



# The Hong Kong Geriatrics Society

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## Health and Social Services for Elders in Hong Kong

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### Introduction

Geriatric Medicine is a branch of Medicine dealing with clinical, rehabilitative, psychological and social aspects of illness in elderly people. The main difference of geriatric medicine from general medical is its organizational approach to the provision of services and a holistic approach to patient care. Geriatric medicine has an armamentarium of acute, rehabilitation and long-stay facilities, day hospitals, multidisciplinary rehabilitation team and a close liaison with the community and social welfare service. They have a very important role of co-coordinating all healthcare needs of elderly people, which will reduce admission into hospitals and prevent unnecessary institutionalization of elderly people.

### Philosophy Geriatric Medicine

- Care and treatment should, wherever possible, take place in the patient's own home
- When a patient is hospitalized, the aim should be to rehabilitate and return them to an independent life at home
- Diagnosis and treatment must recognize the special features of illness in old age and must be based on an assessment of the whole person.
- Treatment must disrupt the patients as little as possible, must be agreed, implemented and monitored by professional staff with a wide range of skills, and must respond to and involve the patient's family and other

carers.

- Treatment and care must be provided in a supportive, friendly, and pleasing environment, whether in hospital, out-patient clinic, day hospital or residential care
- Patient's dignity and right to privacy must be respected and they should be consulted and kept informed about their treatment as far as possible
- The nation's health and welfare services for elderly must be given the funds, staff and equipment they need to ensure the highest standards of care

### **Historical development of Geriatric Specialty in Hong Kong**

- 1975 First Geriatric Unit opened in Princess Margaret Hospital
- 1979 Undergraduate teaching in geriatric medicine started in University of Hong Kong
- 1981 Hong Kong Geriatrics Society founded
- 1985 First lecturer in Geriatric Medicine in Chinese University of Hong Kong
- 1987 First issue of Hong Kong Journal of Gerontology published
- 1990 First issue of Journal of the Hong Kong Geriatrics Society published

### **The Hong Kong Geriatrics Society**

Founded in 1981, the Hong Kong Geriatrics Society is the only professional society of doctors practicing geriatric medicine. All sixteen Consultant Geriatricians and Professor in Geriatric Medicine in Public Hospitals are regular members of our society. All forty-four Fellows of Hong Kong College of Physicians accredited in Geriatric Medicine are regular members of our society. There are up to now 83 regular members and 25 associated members in the Hong Kong Geriatrics Society. The society serves the professionals that are practicing geriatric medicine and the elderly persons.

#### Objectives

- To promote high standards of care in the practice of geriatric medicine
- To promote training and care of the elderly to all persons practicing geriatric medicine
- To promote geriatric research

## **Problems in the Health and Social Services for the Elderly in Hong Kong**

### Demographic change

- The proportion of old people has increased substantially in the past 16 years
- The number of persons aged 65 and above increased from 5% in 1981 to 10% in 1997
- In 1995, Life expectancy at birth is 76.0 for males and 81.5 for females
- Between 1995 to 2010
- Increase 19% for the age group 60-69
- Increase 35% for the age group 70-79
- Increase 127% for the age group >80

### Hospital care

- 10% population
- 33% of hospital admission
- 40% bed-days
- Geriatric beds –10% of total beds
- Planning ratios of Geriatric Services to population is abolished
- Original designated acute geriatric beds are eliminated
- Compete and compare with other services result in adverse outcomes
  - PRG comparison
  - Earlier discharges but sicker discharges
- Central infirmary waiting list: 6000 elderly are on the list
  - With only 500 out of the 1700 infirmary beds are used for admitting CIWL patients
  - Growing at a rate of 100 / month
  - Approximately only 100 can be admitted a year
  - In 1996, only placing those already on the list in 1993

### Primary health care

- The incidence of many chronic disease and disability require continuing care
- A large proportion of elderly require government services and cannot afford private health care because of the need for continuing care
- There is uncertainty as to who should provide such care – HA or DH
- With unclear policies, primary health care will be poorly developed and preventive measures may not be carried out

### Long term residential care

- Care provision is fragmented between HA, SWD and DH
- There is a need for more places and better support from geriatric teams
- Institutionalization rate in Hong Kong is 6.3% of the elderly 65+ (UK=5%)
- 55% are provided in private elderly homes with variable standard of care
- Lack of flexibility to allow movement of elderly people around the variety of long term residential care
- The problem is not only how many beds needed. It is how the services are provided
- Consultant Geriatrician input has been very instrumental in improving these service
- Community Geriatric Assessment Teams (CGAT) developed in 1994 with the following objectives
  1. To provide timely assessment and appropriate management of health problems for elderly persons at risk
  2. To improve the interfacing between medical and social services for elderly persons at district level and in the community
  3. To develop and provide community based rehabilitation programme for elderly persons
  4. To ensure that the placement decision or arrangement for elderly persons in need of residential care are appropriate
  5. To promote quality of care of elderly persons through training and education
- Most of the objectives are achieved, with decreased in A&E attendance, OPD attendance, unplanned acute hospital admission and proper placement and support of elderly at risk
- However, the service is now only limited to subvented C&A homes

### Elderly in the community

- Majority of the elderly are in good health
- 4% has physical impairment (USA 5%)
- 5% has moderate / severe cognitive impairment (USA 7%)
- Less than 1% are using community-based home care
- 22% probably depressed (~13-18 in other countries)
- High suicide rate elderly 28 / 100,000 (General – 12 / 100.000) in 1995

- Existing support service has low utilization rate
- Uncoordinated and lack of communication
- Elderly are prone to secondary complication
- Many of the care-givers are themselves frail and elderly
- The needs of the informal carers are often neglected
- Respite care are under developed and under utilized
- Ecological perspective among different system of care
- Supportive service should be needs led
- For promoting maximum independence for those wishing to live at home
- Bring the community services closer to those who need them

#### Future direction

- Establish central Administrator for the Elderly Services to plan, co-ordinate and monitor service for the elderly
- Defined different types of Geriatric Services for better development and monitoring
  - Infirmity Admission & Utilization should be monitored
  - Consultant Geriatrician led services with full autonomy should be developed to preserve the service organization and working philosophy of Geriatric, practice which are geared to the need of the elderly persons
- Extension of CGAT service to Private Elderly Homes and needy elderly in the community
- Combined central waiting list for all long term care residential facilities
- "Bought place scheme" for elderly of all levels of disability at Private Homes with level of disability assessed by CGAT
- Develop consultant geriatrician led primary health care teams for the elderly with due emphasis on health promotion