inspectors during their inspections. The standard inspection reports can be stored in the computers for completion by the inspectors during inspections.

6.28 **A computerised inspection system can:**

(a) **help ensure that inspections are conducted on a timely basis according to the required frequencies of the SWD;**

(b) **facilitate the inspectors in completing their inspection reports and issuing reminders/warning letters to operators of RCHEs; and**

(c) **facilitate the supervisors of the Licensing Office and the senior management of the SWD in monitoring the inspections of the inspectorate teams and the performance of the RCHEs.**

Audit recommendations on periodic inspections by inspectorate teams

6.29 **In order to provide an efficient and effective mechanism for the SWD to monitor the performance of RCHEs under the Ordinance, Audit has *recommended* that the Director of Social Welfare should:**

(a) **design a standard inspection report for licence renewal for use by the BSIT for inspections of RCHEs;**

(b) **require the four inspectorate teams to always use the standard inspection reports;**

(c) **adopt a risk-based approach to determining the frequencies of inspections of RCHEs so that more inspections are conducted at high-risk RCHEs;**

(d) **implement a computerised inspection system for the planning, recording and monitoring of inspections carried out by the inspectorate teams; and**

(e) **use the computerised inspection system to produce periodic exception reports on those unsatisfactory RCHEs for special monitoring by the SWD's senior management.**

Response from the Administration

6.30 The **Director of Social Welfare** has said that:

(a) the SWD welcomes Audit's recommendations to strengthen its licensing and monitoring of RCHEs. The use of a risk-based approach is needed given the limitation of inspection resources. With effect from April 2001, supervisors of SWIT and HIT inspectors, having considered the inspection reports submitted, would mark on individual inspection files a bring-up date taking account of the RCHE's compliance with the licensing requirements. The SWD would further develop this risk-based approach;

(b) the SWD believes that its work in monitoring of RCHEs can be significantly improved with the aid of a computerised system. The SWD has secured resources to enhance the existing computer system to help monitor the performance of RCHEs; and

(c) the SWD will take into account Audit's advice on monitoring the performance of RCHEs.

6.31 The **Director of Fire Services** has said that:

(a) he supports Audit's recommendation of requiring the four inspectorate teams to always use the standard inspection reports, and has reminded his officers on secondment to the Licensing Office of the SWD to use the standard inspection reports; and

(b) he supports Audit's recommendation of implementing a computerised inspection system for the planning, recording and monitoring of inspections by the inspectorate teams, and will endeavour to provide assistance in the implementation of the system.

6.32 The **Director of Buildings** has said that:

(a) he agrees that there would be benefits if a senior officer of the Buildings Department could conduct random visits to the RCHEs and verify the inspection reports prepared by the BSIT. As there will be resource implications, he will bring the matter up again with the SWD to find a workable solution;

(b) he supports Audit's recommendation of designing a standard inspection report for licence renewal for use by the BSIT. The BSIT is now designing a standard inspection report for inspections of RCHEs;

(c) he supports adopting a risk-based approach to determining the frequencies of inspections of RCHEs. He notes that BSIT's inspections are mainly concerned with building designs and fire-safety construction which are not of a transient nature; and

(d) he supports Audit's recommendation of implementing a computerised inspection system.

PART 7: SWD's MONITORING OF SUBSIDISED RESIDENTIAL SERVICES FOR THE ELDERLY

7.1 This PART examines the SWD's monitoring of subsidised residential services provided by the NGOs through Government subventions and private RCHEs through the SWD's bought-place schemes.

Provision of subsidised residential places by NGOs through subventions

7.2 In 2000-01, the SWD paid a total of $1,673.4 million subvention to NGOs for the provision of 19,250 residential places to accommodate elderly persons at RCHEs (see Table 5 in para. 5.2 above).

7.3 The SWD has imposed limits on the fees (ranging from $502 to $1,994 per month) for residents staying at subvented residential homes. These fees are largely based on the services provided at the subsidised homes. These fees are taken into account by the SWD in making subvention payments to the NGOs which provide the services. Residents who have financial difficulties may apply for CSSA to meet such fees. As at 31 March 2001, of the 18,269 elderly persons residing in subvented residential homes (a total of 19,250 places), 14,464 persons (79%) were in receipt of CSSA.

Provision of residential places through BPS and EBPS

7.4 As at 31 March 2001, the SWD provided subsidies under the BPS and EBPS to 96 private C&A homes. In 2000-01, the SWD paid an estimated sum of $326.8 million subsidies (see Table 5 in para. 5.2 above) to these private C&A homes for the provision of 4,303 places under the BPS and EBPS to accommodate elderly persons referred to them by the SWD. The subsidies paid were specified in the service contracts with individual C&A homes, which ranged from $4,571 to $6,880 for a place each month.

7.5 Residents staying at BPS and EBPS homes are also required to pay monthly fees. These fees are received by the operators providing the services, which are taken into account by the SWD in calculating the bought-place subsidies paid by the SWD to the operators. Residents who have financial difficulties may apply for CSSA to meet the fees of the residential homes. As at 31 March 2001, of the 3,674 elderly persons residing in residential homes under the bought-place schemes (a total of 4,303 places), 1,935 persons (53%) were in receipt of CSSA.

Audit observations on monitoring of subsidised residential services for the elderly by SWD

Requirements to be complied with by subvented bodies

7.6 Subvented bodies providing residential care services at self-care hostels, HFAs and C&A homes are required to comply with the requirements laid down by the SWD for compliance by all RCHEs under the Ordinance (see paras. 6.2 to 6.6 above). In addition, subvented bodies providing all types of residential services for the elderly are required to meet additional performance standards laid down by the SWD in the funding and service agreements with the individual subvented bodies. The major performance standards are as follows:

(a) the average enrolment rate of a subvented home should not be less than 95%;

(b) a subvented home needs to compile an individual care plan for each resident within three months after admission; and

(c) a subvented home should review the majority (not less than 90%) of the individual care plans for residents every year.

Service Performance Monitoring System

7.7 In late 1998, the SWD introduced a Service Performance Monitoring System (SPMS) to be implemented in three phases commencing 1999-2000. Under the SPMS, NGOs receiving subvention from the SWD are required to submit self-assessment reports on 19 Service Quality Standards (SQSs — see Appendix H) to the Service Performance Section of the SWD every year. An assessment report is required for each service unit (e.g. an RCHE) of an NGO. Thereafter, the SWD will select some services provided by subvented NGOs for external assessment. The three phases of implementation of the SPMS are as follows:

Phase 1: Implementation of five SQSs to cover all services of subvented NGOs (1999-2000);

Phase 2: Implementation of additional five SQSs on all services of subvented NGOs (2000-01); and

Phase 3: Full implementation of all the 19 SQSs (Note 24) on all services of subvented NGOs (2001-02).

Note 24: *Based on the recommendations of a consultancy study, the 19 SQSs have recently been consolidated into 16 SQSs.*

7.8 The SWD has provided training to subvented NGOs for their participation in the SPMS. In the event that the self assessments and/or external assessments reveal that some subvented service units of the NGOs have not met the requirements laid down in the SQSs, the SWD would require the subvented service units to formulate action plans for improvement. The SWD would follow up with and review the progress against the action plans to ensure that the service units attain the required standards.

Room for improvement in monitoring subvented NGOs

7.9 Audit notes that the implementation of the SPMS is still in progress. Audit considers that the SPMS will provide an efficient and effective mechanism for the SWD to monitor the performance of subvented NGOs. **In order that the SWD can more efficiently and effectively make use of the SPMS to monitor the performance of subvented NGOs, Audit considers that the SWD should make improvements to the SPMS. This can be done by adopting the good management practices as suggested in PART 6 above.** These practices include the adoption of a risk-based approach to determining the frequencies of assessments, implementation of a computerised system for the assessments, use of hand-held computers for inspections, and production of exception reports for monitoring by the senior management of the SWD.

Requirements to be complied with by private residential homes under bought-place schemes

7.10 Private residential homes providing C&A services under the BPS or EBPS are required to comply with the requirements laid down by the SWD for compliance by all RCHEs under the Ordinance (see paras. 6.2 to 6.6 above). In addition, these private residential homes are required to meet the additional service requirements in terms of the minimum area per resident and staff (see Table 2 in para. 2.14 above and Appendix C).

