SPECIAL ARTICLE

"Will you still cure me, will you still care for me, when I'm 75?" The Hong Kong Geriatrics Society's response to "Building a healthy tomorrow—discussion paper on the future service delivery model for our health care system"

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INTRODUCTION

The Hong Kong Geriatrics Society (HKGS), established in 1981, is a specialist society of 181 doctors who are responsible for the management of acute and chronic illness, severe disability, and terminal conditions in elderly people. They work with multidisciplinary teams who are experienced in the management of old-age disease and in meeting the related ethical challenges. The HKGS is pleased to have the opportunity to respond to the Discussion Paper[1] and makes the following points.

A critique of the approach to elderly care in the Discussion Paper

1. The Discussion Paper realises the challenge of an ageing population (1 in 5 will be over 65 years by 2023), and the need for future planning of hospital bed provision to accommodate the growing elderly population and the differential hospital utilisation patterns of different age groups and genders (§5.8, §5.30[1]). Nonetheless, it fails to provide clear evidence of how hospital geriatric care will be provided. It gives the impression of a simplistic 'solution' to rising health care costs that will divert medical care of elderly people from the hospital to the community.
2. In the Discussion Paper, the future health care delivery model (§3.4[1]) is perceived to correspond to primary, secondary, and tertiary divisions. This is conceptual, and is not necessarily appropriate for the health care needs of many elders that cut across primary, secondary, and tertiary boundaries.
3. The Discussion Paper's framework for community care is based on the "family doctor and visiting medical officer" functioning in the primary sector as the gatekeeper (§4.6, §7.9[1]). It sees this as almost the single solution to limit access and thus the costs of health care. This idealised primary care model, when applied indiscriminately to all elderly people without direct participation of experienced geriatricians, can be ineffective and costly. Elderly care should be maximised in the community. Yet when community health care is deemed less cost-effective than hospital care, seamless access to local general hospitals is required. To deny such a need for hospital care and to confine elderly patients in the wrong environment to manage their health can, and will, jeopardise any success of this health care reform. The available facts, combined with decades of modern health care experience, tell us that elders with multiple illnesses, multiple pathologies, multiple aetiologies, multiple medications, and multiple disabilities need seamless health care—a continuum of care without primary and secondary divisions.
4. At first sight, it would appear that elderly people,

though not explicitly stated as such, will be the target of the public hospital service in the proposed future delivery service model, because of their ubiquitous presence in the four priority areas: acute and emergency care; low income and under-privileged groups; illnesses requiring multidisciplinary professional team work; and training of health care professionals (§3.3, §5.30[1]). Nonetheless the Paper wished and concluded that in the future health care scene, "elderly individuals rarely need to be admitted through A&E departments" (§10.1[1]). On the contrary, the focus of hospital care in the Discussion Paper appears to be on acute catastrophic illnesses (§5.11[1]), and expensive illness entailing advanced technology (§3.3, §5.30[1])—that assumes hi-tech medicine and interventions based on a single organ receive automatic priority in future public hospitals. A service designed for people who have only one complaint does not meet the needs of frail elders with multiple pathologies who will be the major users of hospital services.

5. The current and proposed accident and emergency (A&E) and acute medical service thus have their limitations and problems when tackling the care of elderly people who are frail and acutely ill. The current in-patient service for elderly people is increasingly fragmented with respect to organ-based specialties and new medical technology. Elderly patients, often with common diseases and 'unusual' presentations, do benefit from these specialised services when carefully selected and the service appropriately applied. Nonetheless, the indiscriminate use in the absence of a geriatrics perspective and knowledge base results in costly and harmful medical care, eg adverse drug reactions and postoperative cognitive deficits. Without a systematic approach, good organisation of care, as well as the knowledge, skills, and attitude associated with geriatric medicine, organ-based medicine may be futile for health care of elderly people.
6. Accordingly, the Paper is deficient in the area of acute hospital care of elders ("secondary care" in the framework of the Discussion Paper). In addition, elderly services are grouped in Chapter 7 with long-term and rehabilitation care services ("primary care" in the framework of the Discussion Paper).[1] By concentrating only on community and non-acute care of elders, the Paper fails to address the need for the full spectrum of progressive care from acute to rehabilitative to long-term care, as well as the continuum from hospital to community in the provision of comprehensive, effective, and efficient geriatric care. It also offers a very narrow perspective of the scope of community geriatric care (by discussing only residential care at length) and gives a restrictive role to community geriatric assessment teams (§7.10[1]).
7. It appears, therefore, from this Paper that the Government has not considered properly the role of geriatric medicine and of geriatric specialists in meeting the needs of the ageing society. In the following sections, the HKGS would like to propose ways in which geriatric medicine can usefully contribute to future elderly health care in Hong Kong.

