THE HONG KONG GERIATRIC SOCIETY

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GERIATRIC REHABILITATION IN HONG KONG – OPTIONS OF THE HONG KONG GERIATRIC SOCIETY ON GREEN PAPER "EQUAL OPPORTUNITIES AND FULL PARTICIPATION: A BETTER TOMORROW FOR ALL"

2 June 1992

1. Introduction

This submission is focused on the area of 'Geriatric Rehabilitation', referring mainly to sections 5.25-5.27, 8.16, 9.30, 11.25-11.31 of the Green Paper. It identifies major issues and problems in this area, and recommends possible policies or plans that may help to resolve or ameliorate the problems.

2. Geriatric Rehabilitation as a distinct area of need

2.1 We commend the Green Paper on identifying Geriatric Rehabilitation as a distinct area for policies and services consideration. This is urgently needed in view of the aging of Hong Kong's population, in particular with the rapid growth of the 'old olds' (i.e. those aged 75 or over); it is desirable from a caring point of view, as disabilities and illnesses in old age tend to be multiple, interrelated, and complicated by psychological, financial, social and placement factors; it is practicable from an organizational point of view because much of the current rehabilitation services are already organized on an age-related basis.

2.2 In identifying Geriatric Rehabilitation as a distinct area of need, it

must be noted that at present age-specific data on diseases and disabilities are sorely missing. This hampers policy making and rational allocation of resources.

2.3 Recommendations:

A. That age-stratified data of morbidity and disability be collected and compiled for publication in the Annual Reports of Department of Health, Social Welfare Department, and Hospital Authority.

B. That there should be increased funding of research on the health, diseases, and disabilities in elderly in Hong Kong.

3. Imbalance of Rehabilitation Services

3.1 Previous government policy's attention has been focused on physical / mental handicap of the young disabled, the crippled aged sector was not given adequate consideration despite their life contribution to society. We strongly feel that they should also enjoy equal opportunities and participation.

3.2 There is also an imbalance and skewed input of resources for acute vs. rehabilitation services. The traditional neglect and under-provision of manpower for rehabilitation service forced clinicians to label their wards as acute instead of rehabilitation, so that the urgent (acute care) drives out the important (rehabilitation). There should be a balanced and adequate allocation of resources.

3.3 Even more neglected are appropriate long-stay beds for the severely disabled or chronically ill old persons. This unfortunate minority unable to speak out for them are rapidly discharged from acute wards to nursing homes and soon readmitted to hospitals. This 'revolving door' phenomenon is a cost6ly burden to the acute hospital service.

3.4 Lack of rehabilitative services for the aged not only affects the elderly but also erodes into the young labour force by increasing their burden

of care. Society pays a hidden yet high cost of informal care. With careful individualized assessment and treatment, geriatric rehabilitation not only reduces the degree of disabilities but also prevents unnecessary future impairments.

3.5 Recommendations:

A. That there should be a positive reemphasis of rehabilitation in hospital service. Existing infirmaries and "convalescent hospitals" can be upgraded to provide multi-disciplinary geriatric rehabilitation.

B. That consideration may be given to a programme budgeting system of resource allocation, so as to more clearly identifying the distribution of resources for different sectors of the services.

C. That adequate long stay beds be provided to shorten the present long waiting time to more reasonable duration.

4 Fragmentation of Rehabilitation Services

4.1 The present fragmentation of rehabilitation services between the Social Welfare Department, Hospital Authority, and Department of Health is of concern. Community geriatric rehabilitation, for instance, cannot hoped to be organized effectively without expert inputs from the hospital service, coordination at the primary care (Dept. of Health) level, and home supports from the SWD.

4.2 At present there are 5 Geriatric Day Hospitals in Hong Kong providing medical and rehabilitative care of the elderly in community (mostly after recent hospital discharges). This has in UK proved a very effective interface between hospital and community care. We are disappointed and puzzled that no mention of this mode of service organization is made in either the 'Geriatric Rehabilitation' (s.5.26-5.27) or 'Community-based Rehabilitation' (s.9.30) sections of the Green Paper.