Monitoring of performance of private residential homes under bought-place schemes

7.11 Compliance with the service requirements under the bought-place contracts by private residential homes is monitored by the four inspectorate teams of the Licensing Office during their periodic inspections of these homes (see paras. 6.10 to 6.15 above).

7.12 Since November 1998, the SWD has required residential homes under the EBPS to comply with 19 SQSs which are modified from the 19 SQSs for NGOs (see para. 7.7 above and Appendix H). **However, the SWD has not implemented arrangements for conducting self-assessments and external assessments on those residential homes providing services under the EBPS (the BPS would be phased out in 2003). Audit considers that, in order to ensure that private residential homes under the EBPS would provide satisfactory services in accordance with the SQSs laid down by the SWD, the SWD should, similar to the**

arrangements for NGOs, implement self-assessment and external-assessment arrangements for these residential homes. Good management practices (as suggested in PART 6 above) should also be adopted to improve the efficiency and effectiveness of the monitoring process.

Audit recommendations on monitoring of subsidised residential services for the elderly by SWD

7.13 **Audit has *recommended* that the Director of Social Welfare should:**

(a) **adopt a risk-based approach to determining the frequencies of assessments by the SWD so that more inspections are conducted at those subvented and bought-place residential homes which have not been able to meet the SQSs;**

(b) **implement a computerised system for the planning, recording and monitoring of assessments by the SWD on the subvented and bought-place residential homes; and**

(c) **with the aid of the computerised assessment system, produce periodic exception reports on those unsatisfactory subvented and bought-place residential homes for special monitoring by the SWD's senior management.**

Response from the Administration

7.14 The **Director of Social Welfare** has said that:

(a) the SWD agrees with Audit's recommendations to strengthen the monitoring of subvented homes run by NGOs, private homes under the BPS and EBPS, and homes under the tender arrangements; and

(b) the SWD will conduct the monitoring of these homes in a cost-effective manner by adopting a risk-based approach.

PART 8: HEALTHCARE SERVICES OF RCHEs

8.1 This PART examines the SWD's monitoring of the healthcare services of RCHEs and healthcare training provided by the Department of Health (DH) to RCHEs.

SWD's monitoring of healthcare services of RCHEs

8.2 As stated in paragraph 6.12 above, the SWD has established a HIT in the Licensing Office which carries out periodic inspections of RCHEs to find out whether they comply with the licensing requirements for healthcare services, nutrition and diet for residents, and cleanliness and sanitation of the homes. The HIT has a staff establishment of two Nursing Officers.

Role of DH in enhancing healthcare services provided at RCHEs

8.3 In July 1998, the DH set up the Elderly Health Services which aims at enhancing primary healthcare for the elderly, improving their self-care ability, encouraging healthy living and strengthening their family support so as to minimise illness and disability. The Elderly Health Services provides two main services, namely:

- outreaching health education services provided by 18 Visiting Health Teams (VHTs); and

- integrated healthcare services to the elderly provided in 18 Elderly Health Centres.

8.4 The 18 VHTs pay regular visits to multi-service centres, social centres for the elderly, HSC of the Housing Authority and RCHEs to provide educational programmes to improve the health awareness of the elderly and their self-care ability. The VHTs also provide training and support to carers (i.e. health workers and care workers) to enhance their health knowledge and skills in taking care of the elderly. In 2000, the VHTs conducted 11,944 health education programmes for the elderly and carers at RCHEs, covering 40 topic areas for the elderly and 14 topic areas for carers (see Appendix I). These health education and training programmes were delivered free of charge to centres, HSC and RCHEs and with their agreement. The activities of the VHTs in recent years are summarised at Appendix J.

Audit observations on monitoring of healthcare services of RCHEs

Audit observations during visits to 20 randomly selected RCHEs

8.5 ***Audit's visits to 20 RCHEs.*** In December 2001, with the agreement of the SWD, Audit randomly selected 20 RCHEs (Note 25) and paid visits to these homes. During the visits to the 20 randomly selected RCHEs (Note 26), Audit conducted interviews with carers and residents at the RCHEs with the assistance of consultants (Note 27), and made observations on the facilities and services provided.

8.6 The interviews conducted covered the following aspects:

(a) ***Interviews with carers at RCHEs.*** The audit team interviewed 16 health workers and 80 care workers at the 20 RCHEs (Note 28). An interviewer asked each of the health workers and care workers how he would provide assistance to an elderly resident in ten commonly encountered healthcare and emergency situations (Note 29);

(b) ***Interviews with residents at RCHEs.*** The audit team interviewed 100 elderly persons at the 20 RCHEs (five residents at each RCHE). The interviewer sought their views on the services provided by the RCHEs, including provision of daily care services, quality and quantity of food, provision of social activities, security of personal properties, preservation of personal privacy, handling of complaints, and living environment; and

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Note 25: *As at 31 December 2001, there were 699 RCHEs, comprising 135 subvented and 564 private /self-financing RCHEs. Audit's samples of 20 RCHEs (3% of all RCHEs) comprised 4 subvented RCHEs, 1 non-profit making and self-financing RCHE, and 15 private RCHEs (including 2 EBPS homes).*

Note 26: *At the beginning of a visit to an RCHE, Audit staff advised the home manager that his consent to Audit's visit was entirely voluntary.*

Note 27: *Audit appointed one of the four training bodies which provided training to health workers (see para. 8.27 below) as Audit's consultants for the visits. The training body assigned two of its staff, one of whom was an experienced registered nurse, to accompany the audit team during the visits. The SWD provided assistance by assigning an SWD staff member to accompany the audit team.*

Note 28: *Audit had planned to interview five carers at each RCHE visited. However, some RCHEs did not have five carers on duty during the visits, and some of the carers were unwilling to attend the interviews. Therefore, only 96 carers were interviewed.*

Note 29: *Before an interview with a staff member or resident at an RCHE, Audit staff informed the interviewee that his acceptance of the interview was entirely voluntary.*

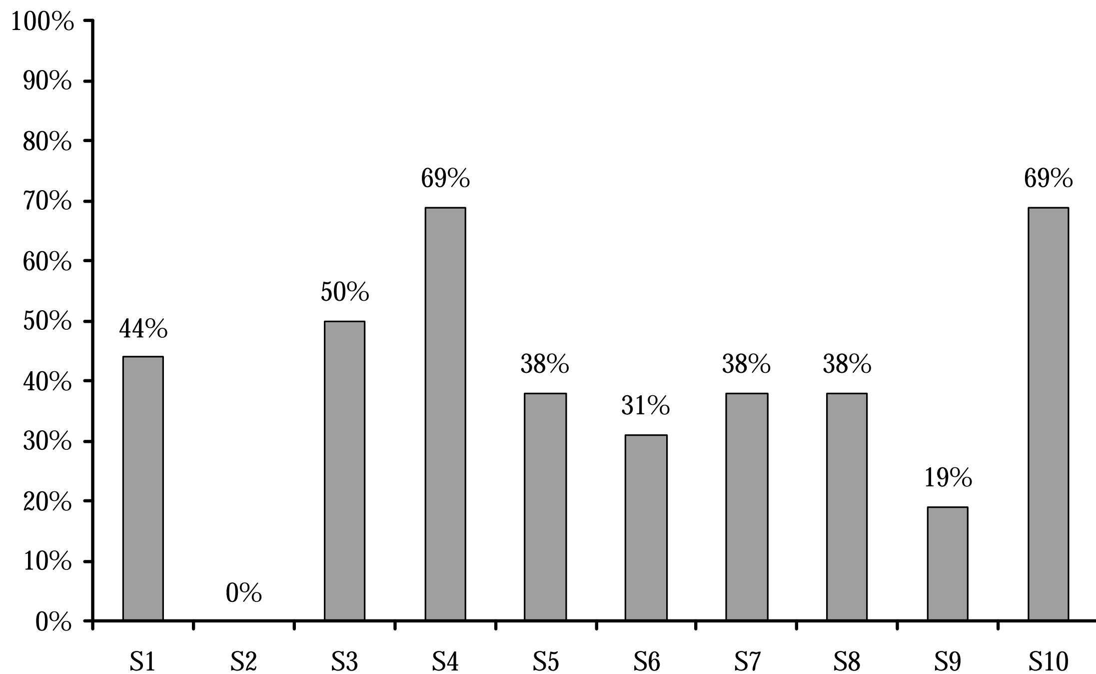
(c) ***Observations of healthcare facilities and services.*** The audit team made inspections of the RCHE's environment and hygiene, clothing provided to the residents, assistance provided to residents during meals, care facilities provided, and measures implemented at RCHEs to ensure their safety.