BACKGROUND

8. A specialist geriatric service was established in Hong Kong 30 years ago, modelled on one in Glasgow, United Kingdom. It was designed to cater for the health care needs of elderly patients.[2] Geriatric medicine originated in the United Kingdom 70 years ago after concerns arose from the apathy towards and subsequent neglect of elderly patients who were thought not suitable for medical treatment and thus obliged to spend their last years in chronic infirmaries.[3] Since Marjory Warren showed that many elderly patients had conditions that could be cured with subsequent rehabilitation,[3] the specialty of geriatric medicine has continued to grow and an impressive knowledge base has accumulated.[4,5] This, combined with increasing expertise in coordinated multidisciplinary treatment and assessment by health and social services staff, has improved the care of ill elderly people.
9. While geriatric medicine originated in long-term care settings, its success in tackling the problems of frail elders led to the earlier involvement of geriatricians in the acute phase of illness. In the progressive care model, separate acute/rehabilitation/long-term environments and facilities are made available for patients at different stages of illness and treatment programmes. For the past 30 years, up to 130 specialists in geriatric medicine have

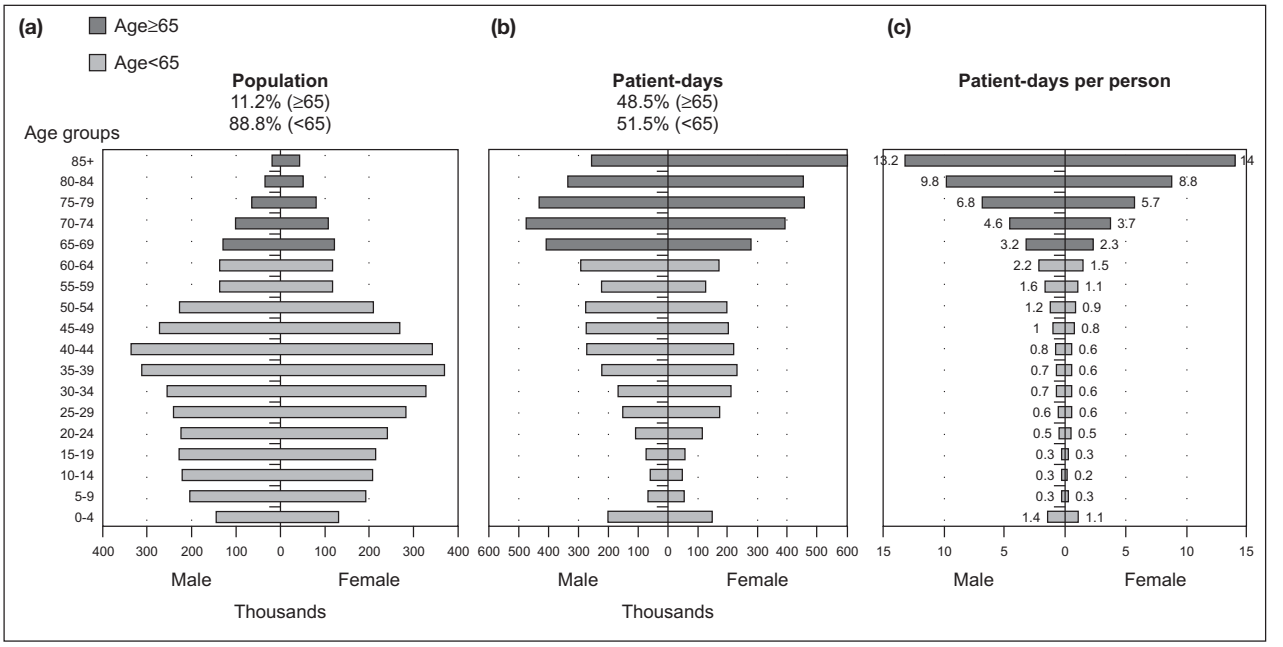

FIGURE 1. Hospital utilisation by Hong Kong population in 2001 by age group and sex[6]
(a) Hong Kong population age pyramid 2001; (b) Patient-days consumed in public hospitals by Hong Kong population in 2001; (c) Patient-days consumed in public hospitals by each person in Hong Kong in 2001 (derived by dividing figures in [b] by figures in [a])

been trained in Hong Kong to meet local service needs.

Ageing in Hong Kong and its impact on hospital utilisation

10. The Hong Kong elderly population aged 65+ is projected to grow from 816 000 in 2004 to 900 000 in 2010, an increase of 10%. The corresponding growth for the population aged 75+ is even higher at 30%, from 339 000 to 442 000. Since the prevalence of illness and disability rises with age, the growth of the elderly population, particularly those in the 75+ age group, has important implications for health and social services.
11. Elderly people are predominant in hospital populations. In the year 2001, the 65+ age group, which constituted 11.2% of the Hong Kong population, accounted for 48.5% of patient-days utilised in public hospitals. Within this age group, the hospital consumption per person per year rises rapidly with increasing age: those aged 85 and over spend on average 13 to 14 days a year in hospital, compared with 6 to 7 days a year for those aged 75 to 79, and 2 to 3 days a year for those aged 65 to 69. This contrasts sharply with the low hospital utilisation rate of under 1 day a year for adults aged below 45 years (FIGURE 1).[6]
12. Knowledge of these differential hospital service requirements according to the age-sex distribution of the elderly population is important for planning hospital utilisation, and draws attention to the 75+ age group in future hospital planning for elderly services.[7,8] Today, there are five and a half times as many people aged over 75 as there were 30 years ago: this age group will triple in number by 2031.
13. The hospital bed-days consumed by the 65+ age group is estimated to rise from 4.1 million to 5.6 million (an increase of 35%) from the year 2001 to 2010, and the corresponding rise for the 75+ age group will be 2.5 million to 4 million (an increase of 56%). By 2010 it is projected that the 65+ age group will consume 51.8% of patient-days in public hospitals, and by 2030, this figure will rise further to 69.1%, a challenge to the hospital services in Hong Kong.