4.3 There is at present often a discontinuity of care between acute hospitals and 'convalescent hospitals'. Elderly patients in the latter are not adequately

cared for by doctors from acute hospitals 'overseeing' convalescent patients. The rehabilitation staff in these 'convalescent wards' has little communication with the acute care doctors, leading to poor morale and suboptimal rehabilitation efforts.

4.4 Many elderly patients, upon returning to the community after a course of intensive rehabilitation in hospital wards or geriatric day hospitals, cannot maintain an optimal level of functioning due to the lack of maintenance physical and occupational therapy at primary care level. Rapid immobilization with all its undesirable complications (e.g. contractures) results, rendering future rehabilitation efforts difficult or impossible.

4.5 Recommendations:

A. That in organizing district-based networks of geriatric rehabilitation (Green Paper s.5.26 (e)) the geriatric day hospitals be utilized as centers for cases requiring intensive rehabilitation, or complicated cases with medical problems superimposed with rehabilitation need.

B. That the geriatric day hospitals may be linked with selected specialist outpatient clinics to act as nucleus for the district-based rehabilitation network. In the longer term it is desirable for links to be established with the future district Primary Health Centres.

C. That domiciliary physiotherapy and occupational therapy be developed to ensure that gains achieved in the intensive phase of rehabilitation can be maintained in the community.

D. That there be enough numbers of geriatric day hospitals to fulfill the needs of intensive phase of geriatric rehabilitation; furthermore the day hospitals should support the primary health centers with multi-disciplinary geriatric assessment service, and trainings for the community rehabilitation team.

E. That there be early implementation of geriatric teams in all acute hospitals (Green Paper s.5.26 (a)).

F. That such geriatric teams should have adequate manpower and

resources to extend care to the 'convalescent hospitals', where the geriatricians can take the lead in upgrading the rehabilitation service (ref. 3.4A above).

5. Inadequate Transport Service for the Disabled Elderly

5.1 Transport service of all types is currently underprovided for the disabled elderly. It must be pointed out that such proposals as mobility allowance (s.11.28) and Adapted Bus Service (s.11.32) cannot service most of the elderly disabled by diseases such as stroke, Parkinson's disease, or severe arthritis.

5.2 Adequate non-emergency ambulance transport service is vital for the disabled elderly to get access to clinic follow-ups or Geriatric Day Hospital service. This is one important issue that faces threats of getting dismissed in the fragmentation between Fire Services Department, Hospital Authority and Department of Health.

5.3 We support the proposal in the Green Paper to expand Rehabus service, which is quite valuable for the mild to moderately disable. The Rehabus however does not completely replace the need for ambulance service for the more disabled elderly. A mix of Rehabus and ambulance service will be necessary.

5.4 Recommendations:

A. That early negotiation of non-emergency ambulance transport service is carried out among the concerned Departments and Authority, to ensure that the service is maintained for the more disabled patients.

B. That there be early expansion of Rehabus service, and that individual Geriatric Day Hospitals be supported for development of Rehabus transport service similar to that operated by the Hong Kong Society for Rehabilitation.

C. That there should be professional inputs in assessing the size and composition of a suitable mix of different modes of transport

for the disabled elderly in various settings.

6. Conclusion

6.1 The size of elderly population in Hong Kong with disabilities and chronic illnesses is expected to rise rapidly in the next two decades. With adequate planning and appropriate organization many will benefit from geriatric rehabilitation.

6.2 For effective and efficient geriatric rehabilitation service to be provided, there must be reasonable resources input; the services must be coordinated with continuity of care; it must be led by experts with knowledge in the treatment of both acute and chronic illnesses in old age, experience in organizing the full range of service (acute, rehabilitation, and long-stay care), and leading skills for the multi-disciplinary team approach.

6.3 The central role of the Geriatric Day Hospital in the active phase of geriatric rehabilitation is emphasized. It should support and train primary medical practitioners at Primary Health Centres in providing community rehabilitation services.

6.4 The Green Paper is commended for identifying 'geriatric rehabilitation' as a distinct area of need. It is suggested that the foregoing recommendations be considered for amendment to the final draft of the future White Paper.