The responses of the interviewees and observations were documented in questionnaires/checklists by the audit team and reviewed by Audit's consultants.

8.7 ***Observations on interviews with carers.*** Figures 9 and 10 below show the percentages of health workers and care workers respectively who could **not** provide satisfactory answers as to how to deal with an elderly resident in ten commonly encountered healthcare and emergency situations at an RCHE. The assessments were made by Audit's consultants based on the answers given by the interviewees.

Figure 9

Percentages of RCHE health workers who could not provide satisfactory answers to questions on commonly encountered healthcare and emergency situations



Ten commonly encountered healthcare and emergency situations (Note)

Source: *Audit's interviews with health workers*

Note:

S1 — *Knowledge on normal blood pressure when conducting a blood-pressure measurement on an elderly person.*

S2 — *Use of appropriate procedures when taking the body temperature of an elderly person who is suffering from epilepsy.*

S3 — *Provision of care to an elderly person who has diabetes mellitus.*

S4 — *Provision of care to an elderly person who is on oral medication.*

S5 — *Use of appropriate measures to prevent choking when feeding an elderly person.*

S6 — *Application of appropriate first-aid management when an elderly person encounters choking during feeding.*

S7 — *Application of appropriate first-aid management when an elderly person has bleeding as a result of a fall.*

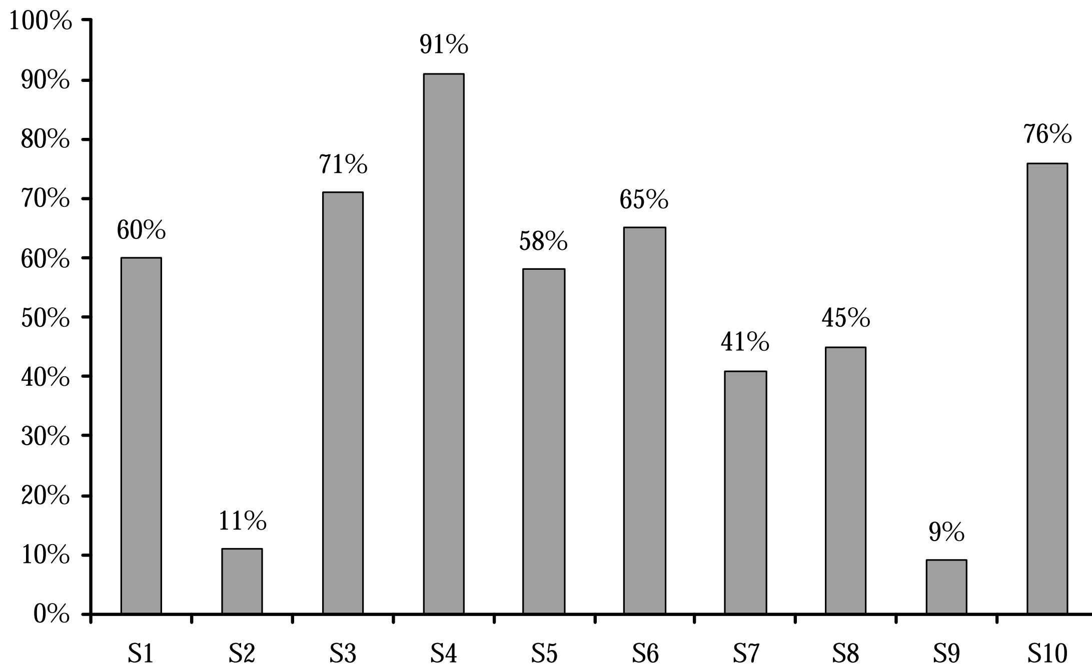
S8 — *Application of appropriate first-aid management when an elderly person is scalded.*

S9 — *Use of appropriate procedures to assess whether the urine output of an incontinent elderly person is irregular.*

S10 — *Use of appropriate procedures to assess whether the urine output of an elderly person who uses an indwelling urinary catheter is irregular.*

Figure 10

Percentages of RCHE care workers (Note 1) who could not provide satisfactory answers to questions on commonly encountered healthcare and emergency situations



Ten commonly encountered healthcare and emergency situations (Note 2)

Source: Audit's interviews with care workers

Note 1: According to the existing arrangements, care workers are not required to possess any healthcare qualifications. As such, they may not have attended training in healthcare. The purpose of the interviews was to assess the adequacy of the care workers' healthcare knowledge with a view to ascertaining their training needs.

Note 2: These refer to the same situations in Figure 9 above.

8.8 The educational background, training received on elderly care, and experience in elderly-care work of the health workers and care workers (who took part in Audit's interviews) are shown in Appendix K.

8.9 **It can be seen from Figures 9 and 10 above that many health workers and care workers have inadequate knowledge of how to deal with an elderly resident in ten commonly encountered healthcare and emergency situations at an RCHE. As shown in Appendix K, 41.2% (i.e. 1 - 58.8%) of the care workers had not received formal training in healthcare for the elderly. In this connection, Audit notes that there are no provisions under the Ordinance, Regulation, or Code of Practice which specify the minimum qualifications of a person to be employed as a care worker (see para. 8.28 below). However, the SWD has laid down a requirement that half of the care workers of the EBPS homes need to have received healthcare training (see para. 2.12 above). Audit considers that there is a need for improving the healthcare knowledge of the health workers and care workers.**

8.10 In March 2002, in response to Audit's observations on healthcare knowledge of health workers and care workers, the SWD said that:

(a) the SWD agreed that there were varying standards in healthcare services at RCHEs; and

(b) the number of interviewees (health workers and care workers) represented only about one percent of care staff working in the field. Not every care staff presently engaged in such work was required to have received training (see para. 2.12 above).

8.11 In order to ensure that carers working at RCHEs can provide proper and effective assistance to elderly residents when the need arises, Audit considers that the SWD should liaise with the DH with a view to providing relevant and necessary training to both health workers and care workers working at RCHEs (see para. 8.26 below). In designing such training courses, the SWD should take into account the observations made during Audit's interviews with carers at the RCHEs, as summarised in Figures 9 and 10 in paragraph 8.7 above.

8.12 ***Observations on interviews with residents.*** Audit's interviews with 100 residents at 20 RCHEs revealed that the residents were generally satisfied with the healthcare services provided at the RCHEs. However, complaints were made in the following major areas:

(a) loss of personal belongings (ten residents, or 10%);

(b) dissatisfaction with the home environment (five residents, or 5%);

(c) lack of follow-up of complaints to the RCHEs (three residents, or 3%); and

(d) the RCHEs were cold during winter time (three residents, or 3%).

8.13 **Audit notes that both the SWIT and HIT also conducted interviews with residents and their family members during inspections. Audit considers that the inspectorate teams should follow up with the RCHEs on reasonable suggestions and valid complaints of the residents. These interviews should be documented as part of the standard inspection reports.**

8.14 ***Observations on healthcare facilities and services at RCHEs.*** Audit's visits to 20 RCHEs revealed that the healthcare facilities and services provided there were generally of acceptable standards. However, there were some inadequacies, as follows:

(a) care workers of one RCHE suggested that they did not know how to properly operate the oxygen and suctioning equipment provided;

(b) an entrance to the bathroom of one RCHE was not wide enough for wheelchairs;

(c) three RCHEs had wet floors;

(d) three RCHEs were not equipped with effective call-bell systems. At these three RCHEs, manual call bells were only provided to elderly residents on a need basis. It appears that a centralised electrical call-bell system is more effective;

(e) seven RCHEs were not equipped with a sufficient number of hospital beds which were required for caring for frail and bed-bound residents;

(f) three RCHEs were not equipped with a sufficient number of geriatric chairs; and

(g) three RCHEs had too much furniture, which might pose a risk to the residents.