THE SCOPE OF GERIATRIC MEDICINE AND EVIDENCE FOR ITS EFFECTIVENESS

14. Demographic trends and the age-distribution of illness make it unrealistic for one specialty—geriatric medicine—to look after all elderly people. What kind of elderly people, therefore, should geriatricians ideally manage? The best

definition of a geriatric patient is one who exhibits the features of 'biological ageing'. It is important to emphasise the term 'biological ageing', rather than 'chronological ageing', because not all patients age at the same rate. Biologically aged patients are characterised by frailty and complexity. Frailty is a failure to integrate responses in the face of stress, so that functions that require integration of higher brain processing, such as maintaining balance, walking, and intellect are more likely to fail when stressed by disease. This results in falls, immobility, confusion, or incontinence—the 'geriatric giants'.[9] The consequences of biological ageing are complex but the most important clinically relevant aspects are: atypical presentation of disease, multiple pathology, disabilities, and adverse social factors.

15. The response to the complex situation of the biologically aged ill person must be correspondingly complex. It is not sufficient to identify acute illnesses and deal with them medically in a narrowly defined sense. The essence of management in frailty is to embrace the complexity of the patients and their need for care. We have complex patients (ie those with multiple diseases, multiple needs, and a multifactorially determined state) in whom we apply a complex intervention (comprehensive geriatric assessment and multidisciplinary care) to achieve a variety of ends. Although these ends can be roughly summarised as lessening pain, improving function, and delaying death, they have many manifestations that also require a complex measurement tool (eg Goal Attainment Scale, Quality of Care from the patient's perspective). Knowledge of length of stay in hospital is insufficient.[9]
16. The essence of geriatric medicine as a specialty is to assess and treat the medical and rehabilitative needs of elderly people. Every ill person deserves a diagnosis. This is carried out through a process known as Comprehensive Geriatric Assessment (CGA). In simple terms, CGA is the process of knowing the frail elderly person: a multidimensional, often interdisciplinary, diagnostic process focused on determining a frail elderly person's medical, psychological, and functional capabilities in order to develop a coordinated and integrated plan for treatment and long-term follow-up.[10] When this is combined with a coordinated package of health and social care delivered by a multidisciplinary team led by a geriatrician, there is evidence that the outcome for elders with multiple pathologies and functional problems is improved in terms of: reduced risk of mortality, greater chance of cognitive improvement, greater chance of improvement in physical function, improved likelihood of living at home, and reduced rate of hospital readmission.[11,12]
17. The means by which CGA within acute hospital[13,14] and community[15,16] settings can meet the needs of an ageing population in Hong Kong has been discussed in policy meetings and open forums. Since CGA can meet both ends of gatekeeping (with appropriate resource utilisation and thus reduction of expenses from ineffective and inefficient care) and goal-keeping (meeting the needs of frail elders),[15,16] the HKGS proposes that the Government consider and endorse this evidence-based practice (CGA) as a policy in health care for elderly people.

HOSPITAL GERIATRIC CARE

18. The single organ–system approach, which characterises much of modern medical specialisation, has its limitations in the hospital care of biologically aged patients. In contrast with the younger adult, in whom the presenting problems can often be explained by one single disease (the dictum 'one patient, one disease'), in the biologically aged patient there are characteristically multiple causes for the presenting problems; and ageing, disease, and treatment interact with one another to modify the pattern of illness. Because of their complexity, geriatric problems are seldom amenable to a simple solution, and are often frustrating to those tuned to singular presentations capable of a single diagnosis. Pitfalls in diagnosis, investigation, and management are prone to occur in the absence of a geriatrics perspective and knowledge base.
19. Iatrogenesis and adverse drug reactions are common among acutely hospitalised elderly patients, with tremendous costs to them and the health care system.[17-20] It has been shown that CGA reduces serious adverse drug reactions while reducing suboptimal prescribing.[21] As studies have shown inappropriate medication and adverse drug reactions to be important

Table 1.
Hospital utilisation in Hospital Authority by frail elders (January 2003 to May 2004)

Target groups	Acute beds per day	Non-acute beds per day
Residents of care homes	880	184
Falls (aged 75+)	457	334
Stroke (aged 75+)	223	400
Delirium/dementia (aged 75+)	12	32

causes of hospital admission of elders,[19,22,23] CGA targeting at polypharmacy can be both goal-keeping in improving medical care of elders and gate-keeping in reducing iatrogenic hospitalisations.

20. Thus, geriatricians should focus their skills on biologically aged patients. The acute geriatric patient can be defined on a need-related basis as: acute presentation with confusion, poor mobility, falls or incontinence; long-standing confusion, poor mobility, falls or incontinence; presenting with specific conditions that require intensive rehabilitation (eg stroke); multiple pathologies and thus multiple medications; residents of residential care homes for the elderly (RCHE) [signifying a degree of physical and/or mental frailty]; and those previously under the care of a geriatric specialist.[24] Such patients consume significant hospital resources, and require a prolonged hospital stay because of their associated disabilities and need for rehabilitation. For example, of the 73 falls (in elders aged over 75 years) admitted daily to Hospital Authority hospitals, there were on average 17 hip fractures, five head injuries, and one subdural haematoma; they occupy 457 acute beds and 334 non-acute beds daily.
21. Whose responsibility? For the reasons mentioned above, the care of a geriatric patient will require a multidisciplinary team led by a geriatrician and involve not only doctors and nurses but also therapists and social workers, working closely together. In addition, there should be close coordination between hospital- and community-based resources.
22. Where to treat?

22.1 Designated acute geriatric wards and beds with progressive care to rehabilitative and long-term care.

22.1.1 The kind of organisation of services as described under paragraphs 16 and 21 is rarely found in acute medical or surgical wards where the emphasis is, understandably, on the management of acute illness based on single organ resuscitative treatments and single interventions. The integrated medicine and geriatrics model, as is practised in many local hospitals, cannot work properly without a supportive ward environment and multidisciplinary team. Pooled or scattered beds are not a solution because this will fragment the multidisciplinary team and undermine the close working relationships that are essential to the kind of care geriatric patients require.

22.1.2 A 6-month survey of hospital utilisation in the Hospital Authority in 2004 (**Table 1**) showed that an average of 1572 acute beds were occupied daily by frail elderly patients who qualified for a definition of acute geriatric patients (care home residents, strokes, falls, delirium, or dementia).[13,14] However, such patients are scattered between different wards, making CGA and intervention impossible.[13,14] In the United Kingdom, it was reported that 69% of the hospital patient population needed CGA and multidisciplinary intervention (the mean age was 65.3 years for acute wards, 73.5 in rehabilitation wards, and 80.8 in continuing care); but again it was impossible to directly provide such care to all the hospitalised elderly people because these patients and their needs were spread between so many wards.[25]

22.1.3 In a systematic review of 20 randomised controlled trials of the evidence for acute geriatric assessment—either care provided by mobile teams or care based on specialist geriatric wards—geriatric assessment wards were associated with significantly more patients who survived and returned to live in their own homes (four extra for every 100 patients treated; 95% confidence interval [CI], 1-6) compared with conventional care in general medical

Table 2.
Acute geriatric beds in 14 acute Hospital Authority hospitals as at July 2004

Cluster*	Hospital†	No. of designated acute geriatric beds	No. of designated acute geriatric wards
HKE	RHTSK	152	4
	PYNEH	6	0
HKW	QMH	0	0
KE	TKOH	10	0
	UCH	108	3
KW	PMH	12	0
	KWH	15	0
	CMC	0	0
	YCH	0	0
KC	QEH	16	0
NTW	TMH	34	1
NTE	PWH	0	0
	NDH	0	0
	ANHN	0	0
Total		353	8

* HKE denotes Hong Kong East, HKW Hong Kong West, KE Kowloon East, KW Kowloon West, KC Kowloon Central, NTW New Territories West, and NTE New Terrritories East

† RHTSK denotes Ruttonjee and Tang Shiu Kin Hospital, PYNEH Pamela Youde Nethersole Eastern Hospital, QMH Queen Mary Hospital, TKOH Tseung Kwan O Hospital, UCH United Christian Hospital, PMH Princess Margaret Hospital, KWH Kwong Wah Hospital, CMC Caritas Medical Centre, YCH Yan Chai Hospital, QEH Queen Elizabeth Hospital, TMH Tuen Mun Hospital, PWH Prince of Wales Hospital, NDH North District Hospital, and ANHN Alice Ho Miu Ling Nethersole Hospital

wards.[26] There was no evidence of benefit from geriatric assessment teams (no patients per 100; 95% CI, -4 to 5). The reasons for these differences are that, firstly, the delivery of daily nursing care differs between the type of wards. In specialist geriatric wards, nurses are trained and experienced in dealing with frailer older adults, but the general medical wards where roving teams operate are staffed by non-specialist nurses. Secondly, the coordination and delivery of recommendations made during CGA can readily be achieved in geriatric wards but not in general medical wards.

22.1.4 A survey in July 2004 of 14 acute hospitals in the Hospital Authority showed that there was a wide variation in the number of designated acute geriatric medical beds/wards available (Table 2).[13,14] Only two hospitals had adequate designated acute geriatric beds that allowed direct admission from A&E to geriatric wards. For the remaining 12 hospitals, ill elderly patients were admitted to medical wards with scattered, floating, or no geriatric beds.

22.1.5 Because the majority of frail elderly patients who require geriatric specialist care are spread between different general medical wards, there is no designated location for geriatric practice (multidisciplinary team, geriatric nursing, disability-free environment). This also hinders a timely response by geriatricians to meet their medical (early detection of diseases despite atypical presentations) and rehabilitative needs. Other specialty wards (eg infectious diseases wards) also find it difficult to manage frail elderly patients with multiple pathologies and disabilities. A revolving door phenomenon occurs because of premature discharge to homes/RCHE without appropriate support and lack of continuity of care. Inappropriate transfers to rehabilitation/convalescent settings also occur (too acute, no diagnostic workup, not benefiting from rehabilitation).