Audit noted that some of the above anomalies or inadequacies were not licensing requirements, e.g. the provision of hospital beds at RCHEs. Nevertheless, improvements in these areas can result in better quality of service to the residents.

8.15 **Audit considers that the SWD's inspectorate teams (especially the HIT) should include in the inspection checklist items such as those mentioned in paragraph 8.14 above. During inspections of an RCHE, when inadequacies are observed, the team should ask the RCHEs concerned to make timely improvements.**

Monitoring of healthcare services of RCHEs by the SWD

8.16 As stated in paragraph 6.12 above, the HIT of the SWD conducts periodic inspections of RCHEs to ensure that satisfactory healthcare services are provided at RCHEs. As at 31 March 2001, the HIT had two Nursing Officers who were responsible for inspecting 671 RCHEs which provided 58,146 places (10,210 + 4,303 + 191 + 7,449 + 35,993 — see Table 1 in para. 1.5 above). The estimated annual staff cost of the two Nursing Officers was $1.7 million (Note 30) a year. The HIT was required to conduct periodic inspections of private RCHEs and self-financing RCHEs on a six-monthly basis, and subvented RCHEs on an annual basis. The HIT was also required to conduct inspections relating to applications for new licences or renewal of licences by RCHEs. Under section 20 of the Ordinance, the Director of Social Welfare may order cessation of the use of premises as an RCHE if the requirements of a direction given by the Director are not complied with within the period indicated in the notice.

8.17 It can be seen from Appendix G that, in 1999-00 and 2000-01, the HIT did not carry out ten inspections on time at six RCHEs. **Audit considers that, with only two Nursing Officers, the HIT cannot be expected to effectively monitor the 671 RCHEs (699 RCHEs as at 31 December 2001) for ensuring that they provide satisfactory healthcare services to the elderly in accordance with the Ordinance.**

8.18 As stated in paragraph 8.3 above, to enhance primary healthcare for the elderly, the DH has established 18 VHTs with 66 officers (Note 31) which conduct periodic visits to RCHEs to provide health education programmes. The estimated staff cost of the 18 VHTs is $38 million (Note 32) a year. Audit considers that these professionally qualified VHTs can provide efficient and effective support to the HIT of the SWD.

8.19 **Audit considers that the SWD should seek the support of the VHTs of the DH for strengthening inspections of RCHEs on matters relating to the healthcare services provided there. The support can include staff secondment and provision of professional advice on designing an efficient and effective inspection checklist, and other related matters.**

Training provided to RCHEs by VHTs of the DH

8.20 Audit notes that, since 1998, the VHTs of the DH have provided training to RCHEs. In addition to healthcare programmes for the elderly, during visits to RCHEs, the VHTs also conduct healthcare education programmes on nursing skills and techniques for the carers working at

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Note 30: *The estimated cost was based on the staff costs stated in the Staff Cost Ready Reckoner No. 2001/1 of the Treasury.*

Note 31: *The 66 officers of the 18 VHTs were: 1 Senior Medical Officer, 3 Medical Officers, 17 Nursing Officers, 18 Registered Nurses, 18 Clerical Assistants and 9 Motor Drivers.*

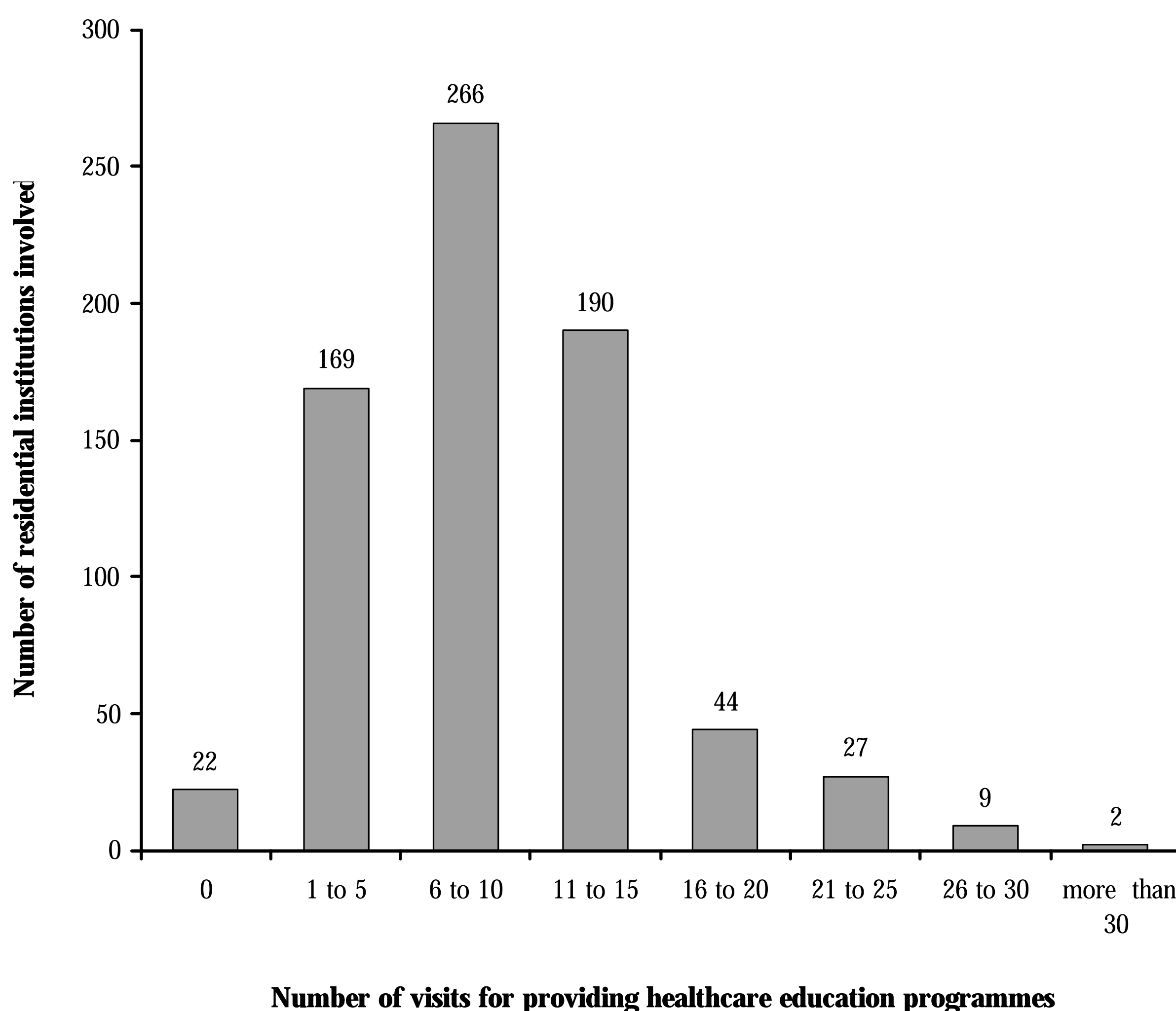
Note 32: *The estimated cost was based on the staff costs stated in the Staff Cost Ready Reckoner No. 2001/1 of the Treasury.*

RCHEs. The programmes include the proper use of physical restraints, feeding techniques and vital signs monitoring (see Appendix I).

8.21 In 2000, of the 729 residential institutions including RCHEs, the VHTs visited 707 institutions (97%). In that year, the VHTs paid a total of 6,812 visits to conduct health education programmes to these 707 institutions (on average 9.6 visits per institution). The health education sessions were attended by 93,651 elderly persons and 26,611 carers. Figure 11 below shows an analysis of the number of visits paid by the VHTs to these 729 institutions in 2000.