22.1.6 The inadequacy of acute geriatric ward/bed numbers will ultimately result in a greater cost burden to society, and include the long-term

care of an increasingly and unnecessarily dependent population.

22.2 Interface with A&E departments:

22.2.1 The benefit of CGA has been shown in A&E departments. Recent editorials[27,28] have drawn attention to the problems that occur in managing frail elders in A&E departments. The few studies that have evaluated CGA in A&E departments demonstrated reduced functional decline, enhanced function, and reduced admission and also use of care homes, with no increased cost.[29,30] Studies of patients who presented to an A&E department with a history of falling, also highlighted the importance of CGA because it resulted in reduced serious injury and subsequent reduced bed-day utilisation.[31-33]

22.2.2 A local survey revealed that 91% of aged 75+ individuals with a history of falls, stroke, delirium and RCHE residents were admitted to hospital via A&E compared with the overall average of 49% in-patient admissions. Specialist geriatric involvement in an A&E department enables early identification of reversible causes of ill health or functional loss. It ensures that those who require acute hospitalisation are admitted and those who would not benefit can be sent home with additional support if required. The diagnostic and therapeutic processes can continue once the patient has seen a geriatric specialist in the A&E department.

22.3 Interface with other hospital specialties: geriatric patients present to many wards, not just medical: a successful geriatric service should be able to reach all such patients (orthopaedics,[34] surgical, neurosurgical, gynaecological, psychogeriatrics) to provide a problem-focused (rather than solely organ-focused) service (eg falls and fracture service, memory service, stroke service), to improve diagnostic accuracy and needs assessment, to reduce polypharmacy and avoid iatrogenesis, and to ensure smooth discharge.

COMMUNITY GERIATRIC CARE

23. The Discussion Paper fails to recognise the extent of the role of a geriatrician in community geriatric care. Their role is not restricted to "discharge planning" and "providing support to doctors of Residential Care Homes for the Elderly" (§7.10).[1]

24. In a local opinion survey[35] of geriatric specialists (58/139 responded) and primary care doctors (113/265 responded) with a special interest in elderly care, 64% of geriatric specialists disagreed that they should focus only on hospital work. A significant proportion (19%) of geriatric specialists also disagreed that Community Geriatric Assessment Teams (CGATs) should concentrate on discharge planning and support of visiting medical officers (VMOs).

25. The geriatric specialist has the knowledge and skills needed to provide specialist medical care to elderly individuals in both hospital and community settings, as well as to provide advice, education, and training to those who plan, commission, evaluate, or provide health services to them.

26. With increasing numbers of frail elderly individuals managed in the community, Challis[36] has warned that an emerging geriatric giant is "informal care." Proper preparedness[37] is a vital component of community care support to ensure that 'informal care' is not replaced by another 'new' geriatric giant, 'inadequate care' or elder abuse. Geriatricians therefore need to work in partnership with general practitioners, social services, non-government organisations and private care providers to provide a geriatric care consortium.

27. The community activities of geriatricians can range from geriatric day hospital (GDH) to assessment of patients at home, in RCHEs, or in primary care settings. The clinical services they provide in the community may include:

27.1 provision of direct specialist medical care, especially targeting frail elders with multiple pathologies and complex problems, whether they live at home or in RCHEs. Local studies have shown that 40 to 50% of RCHE residents are frail, with multiple diagnoses, prescribed polypharmacy, with high dependency levels, and high hospital utilisation rates. All these factors emphasise a need for geriatric specialist support.[13,14,38] Further local studies have shown that CGATs help maintain such frail residents of RCHEs within the community and reduce hospital utilisation.[15,16,39] Stroke patients are the major users of GDH: on discharge they have been shown to have improved physical

function in terms of self-care, mobility, and ability to live at home.[13,14,40]

27.2 giving advice about primary health care through clinical liaison with outreach clinics or RCHEs. In a local opinion survey,[35] medical care at RCHEs was considered a mixture of primary and secondary care (because of the frailty of the residents as explained under 27.1); thus geriatric specialist advice is essential.

27.3 working with a community-based or outreach multidisciplinary team to support domiciliary rehabilitation and frail elders living at home. Most elders prefer to live at home rather than in an institution. While it is reassuring that the total proportion of elders living with their children has remained stable (56.8% in 2001, 57.2% in 1991[41]) the Government should assume a proactive role to ensure that this situation can continue, for example providing mass education, tax incentives, alternative housing, and legal safeguards. Adequate provision of community resources should also be made to enable disabled elders to continue living at home.

27.4 Geriatric specialist assessment prior to entry to RCHE or other community care packages:

27.4.1 It must be emphasised that residential care is costly to the individual elder, his/her family, and society in both financial and humanistic terms. Most elders prefer living at home to living in an institution.

27.4.2 Research has revealed a high prevalence of undiagnosed medical conditions among elderly people prior to entry to care homes: change in status and complaints of an elder that need medical treatment are not entered into a careful diagnostic approach but are falsely attributed to ageing or social problems and responded to with social measures, such as referral for institutional care.