Figure 11

Analysis of number of visits paid by VHTs for providing healthcare education training in 729 residential institutions in 2000



Source: DH's records

8.22 As shown in Figure 11 above, in 2000, of the 729 residential institutions:

(a) 22 institutions (3%) were not visited by the VHTs;

(b) 169 institutions (23%) were visited by the VHTs once to 5 times; and

(c) 38 (27 + 9 + 2) institutions (5%) were visited by the VHTs more than 20 times.

8.23 **The variations in the number of visits paid by the VHTs to these institutions for providing health education programmes might have been due to the different nature and background of these institutions. As utilisation of the VHT services was voluntary, the level of use of the services between different institutions would be affected by the varying degrees of willingness of the institutions to accept such services.**

8.24 From time to time, the DH notified the residential institutions of the health education programmes available to them. The health education programmes were usually delivered at the request of the institutions. For some new institutions or institutions which had seldom made requests for the service, the VHTs would contact the management of the institutions and offer to conduct health education programmes. However, not every institution accepted such offers. The reasons were as follows:

(a) the institutions did not have a need for the service because they were familiar with the health education programmes; and

(b) the time of the delivery of the programmes was inconvenient because the institutions were undergoing renovation.

8.25 **Audit considers that the healthcare education training provided by the VHTs is useful in improving the quality of healthcare services provided to the RCHEs. However, as the DH does not have the authority to require RCHEs to receive the training provided by the VHTs, this affects the effectiveness of the VHTs' training programmes for the RCHEs.**

8.26 **In order that the VHTs can conduct training at all RCHEs, the SWD should consider whether the VHTs can be authorised, under section 19(1) of the Ordinance (Note 33), to provide appropriate healthcare training to the staff of the RCHEs.**

Note 33: *Under section 19(1) of the Ordinance, the Director of Social Welfare may, in respect of any RCHE, give such directions as appear to her to be required to ensure that:*

(a) it is operated and managed satisfactorily; and

(b) the welfare of its residents is promoted in a proper manner.

Health workers, care workers and ancillary workers working at RCHEs

8.27 As stated in Appendix F, "health worker" is one type of staff required at an RCHE to provide care for the elderly. **Under section 4 of the Regulation, a health worker is a person who has completed a course of training approved by the Director of Social Welfare, or is considered by the Director to be a suitable person by reason of his education, training and experience.** Health workers are required to apply to the SWD for registration. The SWD has organised health-worker training courses jointly with four training bodies. Between 1995 and 2001, a total of 73 courses had been organised for 2,482 trainees. Each course comprised a total of 162 hours of lectures, 40 hours of practical sessions and a day's visit to an institution providing elderly services. Trainees were required to attend and pass written and practical tests. The course fee was $7,500, of which the SWD provided a subsidy of $5,000. A trainee was required to sign an undertaking to work as a health worker at an RCHE for at least six months, or to refund to the SWD the $5,000 subsidy (Note 34).

8.28 There are no provisions under the Ordinance, 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. Audit noted that some of the care workers working at RCHEs had attended first-aid training courses or courses on healthcare services (see Appendix K).

8.29 The Regulation (see Appendix F) has laid down the requirement that any two persons (i.e. a home manager, an ancillary worker, a care worker, a health worker or a nurse) shall be on duty at a C&A home (with 40 residents or less) between 6 p.m. and 7 a.m. However, there is no assurance that, between 6 p.m. and 7 a.m. each day, there are staff working at a C&A home who have received proper and recognised healthcare training. **Audit considers that the present arrangements do not ensure that elderly persons staying at C&A homes are provided with satisfactory healthcare services at all times. Elderly persons staying at C&A homes are usually weak in health and are suffering from a functional disability to the extent that they require personal care and attention in the course of daily living activities (see para. 2.2 above). They need close care and attention at all times. Audit considers that the SWD should take action to amend the Regulation to require that at all times at least one staff member who has received recognised training in healthcare is on duty at a C&A home.**

Improvements in healthcare services provided to RCHEs

8.30 **Audit considers that if the services provided by the VHTs are expanded (see para. 8.19 above), the quality of healthcare services at RCHEs can be improved. Audit also considers that arrangements should be made between the SWD and DH to enable the VHTs to**

Note 34: *If the health worker worked for longer than six months but shorter than 12 months, he was only required to refund to the SWD $2,500.*

deliver appropriate training programmes to RCHEs based on the weaknesses, shortcomings or areas needing improvement observed during the inspections carried out by the SWD's inspectorate teams.

8.31 **Audit also believes that healthcare services will be further enhanced by improving the training of carers (see para. 8.29 above) and the healthcare facilities at RCHEs.**

Audit recommendations on monitoring of healthcare services of RCHEs

8.32 **To improve the quality of healthcare services provided by RCHEs, Audit has *recommended* that the Director of Social Welfare should:**

(a) **ask the SWD's inspectorate teams to document their interviews with the residents during inspections of RCHEs and follow up with the RCHEs on reasonable suggestions and valid complaints received;**

(b) **request the SWD's inspectorate teams to conduct inspections of the services and facilities which were found to have been inadequately provided at some RCHEs (e.g. call-bell systems and number of hospital beds); and**

(c) **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 at a C&A home.**

8.33 **Audit also has *recommended* that the Director of Social Welfare, in collaboration with the Director of Health, should:**

(a) **provide more training to health workers and care workers working at RCHEs, particularly on areas relating to the weaknesses or shortcomings observed during inspections of RCHEs;**

(b) **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**

(c) **seek clarification as to whether the SWD is empowered under the Ordinance to authorise the VHTs to provide appropriate training courses to the staff of RCHEs.**

Response from the Administration

8.34 The **Director of Social Welfare** has said that:

(a) the SWD would revise the inspection reports to document the interviews with residents and their family members during inspections of RCHEs;

(b) functioning of call-bell system is being covered by the SWIT's inspections, and facilities for disabled persons would be taken into consideration during the licensing of new RCHEs. Hospital beds are not a standard provision under the existing licensing requirements, though the HIT would remind home managers to procure such beds to meet the care needs of the frail elderly;

(c) the SWD appreciates Audit's concern about inadequate nursing manpower in the HIT to effectively discharge its role in monitoring the healthcare services at RCHEs. With the licensing of all private homes accomplished in March 2001, the SWD is anxious to improve the standard of the service. The SWD will keep the option of legislative amendments for improving the service under review;

(d) the SWD is committed to enhancing training for RCHE staff. The SWD has secured additional resources to provide a total of 2,160 multi-skilled training places for care workers serving frail elderly persons between 2001-02 and 2005-06. In addition, the SWD will continue to provide 1,080 first aid certificate training to RCHE staff, and 684 training places will be provided for health workers in 2002-03; and

(e) the SWD welcomes Audit's suggestion for the SWD to make use of the resources and expertise of the VHTs of the DH in strengthening the monitoring of healthcare services at RCHEs. The SWD will discuss Audit's recommendations with the Secretary for Health and Welfare.

8.35 The **Secretary for Health and Welfare** has said that the HWB is committed to and has secured resources for enhancing training for both front-line and professional staff at RCHEs.

Admission criteria for subsidised places at C&A homes, self-care hostels, HFAs, nursing homes, infirmaries and HSC units

Care and attention home

To qualify for admission to a subsidised C&A home, an applicant should:

(a) be normally aged 65 or over (Note);

(b) be in poor health or suffering from functional disabilities to the extent that assistance in personal care and daily living activities is necessary;

(c) be able to move around with a walking aid or in a wheelchair;

(d) be without family members to provide the necessary assistance, or would cause great stress to his family; and

(e) be mentally suitable for communal living.

Self-care hostel

To qualify for admission to a subsidised self-care hostel for the elderly, an applicant should:

(a) be normally aged 65 or over (Note);

(b) have a social or housing need and be unable to live independently;

(c) be capable of managing personal hygiene and activities of daily living; and

(d) be physically and mentally suitable for communal living.

Home for the aged

To qualify for admission to a subsidised HFA, an applicant should:

(a) be normally aged 65 or over (Note);

(b) have a social or housing need and be unable to live independently;

(c) be capable of managing personal hygiene and laundry of personal clothing;

(d) have difficulties in performing/managing activities of daily living such as cooking, cleaning, going to market and heavy laundry; and

(e) be physically and mentally suitable for communal living.