27.4.3 There is strong evidence that multidisciplinary assessment involving a geriatrician identifies unmet medical needs and results in consequent altered decisions about appropriate residential care[42,43] or future long-term care in hospitals.[44,45] Such pre-admission assessments can identify treatable, previously undiagnosed conditions, improve physical function, and thus alleviate the need for care home placement and reduce total health and social cost. Involvement of a geriatrician thus benefits the individual patient and helps preserve effective and equitable use of expensive community care resources.

27.4.4 One useful index of the state of health of an elderly population is the proportion who live in an institution—the institutional rate. In Hong Kong, the proportion of elders aged 65+ who live in an institution rather than a domestic household increased from 6.2% in 1991 to 9.1% in 2001[41]; the proportion institutionalised in care homes rose from 6.0% in 2000 to 6.7% in 2004 (**Figure 2**).[15,16] These local institutional rates are high compared with those of other developed countries with high life expectancies (overall: 5-10%; care homes: 0.5-6.5%; nursing homes: 2-5%).[46,47] Timely introduction of geriatric specialist assessment prior to care home entry locally, as well as the provision of geriatric support to those elders who prefer to live at home despite disabilities, are important. These measures will help stop this rising institutional rate that has important implications for quality and costs of elderly health care.

27.5 Giving advice about services: following a number of Government initiatives and funding for alternatives to hospital or residential care, many different community projects are being developed. These include enhanced home and community care, integrated home care, and non-hospital infirmary care. Many of these projects depend on multidisciplinary clinical guidelines. Geriatricians should be involved locally in the development, implementation, and audit of these guidelines.

28. Further issues on RCHEs: in addition to the points raised under 22.1.2, 27.1, 27.2, and 27.4 above concerning the roles of geriatric specialists and CGATs, there are further issues of concern in relation to residential care:

28.1 Quality of RCHEs: the quality of RCHEs in Hong Kong, especially those in the private sector, varies considerably in the provision of residential personal and nursing care. While the recently revised Code of Practice for Residential Care Homes has resulted in welcome improvements, there remains a need for regular, committed monitoring of compliance with these regulations. Geriatricians and gerontologists can further enhance

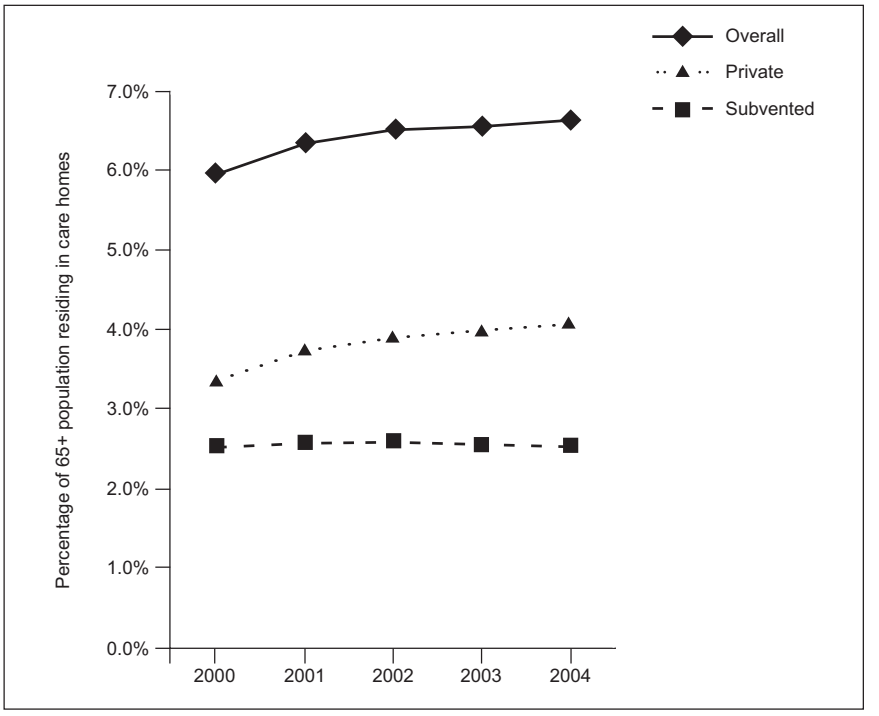

Figure 2. Rising institutional rate of elderly population (65+) in Hong Kong

the quality of RCHEs through accreditation schemes.[48]

28.2 VMO service

28.2.1 In a recent local opinion survey,[35] almost all respondents agreed that VMOs should attend to the basic medical needs of RCHEs on a regular basis. 95.3% of respondents agreed that the Code of Practice for RCHEs should be revised to ensure a doctor reviews and manages residents' medical needs on a regular basis (instead of the present minimal input of a licensed VMO to undertake annual medical examinations).