Nursing home

To qualify for admission to a subsidised nursing home, an applicant should:

(a) be normally aged 65 or over (Note);

(b) satisfy at least one of the following conditions, but provided that he would not require a higher level of care than would be needed in either of the two conditions:

(i) he has a medical condition which is stabilised but he still requires regular basic medical and nursing care; and/or

(ii) he has chronic disability and, in order to move around, requires, with or without a walking aid or wheelchair, one person to assist him. He should in any event not be totally chairbound; and

(c) be mentally suitable for communal living and should not have persistent tendency to violence, self-destruction/self-injury or disruptive behaviour.

Infirmary

To qualify for admission to a subsidised infirmary, an applicant should be an elderly person:

(a) with chronic disability who, after assessment, is in need of long stay and active rehabilitation to maximise his residual abilities with the aim of returning him to an appropriate level of care as far as possible;

(b) with terminal illness requiring continuous medical or nursing care;

(c) with chronic illness and, following assessment, is in need of intensive professional nursing care (e.g. gastrostomy feeding);

(d) who remains incapacitated and is bed-ridden requiring constant medical and/or nursing attention despite trial of intensive rehabilitation; or

(e) who has persistent residual symptoms from chronic psychiatric illness requiring intensive psychiatric care after psychiatric assessment and treatment.

Housing for senior citizens unit (of the Housing Authority)

(a) To qualify for admission to an HSC unit **under the Single Elderly Persons Priority Scheme,** an applicant must:

(i) be aged 58 or over (at the time of allocation of the unit he should have reached 60), have lived in Hong Kong for seven years, and is still living in Hong Kong;

(ii) have a total monthly income and net asset value not exceeding the maximum income and total net asset value limits laid down by the Housing Authority; and

(iii) satisfy all appropriate eligibility criteria applicable to ordinary families applying for public rental housing.

(b) **Under the Elderly Persons Priority Scheme,** two or more related or unrelated elderly persons who undertake to live together upon allocation are eligible to apply. To qualify for admission to an HSC unit, they must:

(i) be aged 58 or over at the time of submitting the application forms together;

(ii) have a total household income and net asset value not exceeding the maximum income and total net asset value limits laid down by the Housing Authority; and

(iii) satisfy all the Housing Authority's appropriate eligibility criteria applicable to ordinary families applying for public rental housing.

Source: SWD's, Hospital Authority's and Housing Authority's records

Note: Persons aged between 60 and 64 can apply if there is a proven need for residential care. Priority will be given to those who are with low income, lack of support from family members or caregivers and/or are living in poor housing conditions.

Appendix B

(paras. 1.5
and 5.5 refer)

Application procedures for subsidised residential places provided by the Hospital Authority and the SWD

Preliminary assessments by social workers

1. Applications for residential care services for the elderly are usually made by social workers of the SWD or NGOs. When a social worker finds an elderly person who is in need of residential care services, he will first perform a preliminary assessment of the health condition and care needs of the elderly person to determine the type of residential care service which is most suitable. Based on the results of the preliminary assessment, the social worker submits an application on behalf of the elderly person to the **Hospital Authority** (for an infirmary place), or the **SWD** (for a place at a nursing home, C&A home, HFA or self-care hostel) for processing.

Assessment of applications for infirmary places provided by the Hospital Authority

2. If an elderly person is found to be in need of infirmary care service of the Hospital Authority, the social worker will submit an application on behalf of the elderly person to the Central Infirmary Waiting List Office of the Hospital Authority. In this Office, applications are assessed on a first-come-first-served basis by the Community Geriatric Assessment Teams of the Hospital Authority. Qualified applicants are placed on the waiting list in chronological order. Some applicants may be granted priority placement by the Assessment Teams according to the laid down criteria. The caseworkers concerned may consider referring elderly persons who are not eligible for infirmary services to the SWD for wait-listing of the residential care services (see paras. 3 to 5 below).

Assessment of applications for residential care places provided by the SWD

3. If an elderly person is found to be in need of residential care services provided by the SWD (i.e. at a nursing home, C&A home, HFA, or self-care hostel), the responsible social worker will submit an application on behalf of the elderly person to the Residential Care Services Delivery System for the Elderly Office of the SWD. In the application form, the applicant may indicate:

(a) his preference for a particular home, homes in a particular district, or homes in a particular region; and

(b) whether he is willing to accept a placement under the bought-place schemes.

4. On receipt of the applications submitted, the SWD places the applications on the relevant waiting lists (i.e. for nursing home, C&A home, HFA or self-care hostel). Each applicant is requested to attend an assessment coordinated by the Standardised Care Need Assessment Management Office of the SWD. The assessors are normally social workers, nurses or Occupational Therapists. If the applicants agree with the recommendations of the assessors, their applications are placed on the appropriate waiting lists (according to the original dates of application). On a first-come-first-served basis, qualified applicants are allocated places when vacancies arise. Unqualified applicants are informed of the results of the assessment.

5. In November 2000, an appeal procedure was established under the Standardised Care Need Assessment Mechanism. If an elderly person is not satisfied with the assessment or allocation of a place, he may lodge an appeal to the Standardised Care Need Assessment Management Office. Similarly, if a subsidised residential home considers that an elderly person allocated to it by the SWD is not suitable for residing there, it may also lodge an appeal to the related assessment office (there are five regional assessment offices). The assessment offices arrange mediation with the parties concerned. If the mediation fails to resolve the disagreement, the applicants or the residential homes may further appeal to one of the five Regional Appeal Committees of the SWD. Each Regional Appeal Committee is chaired by a District Social Welfare Officer, with two or more independent members who may include a medical doctor, para-medical staff, social worker from the welfare sector or community leader. The Committee will decide on the appeal and recommend an optimal welfare plan for the elderly applicant.

Source: Hospital Authority's and SWD's records

Appendix C
(paras. 2.14, 2.15 and 7.10 refer)

Minimum staff requirements in different types of 40-place C&A homes

	Subvented RCHE	**Private RCHE under BPS**		**Private RCHE under EBPS**	
	(Note 1)	**Type A2 (Note 2)**	**Type B (Note 2)**	**Type EA1**	**Type EA2**
Senior Social Work Assistant	1	–	–	–	–
Home manager	–	1	1	1	1
Welfare worker	1	–	–	–	–
Physiotherapist	0.25	–	–	–	–
Registered nurse	1	6 (Note 3)	6 (Note 3)	2 (Note 3)	–
Enrolled nurse	3				–
Health worker	–			2	4
Care worker	8			8	8
Ancillary worker	–	4	4	8	6
Workman II	3	–	–	–	–
Assistant Clerical Officer	1	–	–	–	–
Driver	1	–	–	–	–
Cook	2.5	–	–	–	–
Total staff	**21.75**	**11**	**11**	**21**	**19**

Source: SWD's records

Note 1: At a subvented C&A home, the staff-resident ratios are:

1 enrolled nurse : 14 residents
1 care worker : 5 residents
1 workman II : 15 residents
1 physiotherapist : 150 residents

The capacity of a subvented C&A home usually ranges from 100 to 250 residents.

Note 2: For a Type A2 or Type B RCHE under the BPS, the healthcare staff to resident ratio is 1:7. Of these healthcare staff, there should be at least one registered nurse, enrolled nurse or health worker.

Note 3: These refer to the number of a combination of the following four types of staff: registered nurse, enrolled nurse, health worker and care worker.

Estimate of financial savings and provision of more subsidised residential places

Figures shown in Table 8 in para. 5.20	Basis of estimate
(a) Phasing out 7,537 HFA places	
(i) **$365.2 million** saving a year	[($5,969 × 88 places) + ($4,015 × 7,449 places)] × 12 ($5,969 and $4,015 were the monthly subsidies for an HFA place provided by the SWD and by NGOs respectively.)
(ii) savings can be used to provide an additional 5,895 C&A home places	$365.2 million ÷ 12 ÷ $5,163 ($5,163 was the monthly subsidy for a C&A home place in SWD's recent tender exercise.)
(b) Transferring 1,134 long-term care places from hospital setting to welfare setting	
(i) **$154.8 million** saving a year	1,134 places × ($30,000 − $12,930 − $5,695) × 12 ($30,000 and $12,930 were the monthly subsidies for an infirmary place and nursing-home place respectively, $5,695 was the monthly Infirmary Care Supplement paid by the SWD.)
(ii) savings can be used to provide an additional 693 nursing-home places	$154.8 million ÷ 12 ÷ ($12,930 + $5,695)
(c) Providing 10,210 subvented C&A home places based on the benchmark cost	
(i) **$460.1 million** saving a year	10,210 places × ($8,918 − $5,163) × 12 ($8,918 was the monthly subsidy for a subvented C&A home place, and $5,163 was the monthly subsidy for a C&A home place obtained by the SWD through open tender.)
(ii) savings can be used to provide an additional 7,426 C&A home places	$460.1 million ÷ 12 ÷ $5,163

Figures shown in Table 8 in para. 5.20		Basis of estimate	($ million)
(d) Introducing means test for 23,531 subsidised C&A home places (Note 1), 4,303 bought places and 2,093 nursing-home places (Note 2)	(i)	23,531 subsidised C&A home places: $5,163 × 12 × 23,531 × (1 − 79%) × 50% (Note 3)	153.1
(i) **$269 million** saving a year	(ii)	4,303 bought places: $6,328 × 12 × 4,303 × (1 − 53%) × 50% (Note 4)	76.8
	(iii)	2,093 nursing-home places: [$12,930 × 1,400 + ($12,930 + $5,695) × 693] × 12 × (1 − 79%) × 50% (Note 5)	39.1
		Total	269.0
(ii) savings can be used to provide an additional 175 nursing-home places		$39.1 million ÷ ($12,930 + $5,695) ÷ 12	
(iii) savings can be used to provide an additional 3,711 C&A home places		($153.1 million + $76.8 million) ÷ 12 ÷ $5,163	

Source: SWD's and Hospital Authority's records and Audit's estimates

Note 1: The 23,531 places comprise of 10,210 places at subvented C&A homes, 5,895 C&A home places obtained by phasing out HFA places (see item (a) above), and 7,426 C&A home places obtained by using the benchmark cost (see item (c) above) [10,210 + 5,895 + 7,426 = 23,531].

Note 2: The 2,093 places comprise of 1,400 nursing-home places and 693 places obtained by transferring 1,134 long-term care places from the hospital setting to the welfare setting (see item (b) above) [1,400 + 693 = 2,093].

Note 3: 79% of residents at subvented homes were CSSA recipients (see para. 7.3 above). It is assumed that (a) the remaining 21% (1 − 79%) residents had income and assets which could be used to meet part or the whole of the subsidy; (b) these 21% elderly persons could contribute fees to meet from 0% to 100% of the subsidy, and that these people were evenly distributed. Therefore, on average, these people could contribute to meet 50% of the subsidy.

Note 4: 53% of residents at bought-place homes were CSSA recipients (see para. 7.5 above). $6,328 was the monthly subsidy for a C&A home place under bought-place schemes.

Note 5: $5,695 is the monthly Infirmary Care Supplement which may be needed for taking care of infirm persons transferred to nursing homes (see para. 4.14 above).

Appendix E
(paras. 5.27 and 5.28 refer)

Overpayments of CSSA allowances to elderly persons admitted to Hospital Authority's medical institutions

Elderly (Note)	**Date of admission to Hospital Authority's institution**	**Estimated overpayment of CSSA allowance**	**Remarks**
		($)	
Person A	7.8.2000	$18,216 (23.8.2000 to 22.4.2001)	The SWD was informed of the overpayment when a family member reported the hospitalisation. The SWD would recover the overpayment by 12 installments by deductions from subsequent CSSA payments.
Person B	31.1.2000	$17,138 (17.2.2000 to 16.2.2001)	The SWD was informed of the overpayment when a family member reported the hospitalisation. The elderly person passed away in October 2001. The overpayment was refunded to the SWD in October 2001.
Person C	29.10.1999	$147,920 (30.10.1999 to 24.10.2001)	The SWD was informed of the overpayment when a family member reported the hospitalisation. The overpayment was refunded to the SWD in October 2001.
Person D	24.12.1998	$125,866 (24.12.1998 to 21.11.2001)	The SWD was informed of the overpayment when a family member reported the hospitalisation. The SWD was in the process of determining the recovery action.
Person E	14.8.2000	$58,325 (2.9.2000 to 9.1.2002)	The overpayment was discovered by Audit during an audit examination in August 2001. The SWD was in the process of determining the recovery action.
Person F	4.12.2000	$40,221 (10.12.2000 to 9.8.2001)	The overpayment was discovered by Audit during an audit examination in August 2001. The elderly person passed away in November 2001. The SWD was in the process of determining the recovery action.
Total		**$407,686**	

Source: SWD's records

Note: Prior to admission, the elderly persons resided in either public rental housing or private RCHEs.

Appendix F
(paras. 6.4, 8.27 and 8.29 refer)

Minimum staffing requirements for each type of RCHE under Schedule 1 of the Residential Care Homes (Elderly Persons) Regulation

Type of staff	**C&A home**	**HFA (i.e. "aged home" as referred to in the Ordinance)**	**Self-care hostel**
Home manager	1 home manager	1 home manager	1 home manager
Ancillary worker	1 ancillary worker for every 40 residents or part thereof, between 7 a.m. and 6 p.m.	1 ancillary worker for every 40 residents or part thereof, between 7 a.m. and 6 p.m.	1 ancillary worker for every 60 residents or part thereof, between 7 a.m. and 6 p.m.
Care worker	(i) 1 care worker for every 20 residents or part thereof, between 7 a.m. and 3 p.m.; (ii) 1 care worker for every 40 residents or part thereof, between 3 p.m. and 10 p.m.; and (iii) 1 care worker for every 60 residents or part thereof, between 10 p.m. and 7 a.m.	No care worker required	No care worker required
Health worker	Unless a nurse is present, 1 health worker for every 30 residents or part thereof, between 7 a.m. and 6 p.m.	Unless a nurse is present, 1 health worker for every 60 residents or part thereof	No health worker required
Nurse	Unless a health worker is present, 1 nurse for every 60 residents or part thereof, between 7 a.m. and 6 p.m.	Unless a health worker is present, 1 nurse	No nurse required

Source: Residential Care Homes (Elderly Persons) Regulation

Note: As an additional requirement for a C&A home or an HFA, any two persons being a home manager, an ancillary worker, a care worker, a health worker or a nurse shall be on duty between 6 p.m. and 7 a.m.

Appendix G
(Table 10 in
para. 6.22 refers)

Inspections not carried out on time by the SWIT, HIT, BSIT and FSIT between 1 April 1999 and 31 March 2001 (Note)

RCHE	Type of RCHE (operated under licence or certificate of exemption — CoE)	Required frequency of inspection: once every	Inspections not carried out on time		
			Date of first inspection (a)	Date of the next inspection (b)	Time interval (c)= (b)- (a)
(A)	***9 delayed inspections by the SWIT***				
A	Subvented (CoE)	6 months	22.02.2000	26.03.2001	13 months
B	Subvented (CoE)	6 months	12.02.1999	22.03.2000	13 months
		6 months	22.03.2000	12.01.2001	9 months
C	Self-financing (licence)	12 months	14.01.2000	10.07.2001	17 months
D	BPS (licence)	3 months	01.08.2000	08.02.2001	6 months
E	BPS (licence)	3 months	10.08.2000	15.03.2001	7 months
F	EBPS (licence)	3 months	16.02.2000	27.06.2000	4 months
G	Private (licence)	6 months	18.12.1999	19.07.2000	7 months
H	Private (licence)	6 months	13.01.2000	01.12.2000	10 months
(B)	***10 delayed inspections by the HIT***				
C	Self-financing (licence)	6 months	27.02.1998	21.03.2000	24 months
		6 months	21.03.2000	25.05.2001	14 months
D	BPS (licence)	6 months	20.07.1999	21.03.2000	8 months
		6 months	21.03.2000	02.11.2000	7 months
E	BPS (licence)	6 months	27.04.1999	16.12.1999	7 months
F	EBPS (licence)	6 months	14.12.1998	13.10.1999	10 months
		6 months	13.10.1999	19.06.2000	8 months
		6 months	26.09.2000	18.07.2001	9 months
G	Private (licence)	6 months	28.07.1999	11.07.2000	11 months
H	Private (licence)	6 months	11.01.2000	08.09.2000	7 months
(C)	***3 delayed inspections by the BSIT***				
C	Self-financing (licence)	12 months	19.02.1998	22.07.1999	17 months
D	BPS (licence)	12 months	13.07.1999	12.02.2001	19 months
G	Private (licence)	12 months	21.07.1999	08.12.2000	16 months
(D)	***1 delayed inspection by the FSIT***				
D	BPS (licence)	12 months	13.08.1999	01.02.2001	17 months

Source: SWD's records

Note: During these two years, the SWIT conducted 53 inspections; the HIT conducted 34 inspections; the BSIT conducted 22 inspections; and the FSIT conducted 24 inspections of the ten RCHEs.