28.2.2 73.1% of respondents were willing to spend time looking after the medical needs of RCHEs on a regular basis, and 74.7% of them could devote over 1 to 2 hours per week to achieve this. Nonetheless only 15.3% of respondents were willing to provide 24-hour medical support. This was particularly difficult for private practitioners in solo practice.[35]

28.2.3 While 97.3% of primary care doctors considered that they could act as gatekeepers, a substantial number (43.2%) of geriatricians disagreed.[35] They had strong reservations as to whether it is feasible to employ private primary care doctors to provide 24-hour support to RCHEs and to act as 'gatekeepers' for A&E department attendances and hospital admissions. This was based on recent experience of the Hospital Authority's VMO project in 2003/4 and evidence from the evaluation reports submitted to the Geriatrics Subcommittee in 2004.[49]

28.2.4 In the local opinion survey,[35] the elements that would ensure the success of VMOs as gatekeepers in RCHEs, in order of decreasing importance, were time and frequency of visits by VMOs to RCHEs; financial return from RCHE visits; experience of having worked with CGATs; and possession of postgraduate diplomas such as the Postgraduate Diploma in Community Geriatrics (PDCG) or the Diploma in Geriatric Medicine (DGM).

28.2.5 When asked what would be considered reasonable financial return, 84.7% of respondents considered this to be HK$500 to 1500 per hour (the current Hospital Authority's remuneration package is HK$300 to 500 per hour).[35]

28.2.6 While the Discussion Paper's proposal for RCHEs to employ medical personnel is good in theory, financial considerations would limit its practice. Even with the resources available to the current subvented homes, it is impossible for them to appoint resident VMOs unless new resources are allocated for long-term care.

28.3 Gate-keeping versus goal-keeping: instead of just focusing on gate-keeping, high quality and responsive health care for residents must be a common goal. This should be achieved through effective partnership between a range of disciplines, professions, and departments.[15,16] Continuity of care and quality assurance in RCHEs require collaborative development, implementation, and adherence to multidisciplinary guidelines and protocols agreed by all relevant parties, as well as valid quality outcome indicators for benchmarking. Vested interests are detrimental to such development.

MANPOWER AND TRAINING ISSUES

29. The major reason for teaching geriatric medicine is not simply the increase in numbers of old people, but rather the increase in knowledge about old people, and the need for special attitudes and organisational skills. Although the medical faculties of both universities in Hong Kong now include geriatric medicine in their undergraduate curriculum, the knowledge and skills taught to medical students are inadequate to equip doctors who are confronted with a growing elderly population, and do not fulfil the need to keep up with the growing knowledge base in geriatric medicine. This has become more pressing with the increasing emphasis on community care and the involvement of general practitioners and family doctors in the care of elderly people. It is with this in mind that the HKGS, together with the University of Hong Kong, commenced the PDCG programme in 2000. It aimed to further the knowledge and skills of general practitioners in geriatric medicine.[50] The HKGS also facilitated the establishment of the first overseas centre for the DGM (Glasgow) examination in Hong Kong in June 2005.
30. While recent attempts have been made to enhance the knowledge of general practitioners about the primary care of elders via formal and informal training programmes, there remains a pressing need to enhance the training of family medicine trainees in the module of geriatric medicine to meet the population challenge. The current regulations of the DGM (Glasgow) of the Royal College of Physicians and Surgeons of Glasgow stipulate that to qualify for the examination, candidates should have completed a minimum of 4-month full-time training (or part-time equivalent) in a department of geriatric medicine.
31. As the population grows and demands on emergency and in-hospital services and community care grow, so too does the need for geriatric specialists. The Royal College of Physicians (RCP) and the British Geriatrics Society recommend a minimum requirement for any district of one whole-time-equivalent consultant dedicated to geriatric medicine per 4000 elderly over 75 years.[51] If geriatric departments take on more responsibilities for 'all-ages' acute admissions, assessing patients or providing continuing care for patients within community institutions, considerable extra manpower will be required. A survey within the Hospital Authority in 2004 showed that there were 54 full-time equivalent (FTE) geriatric specialists in that year, a deficit of 31 FTEs if one considers the requirement of 85 FTEs when the RCP recommended ratio[51] is applied to the local 75+ population. The same survey of managers of geriatric services gave a projected overall need for 96 FTEs of geriatric specialists by 2006, close to that estimated from the RCP ratio (94 FTEs). Nonetheless the number of doctors or fellows entering geriatric medicine has declined from 2001 to 2004 (**Figure 3**); it is likely that this deficit will widen if remedial action is not taken.[14]
32. In 1990, the HKGS began to offer certificate courses in geriatrics for nurses. In addition, since 1994, the HKGS has been collaborating with the Institute of Advanced Nursing Studies of the Hospital Authority to conduct the 'Post-registration Certificate Course in Gerontological Nursing'. Nonetheless, there is increasing concern about the lack of acute geriatric wards that can facilitate geriatric nurse/nurse specialist training.
33. Since 2003, the HKGS has advised and monitored the standard of the 'Skills Upgrading Scheme for Health Care Workers' in elderly care sectors, organised by the Education and Manpower Bureau of the Hong Kong SAR Government. It has been observed that recruitment of appropriate workers to the upgrading scheme is strongly influenced by the prevailing economic status in Hong Kong; the elderly health care industry is not regarded as a particularly attractive field of work.