Service Quality Standards of RCHEs of subvented NGOs

Standard Number	
1.	The service unit ensures that a clear description of its purpose, objectives and mode of service delivery is publicly available.
2.	The service unit should have available current, documented policies and procedures describing how it will approach key service delivery issues.
3.	The service unit maintains accurate and current records of service operations and activities.
4.	The roles and responsibilities of all staff, managers, the Management Committee and/or the Board or other decision making bodies should be clearly defined.
5.	The service unit implements effective staff recruitment, development, training, assessment and deployment practices.
6.	The service unit has an effective mechanism by which service users, staff and other interested parties can provide feedback on its performance.
7.	The service unit regularly reviews and evaluates its own performance.
8.	The service unit demonstrates effective financial management.
9.	The service unit complies with all relevant legal obligations and professional codes of practice.
10.	The service unit takes all reasonable steps to ensure that it provides a safe physical environment for its staff and service users.

Standard Number	
11.	The service unit ensures that the service users have clear and accurate information about how to enter and leave the service.
12.	The service unit has a planned approach to assessing and meeting service users' needs (whether the service user is an individual, family, group or community).
13.	The service unit ensures that, as far as practical, it coordinates its activities with other service units to promote the best quality outcomes for service users.
14.	The service unit supports the maintenance of service users' family relationships and social relationships.
15.	The service unit respects the service users' rights to self-determination as far as practicable.
16.	The service unit respects the service users' rights in relation to private property.
17.	The service unit respects the service users' rights for privacy and confidentiality.
18.	Each service user and staff member is free to raise, without fear of retribution, any complaints he or she may have regarding the agency or the service unit.
19.	The service unit takes all reasonable steps to ensure that service users are free from abuse.

Source: SWD's records

Note: The Service Quality Standards apply to all service units of a subvented body. RCHE is one of the service units of some subvented bodies. For each of the standards, the SWD has laid down some criteria for subvented bodies to comply with in order to meet the standards.

Appendix I
(paras. 8.4
and 8.20 refer)

Health education programmes conducted by VHTs of the DH in 2000

(A) Health education programmes for the elderly

1. Back & neck care
2. Burn & scald
3. Cataract
4. Cholera
5. Cholesterol lowering
6. Constipation
7. Diabetes mellitus
8. Depression
9. Dyspepsia
10. Eating problems in the elderly
11. Exercise for the elderly
12. Fall prevention
13. Food poisoning
14. Frozen shoulder
15. Gout
16. Heat stroke
17. Hepatitis
18. Home safety
19. Hypertension
20. Hypothermia
21. Influenza
22. Insomnia / sleep hygiene
23. Ischaemic heart disease
24. Leg care
25. Mental wellbeing
26. Normal ageing
27. Nutrition
28. Oral health
29. Osteoarthritis
30. Osteoporosis
31. Prostate gland disease
32. Protect your hearing
33. Quit smoking
34. Respiratory problems in the elderly
35. Skin care
36. Swallowing
37. Tinea infection
38. Tuberculosis
39. Weight reduction
40. Women screening tests

(B) Health education programmes for carers

1. Application of restrainers
2. Application of topical medications
3. Dementia
4. Blood pressure taking
5. Feeding
6. First aid for the elderly
7. Lifting and transfer
8. Parkinsonism
9. Prevention of blood borne diseases
10. Scabies
11. Stress management for carers
12. Stroke
13. Vital signs checking
14. Walking aids

Source: DH's records

Appendix J
(para. 8.4 refers)

Major activities of the VHTs of the DH in recent years

The following are the major activities of the VHTs since their establishment in July 1998:

(a) the VHTs have collaborated with other elderly service providers to deliver health education programmes for both the elderly and carers. The target groups include the well elderly in the community and those in residential institutions. An annual influenza vaccination programme has been conducted for the elderly residents in these institutions;

(b) in 2001, over 90% of multi-service centres for the elderly, social centres for the elderly, HSC and residential institutions for the elderly were visited by the VHTs at least once for the delivery of health education programmes. In the 2001 Influenza Vaccination Programme, 86.9% of the residents in residential institutions received the vaccination;

(c) in 2001, the DH conducted a client satisfaction survey on attendees of health education programmes and the managers in charge of the centres or institutions, which indicated high client satisfaction with the programmes;

(d) the health education programmes have been delivered in various formats, which include talks with interactive elements, workshops, discussion sessions, and games;

(e) in providing education and skill training to an institution, the VHTs would assess the specific training needs of the institution, taking into account its specific conditions and the skill level of the carers, so as to tailor the programme to target at the deficiencies identified;

(f) the DH conducted a follow-up study among 119 residential institutions which had taken part in a dietetic support education programme delivered between July 2000 and July 2001. The programme included education on nutrition, food hygiene and menu planning. Examination of the menu for the residents before and after completion of the programme showed improvement in 84% of the institutions;

(g) the VHTs undertake public health education to disseminate health advice and messages through various media channels. The VHTs provide a 24-hour telephone information service and a web page, and publish a newsletter and pamphlets on various topics. Video cassettes and video compact discs on topics like healthy ageing and exercises have been produced for distribution to elderly service providers, and are sold at cost to the general public; and

(h) the VHTs have liaised with the Licensing Office of the SWD to examine ways and means to achieve better utilisation of the VHT services by RCHEs, especially those with deficiencies identified.

Source: DH's records

Appendix K
(paras. 8.8, 8.9 and 8.28 refer)

Analysis of education, working experience and training of health workers and care workers interviewed by Audit

Particulars		Total number of workers interviewed	
		Health workers	**Care workers**
		(a)	**(b)**
		16	**80**
Education level:	With no formal education	0%	2.5%
	Attained primary education	0%	28.8%
	Attained lower secondary education	6.2%	45.0%
	Attained upper secondary education	81.3%	20.0%
	Attained post secondary education	12.5%	3.7%
Place of obtaining education:	In Hong Kong	50.0%	35.0%
	In Mainland China	43.8%	52.5%
	Overseas	6.2%	10.0%
	With no formal education	0%	2.5%
Elderly-care training:	Had attended training	100%	**58.8%**
Working experience in care for the elderly:	Less than 1 year	12.5%	22.5%
	1 to 3 years	37.5%	33.8%
	More than 3 years to 6 years	43.8%	36.3%
	More than 6 years to 9 years	0%	3.7%
	More than 9 years	6.2%	3.7%

Source: Audit's interviews with health workers and care workers

Appendix L

Acronyms and abbreviations

BPS	Bought Place Scheme
BSIT	Building Safety Inspectorate Team
C&A	Care and attention
CSSA	Comprehensive Social Security Assistance
DH	Department of Health
EBPS	Enhanced Bought Place Scheme
FSIT	Fire Safety Inspectorate Team
HFA	Home for the aged
HIT	Health Inspectorate Team
HSC	Housing for Senior Citizens
HWB	Health and Welfare Bureau
NGO	Non-governmental organisation
RCHE	Residential care home for the elderly
SPMS	Service Performance Monitoring System
SQS	Service Quality Standard
SWD	Social Welfare Department
SWIT	Social Work Inspectorate Team
VHT	Visiting Health Team