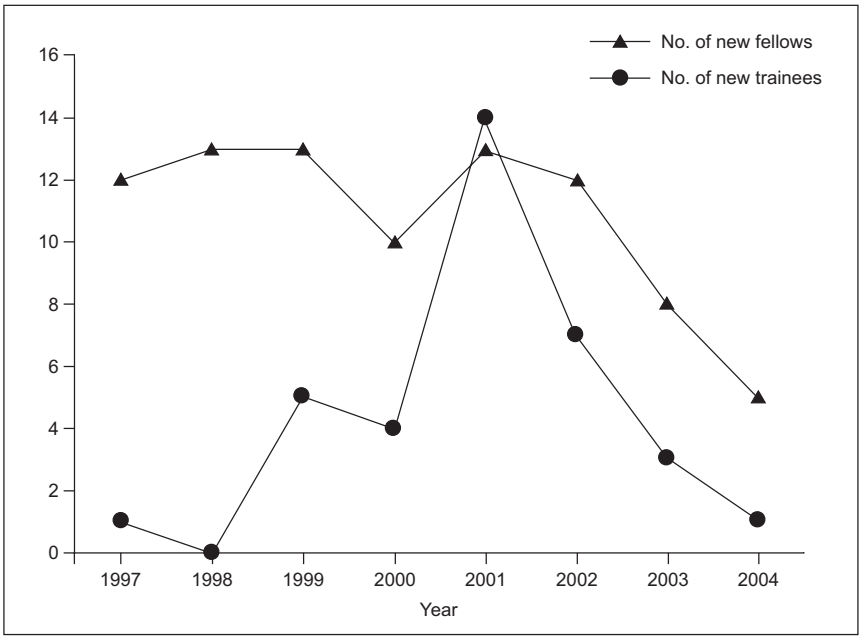

Figure 3. New fellows and trainees in Geriatric Medicine, 1997-2004
Data source: Specialty Board in Geriatric Medicine, Hong Kong College of Physicians

CONCLUSION AND THE WAY FORWARD

34. The proposed care model in the Discussion Paper does not adequately serve the health care needs of elders.
35. The HKGS proposes that geriatric medical care should be explicitly considered in the context of hospital care and community geriatric care.
36. The HKGS suggests that consideration be made to facilitate geriatricians to contribute substantially to future hospital and community care of elderly people.
37. The HKGS is ready to contribute to the planning for the future health care of elderly people and would be happy to see the establishment of a communication channel with the Health, Welfare and Food Bureau for future continuous consultation and dialogue. In this connection, we suggest the establishment of a special task group or working group under the Health and Medical Development Advisory Committee who can further develop the Government's future blueprint on health care.
38. Inadequacies of acute care and rehabilitation services cause inefficient and expensive care. Making progress will need action in many areas. The Government must be committed to preventive and remedial care of elderly people.
39. Implementation of the proposed acute geriatric care model would be initially cost-neutral by striking a balance between the geriatric commitments and non-geriatric commitments of geriatricians. There is potential to reduce expenditure by facilitating optimum use of hospital resources; improving movement of patients between acute, rehabilitative, and long-stay facilities; reducing iatrogenesis and problems associated with polypharmacy; reducing disability; and reducing institutionalisation.
40 Predictors of admission to RCHEs are overwhelmingly health-related (including undiagnosed medical conditions), not social. No individual elderly person should enter institutional care without having first undergone a CGA, supported by appropriate multidisciplinary treatment and rehabilitation.[52] By optimising an individual's health and functional capacity, need for future expensive hospital and long-term care services can be minimised. Timely introduction of geriatric specialist assessment prior to care home entry is particularly important in Hong Kong because of the high institutional rate (that has been rising for the last decade) compared with other developed countries with high life expectancies.
41. Elderly people admitted to RCHEs often have multiple chronic illnesses and complex medical problems. Management of these extremely vulnerable individuals with 'geriatric' syndromes

such as dementia, falls, incontinence, malnutrition, and iatrogenesis, etc requires the specialist input of geriatricians in partnership with primary care doctors, nursing and allied health professionals. Augmentation of the current partnership and support from CGATs led by geriatric specialists are required if these needs are to be met.

42. We will need extra geriatricians but numbers will not significantly increase in the years to come. We do need to maximise the 'division of labour', including primary care doctors with the appropriate experience, competency and commitment; psychogeriatricians; geriatric nurse specialists; and hopefully an increasing number of therapists in providing comprehensive services.
43. Pertinent questions about health care financing have to be solved in order to bring about reform and ensure sustainability, affordability, accessibility, and quality health care for elderly people. The majority of the present generation of low income and under-privileged elderly people in Hong Kong will continue to rely on social security or the goodwill of their children to subsidise health care services. Workable health care financing models for the 'to-be' old, especially the baby-boomers, have to be explored to meet the future escalating health needs of the elders.
44. The Government should assume a proactive role to rekindle the Chinese virtue of filial piety: children living with and supporting their elderly patients, a cultural expectation embedded in the Chinese character for 'longevity', that symbolises the younger generation offering their produce and paying tributes to the older generation, an indication of intergenerational harmony rather than tension. Only then will longevity be treasured or celebrated, rather than feared or viewed negatively as a burden. The Government should take the lead to uproot the ageism that is prevalent within society and the health care system.

These are some of the issues that must be confronted if we are to improve our present medical care of biologically aged patients and successfully negotiate the impending demographic changes. Or else, more and more patients might be hived off into residential care homes, nursing homes or infirmaries where they will spend their days in precisely the way that Marjory Warren in the 1940s found patients in the chronic sick wards and which stimulated her to advocate the development of the specialty of geriatric medicine.

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